

**DUBLIN BUSINESS SCHOOL**

**THE EXPLORATION OF POSTNATAL DEPRESSION THROUGH  
PSYCHODYNAMIC AND FEMINIST PERSPECTIVES**

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## **ABSTRACT**

*Transition to motherhood including the pregnancy and post-partum period can be a very exciting, as well as challenging and overwhelming, time for many women, resulting in postnatal depression (“PND”). This research presents an exploration of PND through psychodynamic and feminist perspectives. Feminists argue that motherhood is a patriarchal institution that sets unrealistically high expectations for mothers and the societal myth of motherhood as a “happy time” often leaves new mothers feeling depressed if they fail to achieve it. On the other hand, the psychodynamic perspective helps to understand the potential cause of PND which is rooted in the infant-mother relationship and determines the formation of the personality. Two prevailing models to explain PND - medical and social - are discussed, and a brief outline of “holding” in therapeutic encounters from the psychodynamic perspective.*

## INTRODUCTION

This paper will explore postnatal depression in women through the lens of both the psychodynamic perspective and the feminist perspective. The notable role of feminist theories and qualitative research methodology has brought to light the contrast between scientific and social paradigms, which will be discussed, and it describes two currently opposing models - medical and social - in explaining postnatal depression. The feminist critique focuses on the social and cultural distortion of the role of motherhood, including the negative effects of social media on new mothers, and defective bonding to infants. The psychodynamic perspective will highlight the importance of the mother-infant relationship as a foundation of object relations theory and the importance of the “holding” environment during the therapeutic encounter. The feminist critique of concepts and theories which surround motherhood will pay particular attention to the anger and the loss for the woman in the postpartum period.

Chapter 1 of this paper will critically discuss the role of motherhood within the current social framework from the perspective of four contemporary psychoanalysts and feminists- Paula Nicolson, Estela V. Welldon, Susie Orbach and Holli Rubin. Motherhood still remains a central role in women’s lives; however, there are high social expectations placed on new mothers and on their way of mothering. The societal myth of motherhood as a happy time often leaves new mothers in shock if they fail to achieve it, and reality often is different, and it brings huge disappointment. Women are supposed to carry out this difficult and responsible role and are often emotionally unprepared. New mothers face contradictory messages from social media about the importance of having a perfect body soon after childbirth, which impact women’s relationships with their bodies, creates confusion and anxiety and, as a result, it can affect bonding with the new-born. Preoccupation with body image issues may disrupt bonding with the infant and the ability to provide the development of a secure attachment. Two competing models - social and medical - currently explain the aetiology of postnatal depression; however,

there is no definite answer in the current research literature as to what causes it. Medicalisation has been criticised for creating labels which pathologizes women's feelings and the uniqueness of each woman's life story. However, it is of utmost importance to choose appropriate treatment for postnatal depression, as it can negatively affect the mother and the new-born.

Chapter 2 will examine the psychodynamic approach to exploring the root causes of postnatal depression, firstly focusing on Weldon's (2004) psychoanalytical concept of "female perversion" from the object relations framework. Perversion of motherhood is the result of infantile abuse and neglect which is passed through generations and emphasises the crucial role of the mother's and daughter's relationship in the development of psychopathological behaviours. It will look at Klein's (1935) object relations approach, which will explain how the mother-infant relationship determines the formation of the personality through the "paranoid-schizoid" and "depressive" stages of development. Bion's (1963) term, "containment", describes the mother's capacity to perceive and process projections from the infant. However, if the "containment" is leaky, it will affect the emotional development of the infant. It will continue with a description of Blum's (2007) emotional conflicts, which are typical for many women who develop postnatal depression. "Dependency conflict" is the new mother's wish to be taken care of which conflict with feelings of embarrassment and envy towards the infant. The "anger conflict" includes feelings of guilt as she thinks it might not be acceptable for her to feel that way. Winnicott (1945) also emphasised the relationship with the mother where she "holds" the infant that way providing "good enough" mothering and environment for the infant's development. The "holding" metaphor is used in therapy where the therapist becomes a symbolic mother and the patient can rework early trauma by becoming a baby again. This is used especially when dealing with postpartum women who were always missing their mother's approval and support, and they can finally find an emotional support in therapy.

Chapter 3 will critically discuss postnatal depression from the feminist perspective, which claims that motherhood is based on a patriarchal institution, that is oppressive to women and sets unrealistically high expectations and rules for women. Patriarchy is established upon the symbolic power of the “phallus”, which is Freud’s psychoanalytic concept, and it has dominated the world of philosophy. Furthermore, Bowlby’s theory of “secure attachment” as a base for healthy infant development has been acknowledged as a norm in our society, regardless of the mother’s own needs and conditions. The theory of “schizophrenogenic mother” by Laing (1961) has overlooked the fact that mothers themselves have had traumatic experiences in childhood and, consequently, it can be argued that mothers who are victims of adverse circumstances in their upbringing are procreating more victims. Additionally, feminists question the term “maternal instinct”, arguing that being a mother is not an instinctive role. Also, the “good/bad” mother myth creates tremendous pressure and unattainable standards for women. Discussion about feelings of anger and loss specifically focuses on these emotions of women suffering from postnatal depression. Nicolson (1998) states that anger is not a socially acceptable emotion, as it contradicts the concept of motherhood and femininity and, as a result, postnatal depression is pathologized. Another crucial theme for postpartum women is the feeling of loss, which also conflicts with the commonly accepted idea of the transition to motherhood. Nicolson (1998) argues that when a woman becomes a mother, she goes through a series of losses which are the result of individual life experience and is very subjective. Our society prevents women from mourning their losses and, instead, it is pathologized, and perceived and treated as depression.

## **CHAPTER 1: SOCIETY AND MOTHERHOOD**

The transition to motherhood can be a very challenging time, although potentially enjoyable, and most women aspire to achieve this role. However, many women fail to make this transition smoothly (Nicolson, 1998, p. 2). Welldon's (2004, p. 18) viewpoint is that motherhood should not be idealised or denigrated anymore in our society as it embodies extremes of pleasure and hard work. Society has glorified motherhood this way, rejecting the idea that motherhood could have any negative aspects. Women are expected to execute the demanding and highly responsible role of motherhood and bring up healthy and strong children, often without much emotional preparation. However, this process depends on the mother's emotional stability and maturity. Unfortunately, in the current social climate, it is expected that "maternal instincts" will function without fail (Welldon, 2004, p. 18).

Orbach and Rubin (2014) emphasise body image distress and disturbances in eating that make women feel anxious about their bodies and have an impact on women during pregnancy and post-partum. As a result, it affects bonding with the baby and the establishment of attachment behaviours. The first few months are crucial in creating the connection between mother and infant, and providing security and resilience for the new-born. To become "an ordinary devoted mother" (Winnicott, 1960) in current times is not a natural process, and can be filled with anxiety and pressure due to women's relationships with their bodies; this is all the more so, given the messages conveyed from social media placing huge attention on the restoration of the pre-pregnant body (Orbach & Rubin, 2014).

Social media adverts, including celebrity mothers who attain skinny bodies soon after delivery, are diverting attention from the most important period post-partum, when the infant and mother are bonding and getting to know each other. In our culture, a new mother is expected to appear as if nothing has happened to her physically and to despise the changes in the body

after such a significant life event as the birth of a baby. Furthermore, the cultural pressure of having a perfect body might cause worry and anxiety in women when their body begins to change during pregnancy. Women may feel miserable about their looks and unable to feel excitement about their pregnancy, and this can contribute to a sense of confusion and guilt. Society and media send contradictory messages to pregnant women by encouraging them to diet and stay slim through certain foods and harsh exercise regimes in order to lose weight faster after a baby is born, while also urging women to indulge themselves while pregnant - and this is causing considerable confusion (Orbach & Rubin, 2014).

For some women, motherhood escalates their previous problems to a level where they cannot cope anymore. Some women achieve fulfilment and happiness. However, unconscious, long-buried pain may resurface, which can cause feelings of despair, hopelessness and inadequacy and can easily transform into hatred and revenge towards the new-born (Welldon, 2004, p. 25). All infants are attachment seeking, and a secure attachment style is known to be a bedrock of resilience and psychological safety. However, many factors can interfere in the mother's capability to provide a secure attachment. Insecure attachment with the infant may develop if the woman has experienced a disrupted attachment coming from parental neglect, separation or abandonment. Moreover, unconscious worries about her body image and eating habits may further disrupt bonding with the baby. A mother's own attachment history coming from her own parenting experience and cultural background establishes the attachment style with her new-born (Orbach & Rubin, 2014).

### **Medical and Social Approach to Postnatal Depression**

Mauthner (2016) argues that postnatal depression ("PND") is mostly a social problem and less medical. Research on PND has been done mostly from a medical and clinical viewpoint, where the medical model has been dominant and has minimised the importance of

women's emotions. It has created labels as "postnatal depression" and has pathologized women's feelings as an "illness" (Mauthner, 2016).

Nicolson (1998, p. 27) states that current research literature defines postpartum disorder as "maternity blues", PND or as a psychiatric disorder- "postnatal psychosis". Numerous studies have been published on PND; however, there is no consensus on its occurrence. There are two competing models currently which explain PND – medical and social science models (Nicolson, 1998, p. 27). Research from a medical perspective shows evidence of dysregulation of hypothalamic-pituitary-adrenal axis activity, hormonal imbalance, genetics and epigenetics playing a part in the development of PND (Meltzer-Brody, 2011). On the other hand, when considering biological reasons, not all women experience PND (Nicolson, 1998.p. 27). The psychosocial model highlights the lack of social support, marriage problems, a history of depression and pregnancy and delivery difficulties (Hagen, 1996). While this is the case, it fails to evaluate the meaning of every event in a woman's life and the potential differences in the experience of becoming a mother. Each woman is entirely different and unique, and each one bears her own distinct model to explain her emotions after childbirth (Nicolson, 1998.p. 34).

Research shows that treatment of PND has been a rather controversial subject, choosing between two - pharmacological and nonpharmacological - treatments. However, if left unattended, it can lead to difficulties in postnatal care, worsening of PND, substance abuse, self-medication, defective bonding with infant, and the danger of foetal exposure to the effects of PND itself. If choosing pharmacological treatment, there is an increased risk of exposing the infant to the effects of antidepressant medication through breastfeeding, which can also affect the infant's development. It is crucial to recognize the risks when using antidepressants, and the problem in accessibility and affordability of nonpharmacological treatments of PND (Misri & Kendrick, 2007). There are a variety of studies examining the efficacy of psychotherapy (as a nonpharmacological treatment) for treating PND with positive results.

Treatments include cognitive-behavioural therapy, group psychotherapy, nondirective counselling, interpersonal psychotherapy and dynamic psychotherapy (Likierman, 2003). Nonetheless, currently, it is particularly challenging for clinicians to recommend an appropriate choice of treatment in the perinatal period (Misri & Kendrick, 2007).

## **CHAPTER 2: A PSYCHODYNAMIC CONCEPTUALIZATION OF POSTNATAL DEPRESSION**

Estella Welldon (2004) has made a substantial new contribution to the psychoanalytic study of the overlooked area of female perversion from the object relations framework, emphasising that the core of it is the perversion of motherhood. It is important to note that there is a significant difference between the psychoanalytical and ordinary use of the term “perversion”. Through the examination of women’s psychopathology, Welldon (2004, p. 11) discovered that perversion originates from continuous infantile abuse and neglect. Common types of perversion for women include self-mutilation and child abuse, which is the result of her own mothering, as she represents her own mother’s extension. The new mother will direct her infantile fear and incapacity into hatred and violence towards her child.

Welldon (2004.p. 22) explains that the perverse woman experiences herself as a part object of her mother, who has not experienced the freedom of being herself as a separate, whole individual. She has been either overprotected or neglected, and she never felt safe around her mother. This caused her to become insecure and vulnerable, leaving her with feelings of hatred towards her mother. As a result, she adapts the role of a victim, and later in life she becomes a victimiser towards a weaker person - her child - just the same way as she was treated herself. Welldon (2004, p.22) describes this unconscious mechanism as acting out the deranged defence against the daunting fear of losing sense of self and the mother.

According to Welldon (2004, p.16), it is not possible to achieve a total understanding of a psychopathological relationship between mother and infant without taking into account the mother’s and grandmother’s early life events. A three-generational approach, at least, is necessary, including social and cultural phenomena, to gain a better understanding of motherhood and the psychopathological behaviour forming between the mother and child.

Piontelli (1992) has conducted an observational and psychoanalytic study where she researched foetal behaviour with the help of ultrasound monitoring, and then observed the development of infants over the next few years. Piontelli (1992) discovered that each foetus is unique and that there is a connection between the mother's physical and emotional state and the intra-uterine world.

Klein (as cited by McLeod, 2013, p. 92) was the leading psychoanalyst who developed an object relations approach, which emphasises the significance of the relationship between self and other, where the earliest unconscious exchanges between infant and human object - mother determine the formation of the personality and self-concept later in life (McLeod, 2013, p.92). For the infant, the mother is represented as a "part-object" of the breast and is either a "good object" or a "bad object" (Klein, 1935). This stage is described by Klein (1935) as the "paranoid-schizoid" position. Later, however, the infant begins to perceive the mother as a whole object and to understand that good and bad can exist side by side in one person. At this point, the stage of the splitting begins to resolve. The next phase of development is characterised by a "depressive" reaction, when the infant realises that his or her mother is not split, but incorporates the good and bad parts together (Klein, 1935). This stage can be accompanied by feelings of anger and disappointment when the infant realises that the mother can encompass good and bad too. There might be a primordial sense of separation and loss, since the possibility of merging with the "good" mother have been lost, and there is a sense of guilt that it was the infant himself or herself who caused the end of the first and simplest stage of the relationship with the mother. One of the central dysfunctional patterns of the relationship with "objects" for humans is *splitting*, which can be traced back to the first month of a new-born's life, and is attributed to defending against complicated feelings and impulses. The assumption is that emotional experiences and resolution of each developmental stage in those early months are the foundation of the emotional inner world in adulthood (McLeod, 2013.p.93).

Bion (1963) was Klein's disciple, and became known for his contribution to psychoanalysis with the theory of "containment" or "container and contained", which explains a mother's capacity to hold the overwhelming projections from her baby, process them and return the experience to the infant in a transformed and acceptable form. The infant can become easily distressed by his or her experience due to lack of internal controls. With the help of the containing function, the mother helps the infant learn to self-regulate (Wadell, 2005.p.35). Traumatic childbirth, depression or lack of external support might be the reason for the mother's incapability to respond emotionally to the infant's communications. If she is responding in an inconsistent manner, it will confuse and puzzle the baby. This emotional absence is experienced by the infant as a "leaky" containment and, in an attempt to hold himself or herself together, he or she will use different tactics to be able to tolerate temporary absence (Wadell, 2005.p.47). A baby may feel that he or she is falling apart and lacking a "psychic" or "second" skin to hold his or her emotional state together. The infant creates psychic defences to survive extreme pain and anxiety (Wadell, 2005.p.47).

Additionally, Blum (2007) describes "dependency conflict" - a new mother's wish to be taken care of in order to be able to care for a baby - as this is the time when she feels deprived and she must struggle through her own emotional reactions to deal with the infant's needs and demands. These wishes, however, may become embarrassing and conflictual, stirring up feelings of envy toward the new-born's advantageous position. Women who want to prove they can carry all duties and responsibilities with no help may be particularly vulnerable to PND (Blum, 2007). Another essential point Blum (2007) elucidates is that many women with PND struggle to handle their anger. They might feel they have no right to be angry and feel guilty or afraid to express anger; however, they might have plenty of reasons to be angry. As a result, this anger might be displaced to the new-born, who is demanding all her attention and seemingly constricts the mother from her sleep and other comforts. If the new mother is not able to

recognise and tolerate these angry feelings, she might develop obsessive thoughts of harming the baby. Tolerating feelings of anger, accepting them and verbalising them is a challenging and vital task for the new mother.

Winnicott (as cited in McLeod, 2013.p.101) was another psychoanalyst who worked within this tradition and who emphasised the relationship with the mother as a central developmental factor for the infant. He postulated that “there is no such thing as the baby”, meaning that the infant cannot exist alone but is a fundamental part of the relationship with the mother (McLeod, 2013.p.93). Winnicott (as cited in McLeod, 2013.p.101) also discussed the importance of “holding” the unintegrated infant and “good enough” mothering to ensure the child’s effective development. Winnicott (1969) also coined the term “transitional object”. While observing infants, he noted that babies get attached to favourite possessions (blankets, teddy bears), which represent emotional security. In the case of losing it, the child displays a grief reaction. Winnicott (1969) recognised that this object replaces the security of the mother’s breast and serves the purpose of a defence against anxiety while away from the mother (McLeod, 2013, p.420).

### **Holding in Therapy**

If a therapist has the ability to become a symbolic mother, the chances of reworking early trauma are tremendously increased. The patient can become a baby again, but with a more perceptive mother. Winnicott’s psychoanalytic process resembles a symbolic maternal repair, which in current times is called relational trauma. The “holding” metaphor has the clinical value of an emphatic response that meets the patient’s need for emotional connection (Slochower, 2013). Holding involves a variety of therapeutic functions. It can help the patient to face and elaborate painful feelings like anger, self-loathing and longing. It can help to downregulate by moving away from an overwhelming emotional state, which also involves Bion’s (1963)

container function whereby the therapist absorbs toxic emotional states, transforms them and then reintroduces them back to the patient. Holding creates an efficient buffer against intense shame states. When the therapist holds, it means receiving, but not altering (Slochower, 2013).

When working with a postpartum woman, a therapist adapts the role of Winnicott's (1953) "good-enough mother" who cares for the infant's emotional and physical needs, building the foundation in the "holding environment". Therapy must be a sanctuary of unconditional acceptance and patience for the client. Anxiety is prevalent in the majority of postpartum women, and they feel as distraught as infants with no security. Some women will never stop yearning for a mother's support and approval, and women in postpartum crisis search for this approval in therapy (Kleiman, 2009.p.23). To support this idea, Menos and Wilson (1998) explored PND with the help of psychoanalytic concepts. They concluded that PND correlated with regressive tendencies in emotional development and expression. This shows the importance of the mother's/therapist's capacity to accommodate the emotional needs of the infant/client in order to reduce anxiety and develop healthy individuality.

### **CHAPTER 3: A FEMINIST CRITIQUE OF POSTNATAL DEPRESSION AND MOTHERHOOD**

O'Reilly (2010), drawing on the feminist writer Rich's (1976) work, claims that the term "motherhood" is based on the patriarchal structure. It is governed by male control and is potentially oppressive to women by setting up societal expectations and rules about how the woman is performing in her role as a mother. Nicolson (1998, p. 100) stresses that women's bodies are generally seen through the patriarchal lens as the "*other*". If childbirth, according to the medical perspective, is perceived as a scientific process, it is not a surprise that women are expected to be overjoyed and grateful for giving birth to a healthy baby. In the same way, Weldon (2004, p. 2) critiques Freud, who regarded female sexuality as the "riddle". In addition, Freud was asking his female colleagues to educate him about women's sexuality, since he thought they were in a position to practice as "mother-substitutes" with their patients; however, they were not supposed to put forward new theories. In psychoanalytic terms, the "penis" is posited as an anatomical reality. On the other hand, the "phallus" is considered as an all-embracing symbol of power; this is how domineering men were in the world of philosophy and ideas (Weldon, 2004, p. 3).

The widespread opinion of the correct way of mothering includes Bowlby's (1951) assertion that a mother's love for an infant is, above all else, a fundamental necessity for the infant's well-being. This love must be ever available and offered without question, regardless of the mother's personal needs and conditions (Nicolson, 1998, p. 10). Bowlby's theory of the "secure base" as an optimal element for infant development has remained as a moral and psychological prescription for psychic health. On the contrary, Hrdy (1999) argues that in some cultures, there were commonly accepted periods of insensitivity and disinterest among mothers while recovering from the physical and mental strains of delivery.

Theories like those of the “schizophrenogenic mother” by Laing (1961), or the “double bind mother” by Bateson (1956), postulate that these mothers transmit contradictory messages to their children, thus creating confusion in their psyche; it never allows them to truly understand the difference between right or wrong, this way seeding the beginning of psychotic organization. These mothers were condemned for their bad behaviour, and nobody ever questioned what happened in their lives. However, it was not remembered by many that these mothers also had traumatic experiences in their childhood, which in turn made them to become schizophrenogenic. These mothers were victims, and sequentially were procreating more victims (Welldon, 2004. p.23).

Hrdy (1999) asserts that women are not “naturally” mothers, and that it is questionable whether women instinctively know how to mother. The commonly referred to “maternal instinct” is determined by cultural and societal norms that shape how women experience motherhood and birth. In addition, Caplan (2000) theorises that the “good mother” myth imposes unachievable perfection standards for women. This allegory contains the idea that the “good mother” never gets angry - she is always generous and nurturing, and inherently knows how to raise well-adjusted children. The “bad mother” is seen as the reverse of the “good mother”, and the assumption of this good/bad mother dichotomy creates tremendous pressure on women to mother in particular ways (Miller, 2007).

## **Anger**

Nicolson (1998, p. 104) points out that research on psychological responses to traumatic life events, dying or being sick demonstrates the presence of acute anger. Therefore, if women with PND are ‘sick’, the current literature on PND fails to include anger as part of this “syndrome”. Nicolson (1998, p. 105) explains that anger is not an acceptable emotion within the mythical concept of femininity and motherhood. Women are not supposed to get angry, and

feelings of anger are not socially acceptable for a new mother, or women in general. New mothers are supposed to be happy. Therefore, PND is better accepted as a pathology than having feelings of anger. Furthermore, Nicolson's (1998, p.105) study of new mothers experiencing symptoms of PND has shown that all women's accounts convey the undercurrent of rage expressed towards the way they are treated, hospital policies, doctors, midwives, their changing bodies and behaviours, their circumstances and their losses. Women also experienced anger towards their partners, who are not prepared for this change and avoid any compromise.

### **Loss**

A critical theme for most women after childbirth is that of *loss*, and it has been a taboo in general literature as it conflicts with the general understanding of the typical transition to motherhood. Nicolson (1998, p.88) identifies loss as a first phase of transitional change, emphasising the importance of status change which happens for a woman through the transition to motherhood and postnatal experience. Paradoxically, becoming a mother involves both the loss of a former social position, identity, independence and control over life, whilst also moving women towards the desired status of "mother"- the archetypal "happy event" (Nicolson, 1998, p.87).

Nicolson (1998, p.90) espouses that each time a woman becomes a mother, she loses her sense of identity, autonomy, friends, career, time for herself, sexuality, health and sense of her own body. These losses are the result of complex and unique individual life experience and are perceived from a subjective point of view. All experienced losses contribute to the realisation that sexuality and femininity have been lost. For many women, becoming a mother means losing their femininity and becoming womanly. Changes in body shape after childbirth and breastfeeding can develop feelings of being sexually unattractive, and consequently fearing the loss of losing their partner's affection.

Many women feel the loss of occupational identity, which involves any activity outside home before the birth of a child. Some women permanently leave their jobs to become a full-time mother; however, it leaves them financially dependent on their partners, and leaves them missing the companionship of working colleagues (Nicolson, 1998.p.90).

Women are prevented from mourning their losses because of unconscious acceptance of social and cultural confinements. Marris (1986) believes that grieving is a means of psychological re-integration; however, in our society, a grieving process for the new mother is denied due to ideological conditions and is identified as pathology. Nicolson (1998, p. 98) stresses that PND is not pathological, but it is a grieving process - a natural and potentially healthy reaction to the loss - but, unfortunately, in the current framework, it is perceived and treated as depression. Nonetheless, many women are ashamed and embarrassed to seek help out of fear of being perceived as a “bad mother”, and the stigma attached to being sick at what should be a happy time (McIntosh, 1993).

## CONCLUSION

The premise of this research was to explore PND from psychodynamic and feminist perspectives. Feminist writings were used as the core literature for this paper, where they provide deep research based on qualitative methodology. They also critique the much neglected area of the woman's role as a mother in society and its negative impact on a woman, which potentially is the cause of PND. The psychodynamic outlook, and explicitly the object relations theory, focused on the mother-infant dyad and its crucial role in the development of the personality.

The first chapter examined the role of motherhood in the current societal climate using the writings of four prevailing feminist writers – Paula Nicolson, Estela V. Welldon, Susie Orbach and Holli Rubin. The main critique was the harmful way in which society and the media affect women during pregnancy and in the postpartum period, affecting their body image and impacting their bonding with the infant. The high social expectations on new mothers to experience motherhood as a “happy time” can result in feelings of disappointment, anxiousness, confusion and can lead to suffering from PND. Two currently opposing models - medical and social - explained PND; however, both approaches failed to recognise women as unique individuals with different life stories which affected their experience of childbirth and the postpartum period. Mauthner (2016) argues that PND is a social problem and the medical approach has shadowed the importance of women's emotions by labelling and pathologizing women's feelings, labelling it as “postnatal depression”.

The second chapter discussed the psychodynamic conceptualization of PND. Welldon (2004) examines feminine perversion through the object relations framework and states that the cause of perversion in women is socio-political and psychobiological. She concludes that perversion in motherhood is the result of a dysfunctional relationship between mother and daughter and, to understand the psychopathology of the mother-daughter relationship, it is

necessary to examine at least three familial generations. Moreover, the importance of the mother-infant relationship was reflected in the work of Klein (1935) where she explains that the infant perceives the mother as a “good” or “bad” object and proposes that formation of personality depends on successful realization of “paranoid-schizoid” and “depressive” developmental stages. Bion’s (1963) theory of “containment” emphasises the mother’s ability to hold the baby’s projections, transform them and return them to the infant in an acceptable form. However, if the mother responds to the infant in an inconsistent way, also called leaky “containment”, the infant will struggle to hold the emotional state together. Following from Bion’s (1963) “containment” theory, Blum’s (2007) psychodynamic perspective on PND highlighted two emotional conflicts new mothers struggle with. The “dependency conflict” reflects the mother’s wish to be taken care of and the envious feelings towards the infant. The “anger conflict” explains the mother’s feelings of guilt as she might feel she has no right to be angry. Blum (2007) contends that there are many reasons for new mothers to be angry and the inability to acknowledge these feelings may result in displacing the anger towards the infant. Winnicott (1945) also emphasised the mother-infant relationship where “good enough” mothering provides a “holding” environment for the infant’s emotional development. The chapter is concluded with Winnicott’s (1945) “holding” metaphor in the therapeutic encounter when treating women suffering from PND. The therapist takes up the symbolic role of the “good enough” mother who “holds” the mother/infant, helping to downregulate the escalated emotional state and helps to process feelings of anger, anxiety and longing for her mother’s approval.

The last chapter explored the feminist critique of PND and motherhood. The feminist analysis provides the argument that patriarchal assumptions, expectations and stereotypes have been dictating the dynamics of the role of motherhood. The psychoanalytical concept “phallus” has been criticized along with Freud’s thoughts about women’s sexuality. Bowlby’s theory of

“secure attachment” has been critiqued for emphasising only the infant’s needs for mother’s love and disregarding mothers’ personal circumstances and emotional state. Lang’s (1961) theory of “schizophrenogenic mother” have neglected the fact that each mother is a daughter to her mother and, therefore, by being a victim of adverse circumstances in childhood, she recreates the same unfortunate circumstances for her child. Equally important is the critique of “maternal instincts”, exclaiming that women are not naturally mothers and it is a socially and culturally constructed norm. In the same way, the myth of “good/bad” mothering is putting a huge strain on women to strive for unattainable mothering standards and, unsurprisingly, the societal illusion of the “good” mother is the mother who never gets angry. To support this notion, the final part of this chapter describes the feelings of anger and loss, prevalent but overlooked emotions for women suffering from PND. Nicolson (1998) asserts that feelings of anger for new mothers or women in general is not acceptable in society as it contradicts the common concept of femininity and motherhood. Society has created the belief that new mothers should be happy and, consequently, PND is accepted as a pathology instead of feelings of anger. In addition, Nicolson (1998) claims that feelings of loss are a normal phase of the transitional change to becoming a mother; it includes loss of identity, autonomy, sexuality and health, among many others. Women do not mourn their losses due to unconscious compliance to societal norms and, instead, it is identified as a pathology and treated as depression. Women do not speak up and are embarrassed to seek help due to societal stigma and blame attached to the postpartum period, which should be a “happy time”.

Finally, it was hoped that this research will raise awareness and deepen the understanding of the causes of PND, as there is no common consensus on what causes it. The aim was to highlight the social stigma and negative feelings new mothers experience due to unrealistic expectations around motherhood, and also to emphasise the necessity for more research in this area.

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