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The exploration of maternal representations during a parenthood-centred psychotherapy from pregnancy to one year postpartum

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Abstract

Maternal representations play a key role in intrapsychic conflicts relating to accession to parenthood and in the formation of the mother–baby bond. Around the birth of the child, the shadows of past objects are cast on the baby and the parent’s self-image. Mother–baby psychoanalytic psychotherapy

helps us to understand internal conflicts that tend to interfere with the mother's representations of her child or of herself as a mother, as well as aiming to reduce the risk of difficulties for the child.

Through a clinical case, this article explores the development of maternal representations in a course of parenthood-centred psychotherapy that begins during pregnancy and ends 11 months after the baby's birth. The psychic change carried out by the mother frees the mother–baby bond from the projections of the past. Excerpts from clinical sessions illustrate mother–baby interactions during the session, the projection of the mother's internal objects on to the baby, and the elaboration and reintroduction of the mother's internal conflicts. Changes in the mother's representations were measured both qualitatively and quantitatively using the 'R' interview, which allows various dimensions of these representations to be measured on a Likert scale.

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Abstract

Les représentations maternelles tiennent une place centrale dans les conflits intra-psychiques liés à l'accès à la parentalité et la construction du lien mère-bébé. Autour de la naissance d'un enfant, l'ombre des objets du passé se dépose sur le bébé et sur l'image que le parent a de lui-même. Les psychothérapies psychanalytiques mère-bébé aident à comprendre les conflits internes du parent qui tendent à parasiter les représentations qu'il a de son enfant ou de lui-même en tant que parent et visent à diminuer le risque de troubles chez l'enfant. Cet article explore, à travers un cas clinique, le développement des représentations maternelles au cours d'une psychothérapie centrée sur la parentalité initiée pendant la grossesse et qui a pris fin aux 11 mois du bébé. Le changement psychique opéré par la mère permet de libérer le lien mère-bébé des projections du passé. Des extraits de séances cliniques illustrent les interactions mère-bébé en séance, la projection d'objets internes maternels sur le bébé, l'élaboration et la réintroduction des conflits internes de la mère. Les représentations maternelles ont été évaluées de manière qualitative et quantitative au moyen de l'Entretien « R » qui permet de mesurer différentes dimensions de ces représentations sur une échelle Likert.

Introduction

The concept of representation in psychoanalysis

Laplanche and Pontalis define representation as 'that which forms the content of an act of thought' and 'in particular the reproduction of an earlier perception' (1988, p. 200). Freud borrows this term from philosophy but gives it a topographical status. Accordingly, the representation is the element of the object that becomes part of the 'mnemic systems', where the memory is multiplied into various associative series. He distinguishes two levels of representation: the 'word-representation' and the 'thing-representation'. In the 'primitive hallucination', the thing-representation is considered by the child as the equivalent of the perceived object and cathected in its absence. The preconscious-conscious system allows the binding of the thing-representation to the corresponding word-representation, unlike the unconscious system that only understands thing-representations. Freud deepens this conception by adding to it the work of psychic revision brought about by repression. The representation is constructed by the psychic dynamics and constantly revised by deferred action. In the first Freudian topography, the representation constitutes one of two expressions of the drive, the other being the quantum of affect that is bound to it. The representation and the drive have different destinies. Representations that are irreconcilable with morality tend to be repressed; they then become unconscious and strive to return to consciousness through the return of the repressed. The less affect-charged representations remain conscious. Affect itself is not repressed; it remains suspended and, lacking its representational support, can easily mutate into anxiety. This suspended affect then cathects the representations that have remained conscious. Freud considers fantasy as one particular variety of representation, focused on an act of satisfaction.

With the accession to the second topography, the concept of representation evolves in Freud's works to refer to the psychic representative of the drive. It is then indissociable from the object relationship and the identifications by which the subject is constructed. Over a long period Blatt (1974) has studied the quality of representations and how closely they are enmeshed with the child's earliest interpersonal experiences. The child transforms the interactions with its first objects into cognitive-affective schemas of self and other. The quality of the subject's representations is enmeshed with the type of relationship that the subject has with his internal objects. They therefore strongly influence the way in which he interacts with the people around him and the quality of his interpersonal relations.

In this article, the concept of 'representations' brings together the subject's, in this case the parent's internal and external, conscious and unconscious perceptions of himself and his principal objects, in particular his child, and object relations. These comprise images as well as affects and fantasies. These representations can be close to objective external reality or more or less distant and distorted, demonstrating pathological internal processes at work that the psychotherapeutic work will seek to 'detoxify'.

Parental representations in the perinatal period

The parents' representations occupy a central place in the perinatal treatment. How the parent perceives himself as a parent and how he imagines and perceives his baby influence his interactions and the quality of the early bond. The conflictual aspects of these parental representations are readily split off and projected on to the child, who tends to identify with these projections. The child's behaviour can be interpreted very differently according to the parent's preconceptions and representations. For example, a baby who cries can be perceived as hungry, sad, capricious or angry, according to the parent's experience and his relationship with his internal objects.

Pregnancy, birth and the first few postpartum months are periods of psychic reorganisation that can foster the transformation of the mother's representations and the baby's positive development. The parental representations and fantasies are enmeshed with internal conflicts that, if unelaborated, can lead to mechanisms of splitting and projection to on the baby of elements expelled from the parent's psyche because they are too painful or anxiety-inducing. The perinatal period is accompanied by a particular phenomenon that Bydlowski (2008) has termed 'psychic transparency', which is characterised by a weakening of the mother's psychic defences. This results in a lifting of repression and a facilitated access to representations and fantasies that reach consciousness much more easily. This is what explains the acute sensitivity, if not anxiety, felt by many mothers, as well as the significant psychic mobility that characterises this period, which is especially conducive to psychotherapeutic interventions.

Three types of representations are strongly elicited and revised during the perinatal period: the representation of the 'parent' object, the representation of the 'child' object and the representation of the 'parent-child' object, and this is transgenerational. In the present generation, it is a matter of understanding the adult's conscious and unconscious representations of himself as a parent, his representations of his child or future child and how he imagines their relationship. These present-day representations are influenced by the previous generation's representations: the adult's representations of his own parents and of himself as a child in relation to his parents in the past. It is not unusual to discover the shadow of representations concerning previous generations that hovers over present-day representations, such as the ghosts in the child's bedroom described by Fraiberg (1980).

The parents' representations play a key role in creating the earliest contents of the baby's thought and the new parent-child bond that is being formed. A reciprocal affective attunement is gradually established by encounters, projections, identifications and the creation of new symbols.

In the domain of the perinatal period and the parent-child bond, several authors have developed theories concerning the concept of maternal representations. Lebovici (1983), Stern (1985), Fraiberg (1980), Cramer and Palacio (1993) have all developed theoretical and clinical models for psychotherapeutic interventions with young children and their parents. In the 1990s based on Fraiberg's works, Fonagy (1993) demonstrated the importance of maternal representations in predicting attachment. More recently, studies by Slade (2005), Ammaniti (2009), Dollberg, Feldman and Keren (2013) continue to address mother-child relational problems and the need to mobilise maternal representations with longer-term therapeutic work.

Several research studies have allowed an evaluation of the increase in maternal sensitivity and the improvement in the child's symptoms following a therapeutic process (Pellet 2014, Isosävi 2019); however, few studies have addressed changes in parental systems of representations. Maternal representations continue to be difficult to understand and describe, although a hypothesis has been developed about how they change during the psychotherapeutic process (Dollberg, Feldman and Keren 2013).

In a metapsychological study of mother-baby therapies, Aguayo and Salomonsson (2017) take the view that the parent-child therapists Golse, Baradon, Anzieu-Premmereur, Emmanuel, Salomonsson, and many others before, have integrated into their approach elements that have emerged from clinical and theoretical works on the baby. They point out that parental distress has a negative effect on the baby and that the baby actively participates in the development of a relational difficulty. The article does not incorporate work on the parental representations but makes a link between the effects of parental distress and the baby's difficulties. Several authors working on mother-baby therapies focus primarily on the development of the baby's representations. Anzieu-Premmereur (2013) presents a mother-baby therapeutic work and illustrates how primitive defences can damage the child's representational capacities. She demonstrates how the therapy allows a dismantling of the baby's primitive defences that interfere with his development. Salomonsson (2014) studies the theory and practice of parent-child psychotherapies, setting out a clinical case on the importance of a three-month-old baby's earliest representations. He suggests the concept of 'early representations' formed on the basis of maternal ambivalence.

The field of parent–child interventions has developed considerably over the past few decades. Dollberg, Feldman, Tyano and Keren (2013) distinguish three major types of approach according to the starting-point adopted. The first concerns the parent, his internal world and his unresolved conflicts, where the psychotherapeutic work on parental representations allows the parents’ unconscious conflicts and traumas to be discovered so as to enable them to understand their child’s needs better and respond to them. The second approach focuses on the parent–child interactions and the reciprocal impact of each one’s behaviour on the other. The third approach centres on the child’s behaviours and representations, with parent–child work that seeks to enable the child to play in the parent’s presence and to help the parent to understand the child’s emotional and developmental needs better (Cohen et al. 2002, Harel et al. 2006). Dollberg et al. point out that what these therapies have in common is the idea that helping the child necessitates a change in the parents’ representations.

Parenthood-centred psychotherapy

The work on the parents’ representations and projections, as well as the elaboration of internal conflicts about the theme of motherhood are at the heart of parenthood-centred psychotherapies (Nanzer et al. 2012). Studied at length in the context of dyadic mother–baby therapies, this model, which elaborates conflicts in relation to parenthood, proved even more effective when it was begun as early as pregnancy, a time when the revision of maternal representations becomes very active. They are therefore easier to mobilise and elaborate during these psychotherapies specific to the perinatal period. The psychotherapeutic process aims to make the intrapsychic conflicts conscious and to ‘detoxify’ them by separating them from their anxiety-inducing infantile fantasmatic content. The adult patient’s psyche is therefore better able to elaborate them and less inclined to resort to defence mechanisms of the splitting and projection type on to the child to be born. It is thus possible either to prevent or to reduce the intensity of the distortion of the representations that the parent forms of his child, of himself as a parent and of their relationship. The mother–baby bond and the child’s real interactions and development are themselves strongly influenced by the quality of the mother’s representations. This psychotherapeutic work therefore has a double objective: to assist the process of parental psychic maturation and to foster the baby’s positive psycho-emotional development.

Parenthood-centred psychotherapy is a psychoanalytically orientated approach directly inspired by the short-term mother–baby therapies designed by Bertrand Cramer and Palacio Espasa (1993) and adapted for use as early as pregnancy. It facilitates making connections between the woman’s representations of the past (her childhood, her perception of her own mother) and her present-day representations (her child, herself as a mother). Parenthood-centred psychotherapy enables the woman to observe her current interactions with her child and to understand them in the light of her past and present

representations. It works on the development of parenthood, exploring the links between past and present and the mother's internal object relations in relation with her baby. It helps the parent to become aware of his identifications, projections, and fantasmatic scenarios in order to modify the gaze (the representations) that he directs at himself, at the child, and at the interactions. As in any psychoanalytic therapy, transference–countertransference movements are in play and are identified by the therapist. However, in parenthood-centred psychotherapy the interpretation applies less to the parent–therapist transference bond than to the 'transference' that the parent makes on to his child, this latter being the main object of study in the therapy; this form of interpretation makes it possible to prevent the establishment of an excessive regression in a transference–countertransference bond that is difficult to elaborate over the duration of a short therapy. Sometimes, however, a direct transference interpretation on to the therapist may be welcome, especially when a negative therapeutic reaction is impeding the therapeutic process. By virtue of his enigmatic nature and his immaturity, the baby constitutes a special form of 'blank screen' on to which the new parents can project elements of their internal world, as they do with the psychotherapist in the transference. We can in fact compare the parent's projections on to his child to his transference to the psychotherapist. Both consist in an attempt at repetition and elaboration, in the interrelational world and with a present-day external object, of unelaborated conflictual relational elements that belong to the subject–parent's past. These movements contribute to the dynamics of transgenerational transmissions.

Methodology

In the course of this article, we develop a clinical case that enables us to analyse the therapeutic trajectory and evolution of maternal representations during the process of a parenthood-centred psychotherapy. We will seek to connect the therapeutic process and the evolution of representations. This case forms part of a clinical study conducted at a public health centre in Barcelona. This complements some research by the Geneva school that studies the impact of parenthood-centred psychotherapy on pregnant women presenting anxious-depressive symptomatology (Moayedoddin et al. 2012) and the improvement of maternal representations (Pellet et Nanzer 2014). The Barcelona study targets a different and disadvantaged population that is being treated in the public health-care system; it received an IPA grant for the research in 2016. The collaboration and regular interventions between the teams in Barcelona and Geneva contributed to the study of the psychotherapeutic process set out here.

The midwives and paediatricians in a district of Barcelona offer all pregnant women, on signature of informed consent, a systematic screening for depression and perinatal anxiety using two questionnaires:

the Edinburgh Postnatal Depression Scale (EPDS), validated for screening prenatal and postnatal depression (Cox 1987), and the State and Trait Anxiety Index (STAI) (Spielberger 1983), which evaluates the patient's current and usual level of anxiety. A short parenthood-centred psychotherapy of 8 sessions is offered to all women whose EPDS score is equal to or higher than 9 or whose STAI score is equal to or higher than 39. The women are then referred to psychotherapists, psychoanalysts specifically trained in parenthood-centred psychotherapy. Four sessions take place before labour and four more between the baby's birth and the age of 8 months. The therapist can add a session according to clinical needs.

The conscious dimension of the maternal representations is studied using the 'R' interview (Stern, Robert Tissot et al 1989), a version adapted to the perinatal period in 2005 by the Geneva school (Qayoom et al 2005). The therapist begins with an open question, asking the mother to describe how she imagines her baby or her future baby. Then he offers her a series of ten characteristics and terms to describe her baby. Each item is presented on a bipolar scale that incorporates both extremes (positive and negative) of the characteristics studied (such as calm–excited, aggressive–unaggressive, happy–sad, difficult–easy). With an ungraded mark, the woman records her assessment. The same procedure is used for the woman's representations of herself as a mother and her representations of her own mother. Fourteen characteristics are studied (such as 'good enough' parent–'bad' parent, affectionate–not very affectionate, tolerant–not very tolerant, confident–fearful ...).

At the time of the analysis, each characteristic is transformed into a scale graded from 0 to 100, on which 0 represents the 'negative' pole of the representation (e.g. ugly) and 100 represents the 'positive' pole (e.g. beautiful) (see Appendix 2). The 'R' interview is used on three successive occasions during the therapeutic process: T1 beginning, T2 postpartum and T3 end of the psychotherapy.

This tool is used by the therapist himself and incorporated into the therapeutic process. Asking direct questions about these aspects is a departure from the classical associative approach of psychodynamic therapies as it only records conscious aspects of the representations, but we hypothesise that it then opens the way towards associations that make it possible to identify more unconscious and conflictual aspects of these same representations when the interview is conducted by a psychoanalytically orientated therapist. The associative process of the sessions then allows a demonstration of the mother's preconscious and unconscious representations concerning the three fields studied: the parent, the child, their relationship, both in the current generation and in past generations.

This study, which is in the process of being published, comprises to date 50 dyads that are studied from pregnancy to eight months postpartum. In addition to the maternal symptoms and representations, it traces the progression of the mother–child relationship and the child's development.

Sylvie's therapy

Sylvie is 28 years old at the time of her first consultation, and 27 months pregnant. The midwife who refers her tells us that Sylvie has signed the consent form to participate in the study. This is her first pregnancy, and she is in a couple that has been stable for five years. The patient suffered from depression at the age of 22 years following a relationship breakdown. Sylvie is at the beginning of her pregnancy and presents anxious-depressive symptoms. The depression and anxiety scores obtained from the questionnaires used by the midwife are high (EPDS: 18, STAI: 85–90). Sylvie is relieved to accept the offer of psychotherapy.

At the first interview Sylvie is very tense and inhibited; she complains of frequent mood changes that remind her of her depression six years earlier. She says she does not dare imagine her baby for fear that he might 'disappear', as she puts it. Talking about the baby would mean for Sylvie feeling the hope and satisfaction and increasing the fear of loss. She mentions a history characterised by many losses and separations. Her anxiety hampers the fluency of her account.

Sylvie's father died a few months ago, having been ill throughout his life with heart problems, obesity and diabetes. He died of a heart attack at the time when Sylvie had distanced herself from him to take care of her mother, who was having a depressive relapse. At this point, she can talk about her father's illnesses but cannot address his recent death.

She has no childhood memories of her mother, who suffered from a severe postpartum depression just after her birth. She was brought up by her paternal grandmother until she returned to live with her parents when she was 11 years old. She has an elder brother who is undergoing treatment for drug addiction.

Sylvie gives a coherent account of her life and her efforts to gain her independence in terms of her studies, her work and her life in a couple. However, the atmosphere in this first session is heavy. Sylvie seems to be clinging to her request for therapy like a lifebelt.

At the end of this first interview, we note the presence of major anxious-depressive symptomatology about her pregnancy, as well as an unelaborated mourning for her father.

We demonstrate the representation of a baby in danger who might suffer if her mother allowed herself to cry. Sylvie is afraid of cathecting a baby who might die or leave her, repeating many separations that she has had to confront in her life.

We are also struck by the lack of reference to her mother, as if Sylvie lacked the words to talk about her or to imagine her.

The therapeutic focus

The therapy sessions allow us to work on two focuses:

- On the one hand, the 'distance, rejection, abandonment' focus: a fantasy of having been rejected by her depressed mother, a fantasy of having rejected and hurt her parents while she was asserting her autonomy to build her adult life, and a feeling of guilt when she thinks she 'abandoned' her dying father.
- On the other hand, the 'clinging' focus—an adhesive type of primary defence (Bick 1986)—that Sylvie develops with regard to the bodily loss, the experience of falling, and the despair at never finding any point of encounter. We link elements of her past with the elements of her internal world that she is now projecting on to her baby: her early experience of emptiness, of falling, during her early childhood.

This line of work takes account of Sylvie's capacities and helps her to establish a close relationship with her daughter, while also allowing the introduction of a third. The therapist-third seems to be ambivalently cathected, with strong expectations, but also an intense fear that she may suffer if she becomes too attached, just as she fears becoming attached to her baby.

The psychotherapeutic work and the mother's representations during the pregnancy

We take great care to build a setting that allows a therapeutic bond of trust to be formed that is not intrusive. Time is needed for the patient to develop trust. We work on understanding and elaborating Sylvie's internal conflicts in connection with the events of her childhood and her relationships in general. Then, finally, in the last prenatal session, Sylvie is able to talk about her guilt feelings with regard to her father's death one year earlier. He had broken off the relationship with her after she had taken care of her mother. He suddenly died of a heart attack when she was trying to get closer to him, without having had enough time to do so. Sylvie feels guilty for not having realised the seriousness of his condition. We work on her guilt feelings and her suffering from not being able to take care of both her parents at the same time. When one is better, the other one falls ill. There is no possibility of triangulation. She shows us a photo of herself as a child, aged 4 years old. By becoming able to address the suffering connected

with her feeling of guilt and the loss of her father, Sylvie allows herself to re-establish contact with her childhood feelings, a beneficial and essential regression that will help her to identify with her child to be born.

Gradually, Sylvie begins to be able to imagine her future baby, whom she imagines as fearful and clinging to her. Her representation of herself as a future mother is characterised by a great deal of worry and control. She imagines herself as very unmaternal. Her representation of her own mother is characterised by absence, absence of memory, absence of words. At the age of 11 years, when she discovers life with her parents, she feels many tensions, and ill humour: a living hell! She tries to free herself from it by taking her independence when she is 18 years old. By contrast, she has a positive representation of her paternal grandparents, with whom she spent her early childhood. We notice that Sylvie has thus also been able to construct a good parental object by which she has felt loved.

We hypothesise that Sylvie perceives her baby as clinging to her, in a mechanism of adhesive identification, to protect herself from the risk of endless falling that she may have experienced when she was suddenly separated from her mother and deprived of her when she was a few days old. There was a loss of contact, and a fear of the void as a defence against a risk of withdrawal or intrusion. We therefore work on a focus concerning distance and the fear of intrusion versus a fantasy of falling and abandonment. This set of themes appears in one of the dreams that Sylvie reports during the pregnancy: she is holding her baby against her, in her arms, and trying to move closer to her husband, but he pushes her away and she finds herself alone. She wakes up anxious, in tears. This dream illustrates the double movement of an adhesive relationship to her daughter to protect herself from the anxiety-inducing void into which she feels projected when the object puts her at a distance. The dreams favour the symbolisation process and allow us to reflect on the latent meaning, as well as the experiences that were undergone. The function of thought opens up to the child who is on the way. The therapist refines her understanding of the fantasies and maternal representations, shedding light on the anxieties, internal conflicts and the already present projections on to the baby that will be revised by the birth and the encounter with the baby as a reality. She is also attentive to this double movement of 'fear of intrusion' and 'fear of abandonment' which, although not interpreted, is present in the transference and in the countertransference experience of great precaution taken by the therapist to find the appropriate relational distance.

The process during the first few months postpartum

Anouk is born at full term and in good health. The care is shared by the parental couple for the first month postpartum. The dad is affectionate and sensitive; he easily manages to calm his daughter. The mum is very anxious, and cries a lot during the first three postpartum weeks.

At the first postpartum session, Anouk is one month old. Sylvie feels rejected by her daughter when she wriggles or makes a sudden movement. In the 'R' interview she describes her as very unaffectionate. The conflictual knot 'intrusion versus abandonment' manifests itself even in the first session. Sylvie perceives her baby as rejecting and abandoning. We then talk about what she feels during the contact with Anouk. We work on touch and caress. The moments of contact are painful for Sylvie: the psychic pain that she feels when there is a lack of contact. At these times, Sylvie prefers to avoid contact, to move away, disappear. Sylvie says she felt a great unease when her husband managed to calm little Anouk during her first days of life, when she herself could not. She expresses it as an extremely unpleasant sensation: *'like someone touching my navel! I can't stand anyone touching my navel!'* The unpleasant contact with the navel seems to refer to the breaking of the bond between Sylvie as a baby and her mother. Today she fears cutting such a precious bond with her daughter. This cut is imagined as inscribed in Sylvie's body. She talks about a contact that she finds intrusive: her navel, to identify the intrusive unease caused by her partner, she feels pushed aside and undermined as a mother, as if this were interfering in her bond with her baby. The conscious representation mentioned in the first R interview of the baby 'clinging' to her has developed and made it possible to address some less conscious and more conflictual representations of a baby who might abandon her and leave her abandoned to herself, evoking the nameless sensation of falling that she may have felt as a baby towards her depressed mother by whom she felt abandoned.

In this perinatal stage, where sensoriality is strongly present, it is noted that the keenly desired close physical contact becomes impossible. Sylvie fears the intrusion of the other: therapist, mother, husband and baby by whom she dreads feeling judged, recreating the hell that she experienced in her youth when she went back to live with her parents.

She is also afraid of being intrusive with her daughter. The representation that she has formed of an 'unaffectionate' baby distances her from the contact with Anouk. This representation might lead her to repeat what she experienced as a baby: the loss of the object. At the same time, Sylvie does not accept this fear of closeness and projects it on to her baby: she thinks that Anouk is rejecting her. Her wish for a 'very clinging' relationship was probably a defence against the fears of falling, emptiness and rejection (Haag 2018).

Sylvie simultaneously fears feeling invaded and not having a place beside her daughter. She says: *'I don't touch her because I can see that annoys her! She is maybe like her Dad who is not affectionate!'* She then begins to withdraw, avoiding contact with the baby. This is a sensitive time. Anouk is one month old and Sylvie is extremely anxious. We can note that the maternal representations already present in the prenatal period materialise in the postnatal period through projections on to the baby that are acted out in the mother–child interactions. These representations take a form at the time when the baby, through his immaturity, is available to receive and embody these projections. The therapist then tries to rework them in the child's presence through the pathological interactions that appear in the here-and-now of the session, as when Sylvie distances herself from her daughter.

During this first postpartum session, we work on the question of the contact with the real and fantasmatic baby, trying to understand what Sylvie is feeling, starting from the senses and the body. From the soma to the psyche, the body's inexorable bond with the mind can be felt (Lévine 2019). We can designate the emotion and pain felt at this distance as 'not having her place'.

At the second postpartum session, Sylvie complains about not being able to help rejecting her partner. She speaks very painfully and expresses her fear that the couple will break up. We connect her fears with her infantile experience: the navel representing the cutting of the bond with her mother, accompanied by an infantile feeling of endless falling. This painful image enables her to understand her fears better. Sylvie identifies that she is projecting on to Anouk the image of her mother by whom she felt both rejected and invaded when she returned to live in the family 'hell'. The therapist's receptive attitude and work to make connections enable Sylvie to feel contained and so to be able to observe herself, think and take up the conflictual elements that she had had to project on to her daughter because they had been impossible for her to elaborate. This movement enables her to discover her own desires and creative capacities, opening up the possibility of writing a new story, freed of ghosts from the past.

Following this session, Sylvie's relationship with her baby and with her partner rapidly improve. She comes to the next session feeling relieved and can elaborate new conflicts.

At the third postpartum session, Sylvie spontaneously talks about her mother, her feelings and her experiences of rejection in relation to her—this Mum for whom Sylvie had not a word in the first therapy session, nor any conscious representation that she could express. It was important that the therapist would tolerate this lack of words for someone who had been painfully absent in Sylvie's life, a mother figure that Sylvie was trying to protect from her ambivalence by a representational void. The therapist's

countertransference experience brings her to live this absence with the patient from the very beginning of the therapy, to tolerate it so as to be able gradually to understand it and put it into words.

During this session, Sylvie talks about the difficulties Anouk is having sleeping. We connect the separation of the evening with Sylvie's experiences of loss. She then associates about the difficult separations that she has experienced and her current fears when she leaves her baby in her cradle. She is afraid that the baby might suffocate: 'I often think this'. The therapist links the fear of death with separation and suggests that Anouk is feeling her Mum's fear, that she is waking up to reassure her and communicate to her that she is really alive. Sylvie understands and agrees.

In the fourth session, despite the worries connected with the evening separation, Anouk can fall asleep alone in her cot. Sylvie says that she is able to want and tolerate this temporary distance that she perceives as important for her daughter's development. She tells the therapist how she has made some space in the evening so that she and her partner can spend the evening with the little girl who now goes to sleep with her Dad ... 'They're small changes, but they do us some good', says Sylvie. The therapist points to Sylvie's ambivalence, in not wanting to 'keep clinging' while being afraid of separating. 'Perhaps you imagine that separation leads to death, like your Dad's sudden death'. Sylvie: 'I do not know how to get rid of this fear!' The therapist: 'Perhaps absence stirs in you a feeling of fright, the impression that in losing the contact, the other might die'. Sylvie: 'It's possible! Yes, it's possible'. She reflects and adds: 'It's possible because I've experienced many traumas! My life is full of traumatic events! I've kept inside all my negative experience ... this resentment has stayed inside me! I feel it very strongly now! Everything I've experienced with my mother, and everything negative I've experienced, is still there!' She points at her heart and adds: 'Everything that happens to me comes from my childhood. That is stopping me living my own life!' The therapist feels Sylvie's strongly expressed and very strongly directed anger. She feels targeted by this rancour and her countertransference experience enables her to understand the force of this rage connected with abandonment. In the short therapy the transference is not interpreted but it enables the therapist to formulate the transference dynamics that are happening between the mother and the baby. The therapeutic bond is strong enough for it to be possible then to speak to her about this resentment that is coming between her and her baby. Sylvie says: 'I feel as if I'm going into a repeating spiral. I behave in this way with my mother because of everything I've been carrying since my childhood and I can't get out of it!' She then adds: 'Even if my mother changes, I won't be able to change ... I always feel on my guard with her ... in our relationship, I was always the one left out. Since I was very little, I've had this resentment and recurrent thoughts in which I'm feeling trapped!' Sylvie expresses her fear that she will never manage to get out of what she describes as a vicious circle of exclusion and rejection, which is something she can now put into words. She has always felt excluded from her mother's

thoughts and does not believe that this exclusion is due to her mother's mental illness. The therapist intervenes: 'These recurring thoughts prevent you from being in contact with your little Anouk and perhaps you feel she is excluded from your mind'. Sylvie remains silent then adds: 'It's true that these thoughts occupy a lot of space in my mind, and I can't think about Anouk when I'm in this constant vicious circle!' The therapist mentions Sylvie's mother's illness, which was probably preventing any positive contact. Sylvie says: 'It's not because of the mental illness. My mother could take care of my brother, but I was left out!' Sylvie vividly describes this wound. She is visibly relieved to be able to express this suffering that has long been silenced and that can be received by the therapist. She says that she has never been able to speak about it before and that she is grateful for the understanding she feels from the therapist. Sylvie adds that she would have liked to have a good relationship with her mother. Instead of interpreting the maternal transference, the therapist tells her: '... as you now want to have a good relationship with your little girl Anouk'. Sylvie says: 'All these thoughts often stop me concentrating on Anouk ...' Her tone of voice becomes reflective, and she looks tenderly at her daughter. The therapist's alpha function (Bion 1962) enables Sylvie to feel thought about, contained, and secure. She can then elaborate her own emotions and internal conflicts, reduce the burden of the projections on to her daughter and be more attentive to her needs. By seeing that her repetitive thoughts and preoccupations are preventing her from giving her baby some real attention, Sylvie takes up for herself, in her internal world, some of the elements she had projected on to her daughter. What Sylvie describes as a 'vicious circle that is being repeated' is characteristic of the repetition compulsion described by Freud in 'Remembering, repeating and working-through' (1914). The psychotherapist's interpretations open up in Sylvie a movement of insight that enables her to elaborate these conflicts intrapsychically and to avoid repeatedly enacting them in the relationship with her daughter. The 'vicious circle' is transformed into hope of change (Freud 1920), which results in a perceptible change in the mother's representations about her daughter.

Sylvie feels relieved to be able to mention that she would have liked to be able to have a relationship with her mother but: *'not too clinging as I now realise that over-clinging relationships are destructive!'* We notice there a new movement of insight made possible by the psychotherapeutic work. The representations concerning the bond with her mother are positively transformed at the same time as the representations concerning her daughter.

At the fifth postpartum session, an additional session suggested by the therapist, the therapist arrives late; she apologises and senses that Sylvie is worried. The therapist says that Sylvie may have felt that she had forgotten her. Sylvie confirms this. The therapist tells her: 'perhaps you often imagine that other people are not keeping you in mind ...' Sylvie agrees and confirms that this often happens to her.

She imagines that people have forgotten her and that she does not exist in the minds of the people around her. The therapist: 'as with Anouk when you think she does not want you'.

Anouk is now five and half months old and she is developing well; she is lively and explores her environment and the relationship with the psychotherapist with interest. She participates in the session by taking interest in a new object, then in the therapist's words and finally in the dialogues of the session. She worries when her Mum expresses painful feelings and calms down when she feels her mother is reassured. Klein (1952) mentions the influence of the mother's capacity for containment in helping the child to tolerate the primitive anxieties that form the basis for the development of her ego. Her bodily tension relaxes; she takes a new interest in what is being said and plays by joining her hands with her mother's. At the end of the session, when she is at her mother's breast, she reaches out her arm towards the therapist, and takes the breast again before stretching out her hand towards the therapist again. This is a movement of opening in which the baby, in contact with the breast, expands the space towards the third, the therapist. Some small finger movements seem to express a wish for closeness. Anouk then shows that a beginning of triangulation is possible, that she can simultaneously receive the content of the mother's breast and the thought and the support offered by the therapist. Contented, the mother looks at her baby. The mother and therapist have a shared gaze and a shared thought towards the child. Sylvie's representational capacities, damaged by a lack of maternal reverie when she was a baby, can now be transformed, supported by the therapist's capacity for reverie. Anouk is nurtured by the alpha-elements processed in the session (Bion 1962). The 'clinging' relationship of the beginning of the therapy has opened up to a mother-child differentiation and to the capacity to introduce a third into this relationship, the beginning of a long trajectory in Anouk's development.

The follow-up session and the last measurement of the 'R' interview take place five months after the end of the therapy because of the lockdown due to the Covid-19 pandemic. Anouk is 11 months old. Sylvie says she is very moved by her daughter's progress, as she is beginning to take her first steps. Anouk is lively and joyful. She has a strong character and gets annoyed when she is told 'no'. When her daughter opposes and resists her requests for closeness, Sylvie feels sad. But she can tolerate her daughter taking some distance, especially during her attempts at walking. Anouk falls over, gets up again, and falls again, under her mother's patient and benevolent gaze. Sylvie now talks more easily about her own mother, whom she defines by absence: '*my mother is like a NO*' with reference to someone who is psychically absent. Sylvie talks about this without resentment, as an aspect that forms part of her reality. She had never been able to speak about it before. The vicious circle has been transformed; Sylvie is more attentive to her husband and to her daughter. When her mother comes to visit them, Sylvie remains watchful, but she can also give her a place beside her granddaughter.

At the final 'R' interview, Sylvie describes her baby as well cathected, beautiful, and rather fearless, unlike the representations of the beginning of the therapy. She perceives Anouk as very lively and describes herself as a satisfied mother. She feels less worried, less controlling, more patient and more maternal than at the beginning of the parenthood-centred psychotherapy. Figure 2 (Appendix 1) shows the evolution of the mother's representations from the beginning of the therapy (T1) until Anouk's age of 11 months (T3). The increase in the scores represents the improvement towards the positive pole of maternal representations.

On the EPDS questionnaire, the depression scores are now lower, moving from 18 before the therapy (T1) to 12 in the postpartum period (T2) and then to 4 at the follow-up session (T3). The same applies to the anxiety scores, which have reduced by 45 points, moving from 85 (T1) to 40 (T3).

An interrelation is observed between the clinical evolution of the dyad and the evolution of the mother's representations.

A second follow-up is organised when the baby is 18 months old and this is carried out by an external examiner, psychologist and colleague at the university, who receives the dyad blind, without any prior information. Anouk's developmental level is evaluated using the Ages & Stages questionnaire; it is good in every area. The PIRGAS assessment, which evaluates the mother-child relationship, is marked at 90 on a scale on which 100 is the maximum mark. The paediatric status indicates normal development and good health.

Discussion

Key element: beginning in the prenatal period

With this type of approach, exploring the woman's representations and internal world, the psychotherapeutic work can begin as early as pregnancy, which we consider a great advantage in relation to most mother-baby therapies, which require the real baby's presence. During this stage in the development of parenthood, the phenomenon of the future mother's psychic transparency allows a major mobilisation of anxieties, fantasies and representations, as well as a greater receptivity to psychotherapy. Sylvie is the first to be surprised by the flood of images, sensations, and memories that resurface and make themselves felt in her, in search of new psychic connections. Sometimes this emotional wave causes intense anxieties and the mobilisation of maniacal defences or denial: a headlong rush, hyperactivity, and denial of the changes caused by the pregnancy and the baby's

imminent arrival. When this psychic transparency and the associated emotional flow are received and tolerated by the woman, they are generally accompanied by a depressivity linked to the developmental work of mourning that characterises this new stage of life. When the intensity of the internal conflicts or external reality factors exceeds the woman's elaborative capacity, it is not unusual to see the emergence of anxious or depressive decompensations. Being able to detect these difficulties quickly makes it possible to suggest an early psychotherapeutic support, which is essential for avoiding the establishment of a chronic psychopathology that may have major repercussions on the mother's availability and on the baby to be born.

The thought and work of the sessions are focused on elaborating internal conflicts, with the future mother usually feeling a strong need to talk about her plans, her fears, her difficulties, and her doubts, in order to prepare herself for her new identity as a mother. In the second stage of the pregnancy, the objectal stage, the baby begins to be perceptible as differentiated from the mother; the latter can begin to think about her baby and to initiate a maternal reverie.

The sessions of the prenatal period make it possible to demonstrate the representations and conflictual fantasies that, to be understood and elaborated, are thought about in the light of the woman's infantile experience. For Sylvie, motherhood reactivates the emotions connected to the unelaborated mourning for her father, who died when their relations were cold, following a childhood from which he had been absent. The representations concerning this absent and ill father are, initially, kept at a distance by Sylvie who will not be able to address them until the third session, just before her labour. It will become possible to link them to her current representations concerning her future baby, whom she fantasises as fearful and needing her constant presence, bringing up claustrophobic anxieties and a representation of herself as very unmaternal. Sylvie's mother suffered from a severe depression after her birth, which may have fuelled Sylvie's infantile fantasy that she was an over-demanding baby who exhausted and depressed her mother, who had no alternative but to distance herself from her during the first 11 years of her life. It is not surprising that this first motherhood reactivates some doubt and anxieties in Sylvie concerning her future identity as a mother in connection with her baby. Will she be able to be the present and available mother that she has not had and that she would like to be?

We note that the process of parenthood, with its projections and its identifications, is activated long before the birth of the real baby. The first representations are already identifiable and they give rise to anxieties and internal conflicts that can be mobilised by the psychotherapy. In this we concur with the conclusions of Isosävi's team, who studied the evolution of maternal representations in the postnatal period, after a psychotherapeutic process. Isosävi considered it necessary to promote research in the prenatal period, suggesting that 'it is pivotal to restore a mother's mentalizing ability first in order to

then work with her'. This study underlines the importance of representations in the prevention of psychopathology; it suggests the importance for the future of studying their relation to attachment problems to evaluate a potential relationship of cause and effect. Although most specialists in the perinatal period emphasise the importance of intervening as early as pregnancy, this practice is still uncommon and few therapies are started before the baby's birth unless the mother presents an overt psychopathology.

How the therapeutic process allowed representations to be developed

The perinatal period is characterised by deep psychic changes in each of the parents. The most important changes concern the sense of the Self, to allow the inclusion of the maternal identity and the activation of the maternal constellation (Stern, 1985). Starting from representations identified as distorted or pathological at the beginning of the psychotherapeutic process, the psychotherapist builds a focus that aims to foster the resolution of underlying psychic conflicts and the evolution of these representations. *For Sylvie, the psychotherapeutic work carried out during the pregnancy enabled her to reconnect with her childhood, to mournings not done and guilt feelings that had previously remained unconscious. At the beginning of the postpartum period, anxieties about emptiness, loss and rejection are relived in her relationship with her baby, damaging the mother–daughter bond. These representations, and the relationship, improve when these can be reconnected with Sylvie's infantile experience. She can gradually detach the images of her past from her current relationship to her daughter.*

During the pregnancy, the work of understanding allows a therapeutic alliance to be established with the woman and fosters continuity with the mother–baby sessions in the postpartum period. The psychotherapeutic work of the postpartum period is therefore based on the elaboration already carried out during the pregnancy. The observation of the mother–baby interactions and the thoughts that arise in the 'here and now' of the session allow the symptomatic interactive sequences to be identified and brought out. These can be seen as the production in the session and in the mother–child relationship of fantasmatic scenarios that belong to the mother's internal world. When the affect of the moment can be demonstrated and the interaction can be connected with the mother's unconscious scenario, the psychotherapist's intervention can generate a deep movement of insight, similar to that produced by a transference interpretation when it allows the affect of the moment to be accessed in the patient. When Sylvie feels rejected by her daughter in the session, the therapist links this representation to the past and to experiences of abandonment. Sylvie can then take on for herself the projective movements carried out on her daughter and adopt a more containing maternal role with Anouk. These changes make it possible to stop the rejection / abandonment fantasy that was beginning to manifest itself in a

mode of transgenerational repetition in the mother–daughter relationship. The therapist’s countertransference helps her to feel and understand better the mother’s projective movements on to the child, movements that are vectors of transgenerational transmissions.

In the baby’s presence, the therapist works to receive, contain and transform the new mother’s anxieties. According to the Bionian model, he lends his apparatus for ‘thinking thoughts’ to transform the affects expressed in the form of beta elements into alpha elements. This enables the mother to understand her representations better and so to free her baby of the distorted projections that were burdening her. The mother’s representations change. The psychotherapeutic process can therefore be described as a work of binding and unbinding of representations and affects, an extremely mobile process at the time of the identity crisis that is constituted by the accession to motherhood.

The utility of the ‘R’ interview in clinical practice: a tool for assessment and assistance in exploring representations

The interest in maternal representations is an essential field of study in the early development of the baby. The representations influence the type of attachment and bond; their study has formed a basis for making indications for mother–child psychotherapy since the 1980s. Several research studies have focused on the possibility of measuring the change and evolution of maternal representations. Ammanitti (2009) states that in the prenatal period the maternal representations can be rich with perceptions or else limited and poorly cathected, especially when they are conflictual in nature. These representations are then poorly integrated, ambivalent, and difficult to verbalise.

The therapist’s use of the ‘R’ interview from the very beginning of the therapeutic process allows a space to be opened for self-observation and thought directed at the mother’s perceptions concerning her infantile experience and her baby. It turns out to be particularly useful in women with limited access to verbalisation and their internal world. They can thus make use of a tool that provides a concrete support on which they can rely. In a second stage, the psychotherapeutic work and the free associations allow the woman to access more unconscious representations and conflicts. The possibility of combining spontaneous expression with self-evaluation on a Likert scale gives access to a broader mental space in which the woman can project her desires and her fears. The use of this tool in the first few sessions can help the psychotherapist to establish his therapeutic focus, which it is essential to define in short

therapies that are centred on one type of conflict, unlike psychotherapies or psychoanalyses of unfixed duration.

After labour and at the end of the psychotherapy, the use of the R interview allows the evolution of conscious representations to be measured and quantified. Although these stages are primarily useful in research, they have also proved useful for addressing fantasmatic sets of themes that moved into the background after labour. Sylvie had no words to speak about her relationship with her own mother. The repetitive and intrusive thoughts concerning her mother, present for a long time, caused major suffering at the time when she herself was preparing to become a mother. These obsessive thoughts disappeared after she was able to allow herself to assume her place as a present and competent mother in relation to her daughter. When the latter is 11 months old, Sylvie spontaneously remarks that she feels at peace: 'During the pregnancy with Anouk, my interior gradually changed. Before, I constantly felt some resentment towards my mother. Now I feel at peace and connected with the people close to me: my husband and my daughter'.

Maternal representations and the baby's development

In 2013, the study by Dollberg et al. of the evolution of behavioural difficulties and the maternal representations after a mother–child psychotherapy showed a rapid improvement in the child's behaviour when the change in the representations seemed to take longer. The authors hypothesise that the change in representations requires the understanding of the experiences lived in the parent's past and a longer elaboration. In 2014, Pellet and Nanzer studied the evolution of maternal representations after four sessions of parenthood-centred psychotherapy with positive results concerning changes in the mother and baby relationship. They conclude that parenthood-centred psychotherapy is particularly well adapted to the perinatal period, which involves the change of representations and plays a part in establishing the early mother–baby relations. In the case of Sylvie and Anouk, as for the other dyads in the ongoing study, we note that the evolution of the baby's development accords with the evolution of maternal representations during the psychotherapeutic process. Anouk presents some difficulties of separation and going to sleep, reflecting Sylvie's fears of abandonment and difficulties experienced by the parental couple, aggravated by the situation of the pandemic and lockdown. These symptoms quickly subside once they are connected with the mother's anxieties.

Some new lines of research should be considered for studying and measuring the impact of maternal representations on the quality of the mother–child bond, on the child's development and on the type of attachment that he develops. Although attachment theory has long been kept apart from the

psychoanalytic field, these two domains seem to us more complementary than opposed when we consider the field of the child's psychological development. These research studies should include the neurobiological modifications that accompany these changes.

Given that the parental representations tend to be inscribed over a long period (Cramer, 1993), it seems important to study the long-term effect of short psychotherapies centred on parenthood and to compare them to long-term psychotherapies initiated during the perinatal period. These comparisons should include the change in maternal representations and psychic functioning, but also the dynamics of the mother–baby interactions and the child's development. They should take account of the acceptability of therapy and compliance with it, given that today short therapies are more easily accepted by patients.

Finally, a field that is still under-researched concerns the importance of the father's representations in the process of accession to parenthood and in the child's development. Works concerning the accession to fatherhood are beginning to appear (Missonnier, 2013). It is recognised that men also undergo psychic revisions that allow them to accede to their new identity as fathers, but the effect of this process and its hazards on the father–child bond and on this latter's development remains an area of research that is still under-explored and that deserves our full attention.

Conclusion

In this article, we have tried to show that maternal representations concerning the woman's image of herself as a mother and her image of her baby or future baby are connected with her internal imagos. The exploration of their quality, quantity and evolution is of great interest to the psychotherapist during the perinatal period, in particular when this process can start during the pregnancy, a time when the woman is especially mobile in psychic terms, with a special access to her internal world. She can then engage with internal conflicts that have remained latent, connected with her parental and infantile imagos, which typically are stirred during the accession to parenthood. These conflicts, if not elaborated, are at risk of being projected on to the child or on to the mother–child bond, impeding their relationship and the child's development.

Maternal representations are present as early as pregnancy and have a strong predictive value for the future mother–baby interactions. They are therefore a major source of interest for the study of attachment and the child's emotional development. The change in pathological representations is easier to achieve and more complete when the psychotherapeutic work begins in the prenatal stage and continues in the postnatal stage. The presence of the real child changes the maternal internal dynamics,

as well as some representations, making it necessary to continue the psychotherapeutic work in the postnatal stage.

Through a clinical illustration, we have shown how increasing the flexibility of maternal representations allows the baby to be freed of the restrictive projections that burden him. The mother's capacity for containment improves over the course of the sessions, especially during the mother–baby sessions. We observe that the mother projects on to her baby a fantasy connected with her own infantile history, leading her to repeat internal conflicts that have an impact on her relationship with her daughter. Through the psychotherapeutic work in the session, the mother can understand and reintroject the aspects that belong to her. This work brings about intrapsychic changes that cause an evolution of maternal representations in a relatively short period that is essential to her identity as a mother. The evolution of the representations thus allows the mother–child bond to be freed of projections connected with the mother's past and prevents the subsequent development of psychoaffective or developmental symptoms in the child. The ongoing study from which this case has emerged should make it possible to show whether these conclusions can be generalised to the entire sample being studied.

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APPENDIX 1 – MATERNAL REPRESENTATIONS

The increase in scores represents the improvement towards the positive pole of maternal representations

Representations of the baby

Handsome

Lively

Confident

Representations of the mother

Happy

Maternal

Confident

Not very controlling

T1: Pregnancy

T2: Postpartum

T3: 11 months postpartum