Reflections on Transference in a Case of Postpartum Depression in Mother–Infant Therapeutic Consultation

Abstract

This paper reflects on transference, as defined by Freud and subsequent analysts, in our work with pregnant women and mother–infant dyads facing social risk. These women's life histories are generally marked by physical and emotional abandonment, maltreatment, violence, and abuse. Most were raised by someone other than their mother. Since 2004, Habitare has developed social projects in which psychologists work within institutions serving low income communities, with the aim of prevention and early intervention. One project is illustrated through fragments of a clinical case: a woman pregnant with her first child, whose care began during pregnancy and continued after childbirth, when it also included her baby, in the context of postpartum depression.

The project, conducted in partnership with the Einstein Program in the Paraisópolis Community, offered therapeutic consultations (Winnicott, 1971; Lebovici, 2000; Oliveira, 2008) to pregnant women and mother–infant dyads experiencing numerous circumstances unfavorable to the development of the mother–infant bond. The case illustrates the importance of positive transference between therapist and patient in making therapeutic consultation possible within an environment of trust. In this setting, the representations evoked by the actual baby and the helplessness experienced during pregnancy and after childbirth favor the re-experiencing of primitive feelings and memories accompanying traumatic experiences. Care and genuine empathy within the therapeutic setting can often restore hope and creativity, elements necessary for good enough mothering. Split-off aspects of the self can thus be integrated, making recovery from postpartum depression possible.

Keywords: Therapeutic consultation; transference; postpartum depression; early intervention; social risk.

Introduction

To understand the contemporary concept of transference, it is necessary to trace its historical development through Freud's definitions. In Studies on Hysteria (1895), he states that unconscious representations cannot enter the preconscious directly and therefore need to connect with representations already belonging to the preconscious, forming a "false connection" that is mistakenly attached to the physician.

In 1900, Freud reformulated the concept of transference in relation to dreams. In The Interpretation of Dreams, he describes how affect can be displaced from an unconscious representation to a preconscious one when the representation of the analyst functions as a day residue in the dream, taking the place of the original objects and contributing to resistance.

Transference was not yet viewed as a fundamental part of the analyst–patient relationship necessary for the success of analysis. The case of Dora illustrates this understanding: transference is seen as a set of past fantasies or affective experiences that must be relived in the relationship with the analyst. The task of analysis would therefore be to identify, explain, and dissolve these transferences.

In The Dynamics of Transference (1912), Freud continues to regard transference as the most powerful resistance to treatment. He describes the individual's development in terms of libidinal impulses, distinguishing a part of the personality that becomes conscious from another that remains unconscious. This unsatisfied libidinal cathexis is then directed toward the physician. With the discovery of the Oedipus complex, Freud describes this unconscious libido as taking a regressive course: the force of unconscious libido becomes stronger than that of conscious libido, and the patient's infantile imagos, such as the paternal imago, are revived through the figure of the analyst.

A new perspective on transference neurosis appears in one of Freud's lectures in 1916, although the role of transference is still explained in relation to resistance. Freud describes greater intensity and persistence of transference as an expression of greater resistance. He distinguishes two types: positive transference, invested with affectionate feelings, and negative transference, involving hostile feelings.

Freud therefore maintained complete recollection, or the filling of gaps in the childhood past, as the ideal of treatment. Transference constituted resistance to this complete recollection because of the intense unconscious emotional content transferred from the original figures to the analyst.

In 1910, Freud introduced the term countertransference in The Future Prospects of Psycho-Analytic Therapy. He describes analytic therapy as resting on three factors: internal progress, increased authority, and the general effect of the work on analysts. Countertransference would thus be the patient's influence on the analyst's unconscious feelings. The analyst's own personal analysis would be essential, since no analyst could go beyond their own complexes and internal resistances.

After Freud, different theories emerged, each drawing on particular aspects of his developing thought. According to Racker (1982), two groups of analysts follow distinct techniques because of Freud's emphasis on two different aspects of the dynamics of transference:

> For one group of analysts, transference is predominantly resistance. The essential element of the analytic process lies in "remembering" repressed childhood itself, in "filling the gaps in memory," and transference is, according to Freud, an instrument for this purpose … For another group of analysts, the essential element of the analytic process lies in transference itself, that is, in reliving, while at the same time "preventing a new repression." (Racker, 1982, p. 48; translated from the Portuguese text)

Winnicott (1954) emphasizes the importance of considering the individual's developmental history when establishing a diagnosis. For him, transference in the classical sense would apply only to patients who did not experience failures of maternal care during the period of absolute dependence (1945). For those who could not rely on a good enough environment

during that period, what is projected onto the therapist consists of experiences of abandonment and helplessness that occurred before the formation of a psychic apparatus capable of representing, and therefore repressing, such content.

Using Racker's (1982) classification, Winnicott would thus belong to the second group of analysts, since he regards transference as fundamental to establishing potential space between patient and analyst. Within this space, through the analyst's work, what has not happened can happen: an experience can be lived, allowing development to resume. Differences therefore emerge between classical clinical practice and Winnicott's approach, which adopts a phenomenological and temporal understanding of human development as unfolding with the support of the environment. The theoretical differences arising from this new understanding of transference lead to changes in the therapeutic setting and a new emphasis in clinical work:

> Winnicottian clinical practice is, in fact, not a clinical practice of meaning, but of happening. It is not a clinical practice of the repressed, but of what has not happened. It is not a clinical practice of the unconscious, but of the a-conscious and the a-unconscious. It also became clear to me that this was a clinical practice in which the conception of transference underwent a profound transformation. Transference could no longer be understood as the result of displacement or projective identification. It is a transference guided by the search for what has not happened. (Safra, 2007; translated from the Portuguese text)

For Winnicott, who regards the setting as a metaphor for maternal care, the analyst in the transference performs the function of the good enough mother, offering the infant a welcoming, reliable, and containing environment indispensable to emotional development. In the analysis of patients who have developed a false self, or whose ego has not formed intact, as in the case presented below, Winnicott (1955–1956) emphasizes the need to give greater importance to management than to interpretation. The analyst must be good enough to adapt to the patient's needs, evoking hope that the true self will not be endangered and can therefore begin to live.

As noted above, the encounter between analyst and patient takes place in potential space, the third area of human experience, where playing is possible and where transference is also possible:

> From this perspective, transference is understood as a form of playing. The patient moves toward finding the analyst, and the analyst, in turn, allows themselves to be found through the patient's particularity and way of being. The analyst is there, available to be used by the patient and, at a certain point in the course of analysis, to be destroyed. The destruction of the analyst as a subjective object is a fundamental moment in analysis. Yet the analyst's willingness to occupy the place of the subjective object also implies the capacity to play, to live within potential space. (Safra, 1999, p. 99; translated from the Portuguese text)

Analysis is therefore possible only when both analyst and patient can experience potential space, using it as a space of co-creation and genuine communication between them (Winnicott, 1971).

The case presented to illustrate our work concerns psychological care for a young mother that began during pregnancy because she showed symptoms of depression, which continued after childbirth. We therefore offer some reflections on this condition.

Depression and the Postpartum Period

Freud described depression in 1915 by distinguishing it from melancholia. In this account, depression is the state inherent in mourning, involving sadness and loss of interest in object relationships, whereas melancholia is a pathological state arising when mourning cannot take place because part of the ego is lost with the object.

In 1935, Klein presented her theory of the depressive position, describing a more developed form of mental functioning that makes it possible to integrate ambivalent aspects of the relationship with the object. Within this dynamic, the attacked object is subsequently repaired. The psychic capacity for integration allows loss, pain, and sadness to be experienced. As Winnicott (1954, p. 442) notes, the depressive position enables a person to feel remorse and concern for the fate of the loved object that has been attacked and to seek reparation. This capacity for concern helps the future mother experience motherhood without becoming ill: she can be concerned for her baby and identify with the baby's needs without entering a pathological state.

The paper's theoretical account proposes that women who could not rely on good maternal care have not worked through the depressive position and become ill after childbirth, generally between the fourth and eighth weeks, with the illness potentially extending through the infant's first six months. These women present major and minor depressive episodes, changes in mood, irritability, feelings of worthlessness, low motivation, disturbances of eating and sleep, and other psychosomatic symptoms. In this account, postpartum depression can prevent the mother from caring for her baby and may also facilitate the acting out of aggression.

Studies of postpartum depression have identified associated circumstances similar to those found in depression during pregnancy:

> "… a previous history of depression (e.g., Gorman et al., 2004; Marcus et al., 2003); unfavorable sociodemographic conditions (e.g., Marcus, Flynn, Blow, and Barry, 2003); adverse life circumstances; low levels of social support; relationship difficulties (e.g., McKnee, Cunningham, Jankowski, and Zayas, 2001, as cited in Figueiredo, 2005), apart from variables concerning the baby, such as poorer general health (e.g., McKnee, Cunningham, Jankowski, and Zayas, 2001, as cited in Figueiredo, 2005), less prenatal healthcare (e.g., Lindgren, 2001), and especially greater consumption of harmful substances, such as alcohol and tobacco (Marcus et al., 2003)." (Gonçalves, 2008, p. 16; translated from the Portuguese text)

Clinical Case

Almost all these circumstances were present in the patient's life. Fernanda[1] was 21 years old when she first came for care and was six months pregnant. At first glance, she seemed younger, almost a girl. Her long hair was tied back. She appeared agitated and spoke very quickly. Her clothes were simple, with no sign of particular concern for her appearance.

At our first meeting, she spoke of her disappointment about the baby. She had wanted a boy and did not feel ready to care for a girl. She described the pregnancy as high risk because of a fibroid and feared dying during childbirth. In recounting her life history, she explained why she did not feel ready to care for a girl. She had been born prematurely, and her unmarried mother had placed her in the care of a married brother who already had children. When Fernanda was seven, her mother asked her to come and live with her. However, because her mother worked all day, Fernanda stayed home alone and began visiting a neighbor, who sexually abused her when she was nine. Afterward, her aunt came to take her back and raised her very strictly. According to Fernanda, she was not allowed to leave the house.

Fernanda is now married and says her husband treats her as the uncle who raised her did. She describes herself as a homebody and can visit relatives only if she has an excuse to go to their homes. She is afraid to go out alone and worries excessively about what others think of her.

Her concerns about pregnancy involved the baby's physical appearance: she feared the baby would be ugly and badly behaved. She wanted the baby to be like her, calm and good, as she described herself. She said she would hit the child for doing something wrong but would never reject the child as she felt her mother had rejected her.

Care was interrupted around the birth and resumed when the baby was one month old. At that consultation, Fernanda said the birth had been difficult, that she had experienced considerable pain, and that a cesarean section had been necessary. She had been very afraid of dying. The baby had swallowed meconium and had taken time to cry, causing her great concern.

She spoke with considerable sadness about receiving no help from her family during postpartum recovery, only from her husband and a neighbor. This had deeply hurt her. She seemed to compensate for the suffering by saying that the baby was just as she had hoped, very calm. During the consultation, she looked at the baby affectionately and spoke on the baby's behalf. I concluded that their bond was developing well and brought treatment to a close, while agreeing that she could request another consultation whenever she felt it necessary. One of our aims is precisely to provide a place for listening and emotional support.

Approximately three months later, Fernanda asked to return. She arrived very agitated, speaking quickly and loudly, and avoided looking at the baby. This evoked intense discomfort, making clear how unable she was to care for her baby and how much help she needed.

The five-month-old baby cried and squirmed in her lap while Fernanda, very agitated, offered the breast in an attempt to soothe the child. I felt flooded by a torrent of words poured over me. After this discharge, however, both mother and baby would settle, and we could talk.

Fernanda reported that she had assaulted the baby on a day when she became extremely upset. She was cooking, and the baby would not stop crying. Irritated and out of control, she threw the baby onto the bed and punched the child all over the body. Once she calmed down, she saw that the baby had turned purple from crying and felt guilty. She spoke with great pain about what she had done. Her emotion was genuine, and she clearly understood that she had done something wrong. She acknowledged losing control and was asking for help. Taking responsibility for harm and being conscious of one's actions express guilt and accompany the wish for reparation, which are characteristic of healthy depression (Winnicott, 1963).

Following this disclosure, her husband, an available neighbor, and her sister-in-law were each asked to attend separately. They were told that Fernanda was very ill and needed their care around the clock because the baby's life was at risk. At the same time, an urgent psychiatric referral was requested.

Support from relatives and acquaintances helped Fernanda feel more protected. In consultations, she showed the extent of her identification with the baby. This was not the identification that enables a mother to provide needed care, but an undifferentiated identification. When offering the baby a toy, Fernanda would take it and play with it herself, ignoring the baby. Her inability to care for her child was evident. She herself needed a mother's care. The trust experienced within the therapeutic setting through positive transference enabled her to disclose not only aggression toward the baby but also aggressive fantasies.

Fernanda mobilized her whole family to make them aware that she was ill. Her biological mother came from Piauí to help care for her and the baby. However, her mother maintained that Fernanda did not need medication, only family support. The account describes the mother as unable to repair her guilt about not having cared for Fernanda through the care offered to her daughter and grandson. Fernanda, now able to oppose her mother and express her wishes in a way she could not as an infant, decided to stay and asked her mother to return alone.

Fernanda spoke of her anger at the baby for the care required and at her mother for leaving her once again and failing to protect her. These were the many failures experienced in childhood and relived within the therapeutic setting.

With help from her husband, who began paying more attention to her, listening to her complaints, and helping with housework and the baby, Fernanda felt better and more supported. She began taking responsibility for her medication. She had relapses and again assaulted the child. As might be expected, she also had difficulty weaning the baby, believing that breast milk was the only thing connecting them.

Pedro[2] showed developmental delay. He was very small and thin for his age and frequently became ill. During consultations, when Fernanda addressed him in a sweet voice and spoke

on his behalf, he would smile and seek my gaze, as though he did not have a steady, attentive gaze directed toward him outside that space.

Witnessing Pedro's suffering with a mother who was ill and unable to care for him at that time evoked intense countertransference feelings in the therapist. Considerable mental work was needed to process the distress and avoid acting out anger toward the mother by abandoning the case. There were significant improvements, which Fernanda reported joyfully. She began recognizing what made her upset and identifying her limits of tolerance, handing Pedro to someone else to avoid hurting him. The pain expressed through her tears showed that she suffered because she could not care well for her son and understood the harm she had done, to the point of fearing that he would never forgive her.

The opportunity to re-experience very early failures following the baby's birth allowed Fernanda to express irritation, agitation, and suffering. Over treatment, she began making different use of the therapeutic space and describing new experiences. She started leaving the house more often, visiting relatives when she wished, and going out with her husband when she wanted. This suggested that her true self was beginning to develop in reality, a change made possible through work in the transference.

Fernanda also reported understanding herself better, worrying less about what others thought, and being able to focus on what she wanted. She seemed to be moving toward independence. Whenever she ran out of medication, her anxiety returned, as did maltreatment of her son. By the end of treatment, she could finally recognize the need for medication, although she expressed a wish to become well. We also heard this as a wish to grow, become an adult, and care for herself and her family, since the desire and hope for health are fundamental to treatment working.

When Fernanda was more psychically integrated, she could prioritize her baby's care and leave household tasks for later. She played with him, spoke on his behalf, kissed and hugged him, and looked at him affectionately, making Pedro smile. He soon began crawling and standing and showing interest in toys.

Because of institutional circumstances, treatment ended, and Fernanda was referred to another therapist. She was sad and worried. She asked whether I was married and had children because she found it remarkable how well I understood her, demonstrating the positive transference that had existed between us.

Concluding Considerations

In this case, therapeutic consultation extended beyond a brief series of meetings because of the severity of the situation and the risk to the infant's physical safety. The mother's early traumatic experiences had seriously damaged her mental health. Treatment offered a genuine experience of care which, together with positive transference and the therapist's receptive response to the patient's helplessness, contributed to the treatment's success.

Clinical management that sought support within the family and neighborhood was decisive, since Fernanda presented all the circumstances associated with postpartum depression mentioned earlier.

The case illustrates the effectiveness and importance of projects such as ours, which seek to provide preventive maternal mental health care for socially vulnerable populations.

Notes on the Translation

1. Fernanda is a fictitious name.

2. Pedro is a fictitious name.

Quotations are translated from the Portuguese text rather than reproduced from published English editions. The original's apparent date error for Freud's Studies on Hysteria has been corrected from 1985 to 1895. Incomplete bibliographic entries are identified below. The passage concerning Fernanda's biological mother is ambiguous in the source; the translation follows its stated sequence without adding events. Clinical interpretations and descriptions reflect the original manuscript and have not been independently updated or validated.

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