The Importance of Therapeutic Consultation in Facilitating the Process of Becoming a Mother

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Abstract

Maternalité is defined as the set of psychoaffective processes that develop and become integrated in a woman as she becomes a mother (Racamier, 1961). This paper illustrates the importance of therapeutic consultation as a means of facilitating this process. We use this approach in our social clinical work through a partnership between the nonprofit organization Habitare and the Einstein Program in the Paraisópolis Community. Our projects focus primarily on prevention and early intervention in maternal and infant mental health.

Drawing on Winnicott and Lebovici, we seek to support the processes of becoming a parent and becoming a mother through a therapeutic consultation model within an adapted clinical framework. Consultations are offered to pregnant women and mother–infant dyads experiencing circumstances unfavorable to the development of the bond with the baby. They provide a space for specialized psychological listening that receives the anxieties accompanying pregnancy and motherhood, which, in this population, are intensified by poverty and helplessness. This welcoming space extends through the infant's first six months and aims to become a point of reference for the family.

The case highlights therapeutic consultation as a means of enabling a mother herself to experience being mothered. This allowed her to enter the process of becoming a parent to her baby, enabling both to experience continuity of being and strengthening of the ego.

Keywords: Maternalité; therapeutic consultations; underserved communities; mother–infant relationship; prevention; intervention; mental health.

Introduction

Women who become mothers generally experience a particular psychological state that enables them, without conscious awareness, to respond to their child's movements and needs (Winnicott, 1956, primary maternal preoccupation). The term maternalité refers to the psychoaffective processes that develop and become integrated in a woman as she becomes a mother (Racamier, 1961). However, adverse circumstances in the future mother's childhood and present life can hinder or prevent this psychological state from emerging, putting the infant's maturational processes at risk. Importantly, this process takes place through an interaction in which both infant and mother play an active role.

At birth, the infant brings personal characteristics, such as sex, vitality, irritability, and consolability, that evoke different experiences in the mother and give the mother–infant

relationship its emotional coloring. From this perspective, both development and clinical work with the mother–infant relationship should be understood transactionally. The infant contributes an inherited potential for maturation, while the mother, as the environment, brings her experience of having been a baby cared for by a mother, her mental representations, and her capacity for mothering.

In healthy circumstances, communication between mother and infant occurs from the beginning, as the mother puts herself in the infant's position and recognizes disturbances arising from the infant's vulnerability (Winnicott, 1963). In certain maternal conditions, such as depression, the infant encounters a dead internal object within the mother. Being alive then becomes everything, without appreciation of what life and living bring. Maternal depression has received particular attention from clinicians and researchers, alongside postpartum depression. The original paper cites an estimate of approximately 20 percent of women experiencing this condition, which requires special care because it can endanger the health of the mother, infant, and family.

This presentation illustrates early intervention in maternal and infant mental health through an account of mother–infant therapeutic consultations conducted by Habitare psychologists in a psychosocially vulnerable community. The work is carried out through a partnership between Habitare and the Einstein Program in the Paraisópolis Community and draws on Winnicott (1945; 1956; 1971) and Lebovici (1999).

We seek to support mothers' and fathers' capacities to care appropriately for their children by offering an experience of care within the therapeutic space. We believe in recovering their potential to care for their children: after all, each of us was once a baby and was therefore cared for by someone. This welcoming, integrative space is used by the infant, mother, father, and family to speak about the baby, themselves, their families, their past, and repeated patterns of behavior. Therapeutic consultation allows parents to modify their fantasy-based projections onto the infant, transforming identification processes across generations and freeing the infant from becoming the repository of parental conflicts.

Clinical Illustration

Diana[3], a married 23-year-old woman living in the Paraisópolis community, was six months pregnant when she approached the Pregnancy Care Program. Following an interview with the nurse, she was referred for psychological care because of what the nurse described as "anxiety and aggression."

During pregnancy, Diana spoke of her intense fear of childbirth, "associating it with a pain of death." She described an unplanned pregnancy and showed no positive affection toward the baby. She said she found it irritating when other pregnant women in the group stroked their bellies, sang to their babies, or talked to them. She saw no meaning in these behaviors.

At the first consultation shortly after the birth, Diana reported having had a vaginal delivery assisted by forceps. She described the experience as difficult and painful. She complained of difficulty caring for the baby, appeared anxious, and spoke of wanting to die. She and her baby were therefore referred for consultations with two therapists present.

At the first of these consultations, Diana came with her baby Luis[4]. Her appearance was neglected, with no apparent attention to grooming and even a decline in personal hygiene. She was very thin and looked tired and tense.

She complained of how difficult it was to care for the baby alone. She could not sleep and no longer had time even to shower. She said she could rely neither on her husband nor on close relatives, such as her mother and siblings, for help. At the slightest cry signaling the baby's discomfort, Diana responded with abrupt gestures and words expressing deep irritation and displeasure toward him. Her movements sometimes suggested that she wanted to free herself of the baby. These were difficult moments that evoked intense countertransference feelings of anger and distress in the therapists. We were also moved by the pain of this young woman who, despite carrying a baby in her arms, could not be a mother. Through her, we witnessed the hatred toward the baby described by Winnicott (1947).

As consultations progressed, the therapists attempted to engage Luis by showing him toys. Initially these held little interest for him. We nevertheless noticed Diana's ambivalence: as soon as we invited him to play, she called him back to her. When we drew attention to this movement, she could speak of feeling unable to leave the baby with anyone else, even his father. She said she trusted no one.

Diana seemed unable to recognize any need or discomfort in Luis other than hunger, which she imagined could be resolved by offering the breast. This gesture was generally accompanied by the words, "He won't let go of me."

As she spoke about her anxieties and anger, she gradually allowed Luis to interact with us, and he began taking an interest in other objects we offered. The therapists attended to his spontaneous movements and offered objects or demonstrated ways of playing. Luis became more interested when we took him out of the room so that Diana could speak freely about her anxieties.

This arrangement proved helpful in enabling Diana to recount painful experiences, including losing her brother, who died by suicide in front of the whole family, and her insecurity in relation to male figures. Meanwhile, Luis had an opportunity to express curiosity about objects apart from his mother.

The first times we took Luis out of the room, both he and Diana were tearful and distressed by the separation at the end of the session. Diana went to find him, saying, "I can't bear to hear him cry; he needs me," and then offered him the breast. During later separations, they gradually tolerated longer periods apart until they could remain separate throughout the session.

The development of both became clear. Diana now spoke more calmly, freely expressed her anxieties, and did not require Luis to remain in her lap. Luis began playing independently with toys. When he called his mother, it was to show her toys or invite both her and the psychologists to play. It seemed that this separation gave Diana an opportunity to experience absolute dependence with the psychologist, relying on a safe and welcoming environment.

In other sessions, Diana described difficulties in her relationship with her husband. Her feelings of hatred were sometimes acted out toward him. She dismissed his attempts to help,

saying that he should know what she wanted without her having to tell him, just as a mother should imagine her infant's needs.

In a regressed state, Diana needed holding and sensitive, receptive listening. This enabled her to recount childhood episodes in which she had felt abandoned, particularly by her father. She described feeling insecure and having low self-esteem because her sisters looked different from her and because she alone had been asked by her father to work in the family shop. This lived fantasy of being rejected and singled out by her father may have been transferred to her relationships with her husband and son. She could not recognize their care and attention and continually felt helpless and rejected.

In a safe environment resembling a mother's lap, Diana found support for her subjectivity to emerge. She began telling us about things she liked doing and attending consultations more carefully dressed, with her hair groomed, wearing earrings and even makeup. She was managing to ask a niece to look after Luis so that she could care for herself.

At this point, we observed and accompanied both Diana's and Luis's development. Diana was presenting herself as a mother and recognizing her son's needs more accurately. As she became stronger, she realized that crying did not always call for breastfeeding and that she could and should offer her son other things, including play and the freedom to separate. Luis, now more differentiated from his mother, could develop the psychic and physical capacities that enabled him to play independently.

Conclusion

Therapeutic consultation takes place within an adapted setting in which the patient can re-experience absolute dependence through the process of regression described by Winnicott in 1954. In this setting, the therapist offers an environment of trust and, above all, holding (Winnicott, 1960), enabling the patient to survive the experience of omnipotence (Winnicott, 1971a/1984).

This case shows how consultation through co-therapy supported the patient's process of becoming a mother. Separating mother and infant allowed the mother to experience absolute dependence within a safe and welcoming setting, facilitating the integration of split-off aspects of her self. In addition to easing her depression, this enabled her to enter the process of maternalité and form a healthy bond with her son. As the co-therapist introduced objects to the baby, he could continue his maturational process and subsequently receive care from a capable, good enough mother.

Author Information and Notes

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Translation note: Maternalité, translated here as “the process of becoming a mother,” refers to the psychoaffective processes defined in the paper, rather than motherhood solely as a social or biological status. Author affiliations, clinical interpretations, and statistical statements reflect the original manuscript and have not been independently updated or validated. Original reference titles are retained with English translations in brackets. The source alternates between “Recamier” and “Racamier”; “Racamier” is used consistently in the translated text. Some works cited in the text do not appear in the original reference list.

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