Social Clinical Practice and the Therapeutic Act of Care and Cure

Tereza Marques de Oliveira[1]

Nadia Regina Prando[2]

Abstract

This paper describes our experience in social clinical practice with an at-risk population as part of projects developed by the nonprofit organization Habitare in partnership with the Einstein Program in the Paraisópolis Community. The 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 through a therapeutic consultation model within an adapted clinical framework. This framework allows us to rethink clinical practice in terms of "care–cure": an experience of care in which the therapist, by putting themselves in the other person's position without judgment, offers potential space for personal care and mothering (Winnicott, 1971; 1976). Therapeutic consultations are offered to pregnant women and mother–infant dyads when the child's developmental difficulties arise from dysfunctional relationships. This welcoming space extends through the infant's first six months and aims to become a point of reference for the family. The projects have proved highly effective in helping prevent pathological patterns in parent–infant relationships from becoming entrenched, thereby supporting healthy development.

Keywords: Therapeutic consultations; care–cure; mother–infant relationship; prevention; mental health.

Introduction

> "Psychoanalysis is not simply a matter of interpreting the repressed unconscious; rather, it provides a professional context for trust within which this work can take place." (Winnicott, 1996, p. 89; translated from the Portuguese text)

Habitare

Habitare is a nongovernmental organization founded in 2000 to provide preventive psychological care and interventions for populations facing biopsychosocial risks, primarily pregnant women and children from birth to three years of age. Throughout its work, the organization has focused on prevention and early intervention in maternal and infant mental health, making scientific knowledge on the subject accessible. Since 2004, Habitare has partnered with the Einstein Program in the Paraisópolis Community[3] (PEC), working with this vulnerable community to support mental health from pregnancy through the first three years of life.

Over these years, Habitare has proposed and developed two projects within PEC's Maternal and Child Department. The first, Parenthood[4]: Becoming a Mother—Therapeutic Consultations with Pregnant Women, began in 2004. It serves women enrolled in the program who show signs of mental health risk that may compromise the mother–infant relationship, including unwanted pregnancy, symptoms of anxiety and depression, pregnancy at an early or late age, somatization, family conflicts, and lack of social support.

The second, Parent–Infant Therapeutic Consultations: Prevention and Mental Health Prophylaxis in Infancy, offers care to children and their parents or caregivers[5] when developmental problems associated with dysfunctional relationships are identified. Both projects primarily aim to provide a space for specialized psychological listening, receiving anxieties arising during pregnancy and the early years of life, as well as conflicts involving transgenerational psychic inheritance.

Pregnant women and families are seen through the therapeutic consultation model, grounded in theories and techniques developed by Winnicott (1965, 1971) and later expanded by Lebovici (1993 and other works). This intervention involves a small number of meetings, averaging three to four, and focuses primarily on the conflict–symptom: dysfunction in the bond beginning during pregnancy and, subsequently, interactional phenomena characterizing the infant–mother–father–family relationship and possible difficulties within it.

In this work, we recognize that an environment marked by profound helplessness intensifies the need for emotional support from the therapist. This support, or "holding," can be understood as an extension of the "care–cure" described by Winnicott (1989).

For Winnicott (1989), care–cure refers to the care healthcare workers must offer patients to make healing possible. It differs from medical diagnosis and treatment, representing a professional ethic that does not limit itself to treating but includes caring as part of treatment.

Winnicott (1989) describes the following principles of care–cure: hierarchy, dependence, the effects of the position, subsequent effects, gratitude, and holding.

• Hierarchy refers to the fact that, in therapy, we are two human beings on the same level, without hierarchy.

• Dependence involves both patient and therapist accepting that they depend on one another to exist within that situation.

• The effects of the care–cure position involve the therapist being nonmoralistic, honest, trustworthy, and noncruel, while accepting the patient's love and hatred.

• Subsequent effects concern the therapist's capacity to enter imaginatively into the patient's thoughts and feelings, that is, to engage in cross-identification.

• Gratitude involves accepting the affection of patients who improve.

• Finally, holding is the emotional support the therapist offers the patient. Like a mother holding her baby in the womb, it provides conditions in which an immature patient can grow

and develop.

Building on these principles, Figueiredo (2009) developed a metapsychology of care. In his article “Metapsychology of Care” (2009), emotional support is a form of care through which the therapist enables the patient to “make sense.” This care makes possible an “experience of integration” (Figueiredo, 2009, p. 134), allowing aspects of the self to be integrated. As therapists, we are agents of care and fulfill our role through an “engaged” presence. This engaged and/or reserved presence encompasses several modalities, understood as forms of otherness: supporting and containing, recognizing, and addressing and reclaiming.

• Supporting and containing can be represented by the mother–infant relationship, in which the mother offers holding (Winnicott, 1960) before she is perceived as another person. She simply supports and contains. This can be related to the holding described by Winnicott (1989).

• Recognizing involves the capacity:

> “… to pay attention to and recognize what is unique and particular about the person receiving care, to bear witness to it and, if possible, to reflect their own image back to them.” (Figueiredo, 2009, p. 138; translated from the Portuguese text)

• Addressing and reclaiming (Alvarez, 1992) is the modality through which the caregiver awakens the patient’s instinctual vitality toward life, order, and existence.

These three modalities form a metapsychology of care enacted through a therapist who is both engaged and reserved. According to Figueiredo and Coelho (2000), the therapist is engaged through commitment and active participation, while remaining reserved by relinquishing omnipotence and accepting dependence.

We therefore recognize a mutuality in care: one must know how to care for oneself as well as for another person. This mutuality, together with the three modalities of care and the principles of care–cure, can be observed in our social clinical work, leading us to consider a clinical practice of care–cure.

A Clinical Illustration of Care and Cure

Junior[6] was two years old when the health team at PAB, the Infant Care Program, referred him for Mother–Infant Therapeutic Consultations because his parents were having difficulty accepting a baby with a syndrome.

His mother reported that she had already been referred for psychological care during pregnancy. The pregnancy had been unplanned, and her husband had not wanted another child because they already had a boy and a girl. This had led her to want an abortion, although she did not act on it. Anxiety arising from guilt and fear that the child might be born with a problem nevertheless accompanied her throughout pregnancy.

Tina said that, immediately after Junior’s birth, she noticed that he was floppier than other babies, although the medical assessment found him to be within normal limits and he was discharged from hospital. The authors consider that her perception of the baby may have been related to guilt about having wished to terminate the pregnancy, shaping a

representation of a different and/or ill baby.

Over time, Tina realized that her baby was indeed different. At ten days old, he began having tremors and staring fixedly for several minutes. When she sought medical help, she reported that the doctors could not tell her specifically what was wrong. They found that his brain function was severely impaired. He had marked generalized hypotonia that prevented muscular movement, almost impeded breathing, and left him without head control. A speech and language therapist identified impaired coordination of swallowing, causing choking and aspiration of food. A feeding tube was needed, along with supportive positioning pillows. Tina was not following the professionals' recommendations, which prompted the referral for psychological care.

During consultations, the therapist offered holding and deep empathy for the family's suffering. Tina gradually became aware of the guilt affecting both herself and her husband, who had supported abortion. It also became clear that their refusal to follow the healthcare team's recommendations was related to resistance to accepting the baby's condition. Because they believed he faced a life in a vegetative state, they felt death would be preferable.

The transgenerational dimension emerged when Tina reported that children born to her siblings had, in her view, experienced the same problem as Junior. Some had died, while others had recovered and were now healthy, giving her hope. At the same time, there was widespread denial within the family about these unusual occurrences. Everyone pretended nothing was wrong, increasing Tina's sense of helplessness because her family did not offer support or understanding. She found these instead in the therapeutic consultations. The baby also received care addressing basic needs related to his neurovegetative impairments, including interpersonal interaction that recognized and supported his subjectivity.

Junior's father, who had not attended consultations because of work, was invited to participate. He came and confirmed his wife's account of the unwanted pregnancy and his preference for abortion. He also agreed with her refusal to follow treatment recommendations: since there would be no cure, he believed death would be better. Through the consultations, this position changed. He stopped blaming his wife and began actively participating in the baby's care. Both parents came to support their child's survival, accepting the placement of a gastric feeding tube, arranging his baptism, and providing specialized care to ensure his comfort and well-being.

Guilt, unresolved mourning, and transgenerational issues can hinder the development of a healthy mother–infant bond. These were particularly significant given the baby's illness and the fact that Tina's mother had died shortly after Junior was born. By speaking about her suffering, Tina could work through these issues and recognize the other person not only as a therapist but also as someone facilitating an experience of her own image, her self.

This recognition of the self began to help Tina. As she recognized her suffering and guilt, she could relinquish omnipotence and acknowledge her dependence, which was met by the therapist's holding. Only when she felt sufficiently welcomed and held could she acknowledge that she had wanted Junior to die, believing that a life of unending care would not be the best option for him, herself, or the family who would have to care for him

indefinitely.

By acknowledging this wish, Tina could integrate part of her self. With a more integrated self, she could allow her instinctual vitality to be reclaimed by the therapist. In other words, this integration enabled her to respond to the therapist's calls toward life: she was a good mother with healthy children, and what had happened to Junior was a misfortune. The therapeutic work emphasized that no one was to blame for his developmental impairment.

The case illustrates the success of therapeutic consultations beyond the consulting room and traditional setting, extending the reach of psychoanalytic practice by adapting to the demands of contemporary clinical work (Figueiredo, 2009). In the projects developed by Habitare, we have observed this possibility for social clinical practice to become a practice of care–cure.

Author Information and Notes

1. Doctorate from the Institute of Clinical Psychology, University of São Paulo (USP); president and coordinator of HABITARE; member of the Department of Child Psychoanalysis and Espaço Potencial at Instituto Sedes Sapientiae, São Paulo.

2. Psychology graduate of PUC São Paulo; undertaking specialist training in Child Psychoanalysis at Instituto Sedes Sapientiae, São Paulo; volunteer team member and project coordinator at HABITARE.

3. A program developed by Sociedade Beneficente Israelita Brasileira Albert Einstein (SBIBAE) in the Paraisópolis community.

4. Serge Lebovici began using the concept of parenthood in place of "family," emphasizing that being a biological parent or being designated a father or mother is not enough. It is necessary to "become parents, which takes place through a complex process of working through, at conscious and unconscious levels, one's own conscious and unconscious material and that inherited from parents and ancestors" (Lebovici, 2004; translated from the Portuguese text).

5. Although the proposal is to work with the child and parents/caregivers, most sessions take place with only the mother and infant. Various everyday circumstances have prevented fathers from attending, and Habitare has been reflecting on these factors. We intend to present and discuss them on a future occasion.

6. Fictitious name.

Translation note: Author affiliations reflect the original manuscript. Quotations are translated from the Portuguese text rather than reproduced from published English editions. The clinical account and its interpretations have been preserved; this translation does not independently validate them. Original publication titles are retained, with English translations in brackets where appropriate. Some works cited in the text have no corresponding entry in the original reference list.

References

Alvarez, A. (1992). “Reclaiming.” In Live Company: Psychoanalytic Psychotherapy with Autistic, Borderline, Deprived and Abused Children. London: Routledge.

Figueiredo, L. C. (2009). As diversas faces do cuidar [The Many Faces of Caring]. São Paulo: Escuta.

Lebovici, S. (1993). Consulta Terapêutica madre-lactante [Mother–Infant Therapeutic Consultation]. Revista de Psicoanálisis APdeBA, XV(1), 125–146.

Winnicott, D. W. (1965). O valor da consulta terapêutica [The Value of the Therapeutic Consultation]. In Explorações Psicanalíticas [Psychoanalytic Explorations], D. W. Winnicott, R. Shepherd, and M. Danis, pp. 244–248. Porto Alegre: Artes Médicas, 1994. [Names reproduced as supplied in the source.]

Winnicott, D. W. (1958). Da Pediatria à Psicanálise – Textos selecionados [From Paediatrics to Psycho-Analysis: Selected Papers]. Rio de Janeiro: Francisco Alves, 1993.

Winnicott, D. W. (1971a). Consultas terapêuticas em Psiquiatria Infantil [Therapeutic Consultations in Child Psychiatry]. Rio de Janeiro: Imago, 1984.

Winnicott, D. W. (1971b). O Brincar e a Realidade [Playing and Reality]. Rio de Janeiro: Imago.

Winnicott, D. W. (1989). Tudo começa em casa [Home Is Where We Start From]. Translated by Paulo Sandler, 4th ed. São Paulo: Martins Fontes, 1989.

Oliveira, T. M. (2008). Atenção Materna primária: Consulta terapêutica uma proposta de Prevenção Comunitária [Primary Maternal Attention: Therapeutic Consultation as a Proposal for Community Prevention]. Doctoral dissertation, Institute of Psychology, University of São Paulo.