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Parent-infant psychotherapy in the context of malformation: implications on the mother's perception about the babys development

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ABSTRACT

INTRODUCTION: Maternal representations of the infant can be quite distorted when the infant has a malformation. Within this context, there is a need of psychological interventions aimed at helping parents to adapt their psychic representations with the purpose of avoiding projections and conflicts in order to promote the infant's physical and psychic development. In this sense, the present study investigated the impact of a short-term mother-infant psychotherapy on the maternal representations of the infant's development when the infant had a cardiac malformation. **METHODS:** The short psychotherapy process (24 sessions) of a mother-infant pair is reported. The authors describe how the issue of life and growth changes throughout treatment. **RESULTS:** The results evidenced several changes in the maternal representations of the infant, as well as the mother's attitude regarding the search of information on malformation and child care. **CONCLUSION:** The results emphasize the benefit of short mother-infant psychotherapy for the context of infant's malformation, mainly for the maternal representations of the infant's development.

Keywords: Malformation, psychotherapy.

INTRODUCTION

Even within a normal context, motherhood is associated with several mournings[1] such as the lost of the woman's complete autonomy, or the lost of the position of being only a daughter, as well as complex psychic and relational reformulations that are inherent to this moment.[1,2] In that sense, the birth of a child with a malformation is an additional crisis, and all the difficulties are even more intense.

Therefore, there is a gap between what the mothers wished for and the reality, and many expectations need to be put away, which may impair the child's idealization and libidinization process.[3] There are several possibilities of outcomes in this relationship, from a gradual acceptance to responses of anxiety, depression, use of pathological projections, which make the child into a scapegoat that carries all the family's failures, or excessive overprotection.[3,4]

Thus, one single pathology may present different unconscious psychic representations depending on who is its carrier or who analyzes it, that is, depending on the position of the baby in the parents' mind.[5] In other words, malformation itself does not seem to be enough to accurately determine all the limitations or potential of the psychic development in these situations, and the maternal representation of the baby end up having a fundamental role in this prognosis.

Stern[6] corroborates this idea suggesting that the world of parents' representations plays a determining role in the type of parents-baby relationship that is as important as or sometimes more important than the role played by the real external world. Such representational world is related to how the parents subjectively experience and interpret the objects that are objectively available in their interaction with the baby, including their behaviors and the baby's behavior. Thus, not only the parents' experiences resulting from the interaction with the baby are part of this representational world, but also their fantasies, fears, dreams, recollections of their own childhood, parental models, and expectations regarding the baby's future.

According to Stern, this representation process is very intense, being present even during the pregnancy. This author emphasizes that the experience of motherhood activates so many changes in the mother's mind that, based on that, he[6] developed the concept of "motherhood constellation." Such constellation is related to a new psychic organization that will define several mother's actions, fears, fantasies, and desires, becoming the dominating axis of a woman's psychic life. The author points out that the motherhood constellation encompasses three concerns and speeches that, in spite of being different, are correlated: the mother's dialogue with her own mother, the mother's dialogue with herself, and the mother's dialogue with the baby. The mental reelaboration concerning this trilogy of motherhood creates four topics: "life and growth;" "primary relationship;" "support matrix;" and "identity reorganization." The first topic, life and growth, involves the issue of the mother feeling able to keep the baby alive after the birth, providing him/her with continual development and physical growth. This topic usually produces fear and anxiety for the mothers regarding disease, death, etc., as if these happenings could evidence that they are not good mothers. The topic of primary relationship is related to the capacity of providing maternal love and recognizing the baby as her child. The third topic, support matrix, is related to the mother's need of creating and allowing the existence of a protective support network so that she is able to promote the baby's physical and psychic development. The fourth and last topic, identity reorganization, is related to the mother's need of transforming and reorganizing her identity so that she can have a new attitude as a mother without so much autonomy.

The author[6]did not investigated specifically the issue of malformation, although he wrote about some ideas that allow us to assume how maternal representations may turn out in this situation. As mentioned above, the author states that the representations require a subjective experience of being with the baby that can be mental or real. This is related to the possibility of imagining, providing it with meaning and waiting for the baby. When there is a malformation, Stern highlights that the parents cannot plan and design a course of development for their child; they are not allowed to have a more concrete idea of their child's future due to a medical reality. Later, Stern adds that, within such a context, the mother losses a large part of the imaginary process, which may lead to difficulties in building a representational structure of the future, creating, according to the author, a representational vacuum. Stern states that: "And when you cannot imagine the future, you cannot evaluate the present. One of the main pillars of the enterprise of representation has been taken away."[6] The author believes that is fathers and mothers are not helped to look at this

vacuum, there is severe risk of failure in the ontogenesis of the parents' representation of the present and future child, in addition to a related failure in the child's own representation.

In such situation, psychological interventions are often necessary because they can help the parents, and mainly the mothers, to play their role more effectively, thus providing safer bases for the baby's good psychic development. Short-term mother-infant psychotherapy carried out by Cramer & Palacio-Espasa[7] could, according to these authors, provide a significant improvement of the baby's symptoms, as well as in terms of interactive behaviors and representations of parenthood. After performing a deep analysis of the factors that originated changes in the short-term mother-infant therapy, the authors considered that, when parents change the investments and representations of their child, they reduce the projections on the child. Curative processes are established at different levels: changes in the interactions, related to the reduction of projections; changes in the maternal representations of the child, especially by means of decontamination of parasite elements originated in the mother's internal world; and changes in the investments on the child, including libidinal, aggressive, or narcisistic investments. This objective may be in agreement with the baby's abnormalities, since the maternal representations of the child need to be more widely changed and adapted to a new reality.

METHOD

Participants

The participants of the present study were the mother (let's call her Camilla, 22 years old, housewife, who completed high school) and the baby (let's call him João Otávio, Jota, 11 months old). The baby had a severe heart malformation compatible with life. The father, let's call him Jorge, 49 years old, who held a university degree, was invited to participate in the psychotherapy, but his presence was not possible due to professional reasons, and the attended only two sessions. The family lived in very unfavorable economic conditions. They went through very basic needs, with shortage of food, clothes and household resources, in addition to difficulties to buy Jota's medication.

Study design, procedure, and instruments

The mother-infant pair was seen by the first author of the present study during a short-term mother-infant psychotherapy as detailed above.[8] The process included 24 sessions throughout 7 months. These sessions were divided into three moments of the study: six initial assessment sessions (phase I); 17 mother-infant psychotherapy sessions (phase II); one post-psychotherapy assessment session (AS) (phase III). All interviews and sessions were audio- and viderecorded and later they were transcribed for analysis.

During phase I, Camilla was informed about the objectives of the study and the assessment procedures for the participation in the mother-infant psychotherapy. Once she accepted to participate, the mother signed a written consent form (Group of Social Interaction, Development and Psychopathology - GIDEP, Childhood and Family Study Center (NUDIF), Diagnostic Interview, Porto Alegre, Institute of Psychology, Universidade Federal do Rio Grande do Sul - UFRGS, Instrument not published, 2003) and the initial contact record was completed (GIDEP, NUDIF, Instrument not published, 1998). Next, the therapist suggested that she reported how she was feeling and which were the reasons that led her to seek treatment. Throughout of the other five initial assessment sessions, the Mini International Neuropsychiatric Interview (MINI)[9,10] and the Beck Depression Inventory (BDI)[11,12] were administered with the purpose of assessing the mother's emotional aspects. In addition, the emotional aspects were also more qualitatively investigated using the diagnostic interview (GIDEP, NUDIF, Diagnostic Interview, Porto Alegre, Institute of Psychology, Universidade Federal do Rio Grande do Sul - UFRGS, Instrument not published, 2004). Also, the following instruments were administered: the interview on pregnancy and delivery (GIDEP, NUDIF, Interview on Pregnancy and Delivery, Porto Alegre, Institute of Psychology, UFRGS, Instrument not published, 2003), the interview on the baby's development (GIDEP, NUDIF, Interview on the Baby's Development, Porto Alegre, Institute of Psychology, UFRGS, Instrument not published, 2003), and the interview on motherhood experience (GIDEP, NUDIF, Interview on Motherhood Experience, Porto

Alegre, Institute of Psychology, UFRGS, Instrument not published, 2003). Both the instruments to asses the emotional aspects and the interviews were used, during this first phase, to provide the therapist with important data regarding the mother's emotional state, the compatibility or not of the case with the indication for short-term mother-infant psychotherapy, in addition to providing data on the baby's history for that family and on the mother's history, which was useful for the psychotherapeutic process.

During phase II of the study, the family was offered free of charge short-term mother-infant psychotherapy with an additional transportation allowance, since the family did not have enough money to pay for the transportation. The family was treated with psychotherapy by the first author of the present study.

Phase III took place 2 weeks after the end of the psychotherapy when a post-psychotherapy assessment session was scheduled with Camilla and Jota. This session was conducted by another psychotherapist and involved a new assessment of the mother using the following instruments: diagnostic interview, BDI, interview on the baby's development, and interview on the motherhood experience. During this phase, the assessment instruments regarding the emotional aspects and the other interviews were also used to evaluate occasional changes caused by psychotherapy. All interviews conducted during the initial assessment sessions and the post-psychotherapy session, as well as the psychotherapy sessions were audio- and video-recorded, being transcribed for later analysis. The psychotherapy process is thoroughly described in the PhD dissertation of the therapist who treated this family.[13]

In addition to providing psychotherapeutic treatment, the psychotherapist participated in a supervision group comprised of other four psychotherapists and a clinical supervisor, psychiatrist and specialist in the mother-infant psychotherapy technique. During these meetings, which were held once a week, the case was discussed including both theoretical and technical aspects.

The study designed used was of a longitudinal single case study,[14] with the purpose of investigating the impact of short-term mother-infant psychotherapy on the maternal representations of the baby with malformation. This impact was assessed in more detail based on the first of the four topics of the motherhood constellation proposed by Stern,[6] "life and growth." The impact of psychotherapy on the other topics of the motherhood constellation suggested by Stern,[6] "primary relationship," "support matrix," and "identity reorganization," was also analyzed by Gomes[13] in the PhD dissertation that gave origin to this manuscript. We performed a qualitative analysis of the manifested and latent contents of the mother's speech and the mother-infant interaction based on the psychoanalytical frame of reference. With that purpose, the transcriptions of the whole material were read for several times, using also the videos in order to watch the sessions again.

Next, the result of the analyses is shown. The sessions were grouped into phases divided based on the main changes observed in the speech and mother-infant interaction, always illustrating the analyses with passages of the session. Therefore, we intended to clearly show the psychic movement of the maternal representations during the main moments of treatment, as well as to discuss such evidence based on the literature. It is worth mentioning that the material is often presented using the first person singular with the purpose of showing a reliable picture of the closeness of the author's involvement with the participants and with the whole psychotherapeutic process.

RESULTS AND DISCUSSION

The first phase of the topic "life and growth" lasted from the first assessment session to the second psychotherapy session (PS). During this phase, the maternal representation of the baby was evidenced as being quite partial. That is, Jota was mainly seen based on idealization, with regard to the normalization of his growth restriction and being overvalued in comparison with his twin sister, who did not have malformation:

But he is fine. He is quite active, he just has this little problem of not growing, you know. This is normal, you know, typical of children. But he is fine. He much smarter than his sister, who is bigger than him... (1st AS)

It is possible to consider that the mother had a need of compensation his malformation by promoting her son to higher potentials that could reduce the inherent limits of his health condition. However, in spite of the fact that it may be consider a type of denial, and even the use of a reactive formation, we believe it was a necessary movement so that the mother could see that her son had growth potentials and, thus, invest him with affection and hope.

The literature suggests that this is a quite common relationship in parents of children with malformation. Due to their trauma, these parents develop unconscious defensive responses. These responses range from denial to reactive formation, which not only repeal the restrictions, but also transform them into potentialities.[15] Also according to this point of view regarding the mother-child relationship in situations of malformation, Sinason[16] points out the frequency of the overprotection behavior as this type of attitude relieves the suffering caused by the limitations and protects against the natural risks this child is more vulnerable to. Considering children with heart malformation, this attitude is quite significant[17] and has the purpose of removing as much as possible the threatening reality. While she saw her idealized son, Camilla was somehow overprotecting him, since this way she deleted his limitations and sufferings.

Nevertheless, while talking about Jota's possible sufferings, she burst into tears. I understood that she was connecting to the maternal pain that, although a little reduced by the compensating point of view, was there and also belonged to her son. Some authors have promoted the importance of the word in the treatment involving infants, since the speech can help to express suffering, thus leading to its ellaboration.[18,19] Therefore, I decodified for Jota the possible meaning of his mother's cry:

You know, Jota, this is a difficult issue, you know. So many things I will have to face. I'm little, I have many things to do. (1st AS)

Only after that event, Camilla could express her suffering without using so many masks, talking about the discomfort she felt when she went out with Jota, because people would ask her about his condition, and she did not feel like answering. "People say poor little boy, what a pitty! And I don't know. I don't like it" (1st AS). It seemed that what she did not say also hindered her psychic expansion because she was afraid of facing her fears and anxieties.

However, despite my attempts to integrate Camilla's point of view and feelings of pain and hope at the same time, she showed she needed to live more partially for a while and idealized the baby again at the end of the session: "In my opinion, despite the fact that he is a little thin, she is normal, there is nothing wrong" (1st AS). Such attitude is totally expected considering the complexity of this transformation and the fact that we were in the beginning of the treatment. It seemed that to really help Camilla and Jota it was necessary tolerate a schizo-paranoid functioning,[20] and the evolution to a depressive position would take some time to happen naturally, especially due to all their experiences of object instability.

In the beginning of the second assessment session, Camilla brought me a gift. It was a plaster sculpture she made of two singing priests. I thank her and complimented her on her skills. I thought about something connected to "life," "singing," "music," and "trust" (priests are secret confidents). She seemed to be thankful for the attention, in addition to being willing to please me, maybe because she believed that this was the only way she could continue to have a more constant and continent object. Soon after that, she praised her son's smartness: "He was stretching out to see what was going on" (2nd AS).

It is possible to consider the libidinizing function that I, as a therapist and a third element in the relationship, could be performing. As if I were a mirror, I reflected for Camilla, when I complimented her on her artistic skills, her own values and, as a consequence, she was able to, by facing this image of herself, also according to a speculative point of view, provide Jota with higher value and thus reflect on him a more enchanting vision. Lacan[21] and Winnicott[22] described the mirror function on the psychic constitution. They believed that the son, being an extension of the mother, is seen as a similar element. When Camilla felt undervalued and rejected, she tended to see her son in the same manner, which was exacerbated by his malformation, a concrete and real factor that can

intensify narcissistic failures. However, on the other hand, if Camilla could – maybe as in that moment when she felts more valued – see herself less undervalued, the chances of Jota representing a more complete son with potentials for her would increase significantly.

It is worth mentioning and thinking that throughout this session she was able to reveal situations related to her strong fear of loosing her son soon after he was born:

He was wearing some kind of glasses, a lot of stuff to make him breath... at the ICU... a feeding tube, very thin, his foot sole was with raw skin... and, on the next day, the cardiologist explained everything to me. Then I got desperate, you know. (2nd AS)

Above all, I felt she was really starting to count on me to reexperience those difficult scenes that added an intense fear that Jota will not get better and could die. Her faith on the fact that Jota could live and grow was completely weak at that time: "I could get there on the next day and he could not be there anymore... To tell you the truth, I though he would die" (2nd AS).

Stern[6] remind us how it is important for parents to be able to see a future for their child so that they can build a psychic representation of their child. Camilla was often unable to have that evolutive notion, which leads us to believe that the psychic representation she had of Jota was not linear and constant.

Furthermore, each one of Jota's achievements was much more valued than any progress made by a normal child. In face of that, it is possible to see the different position assumed by a child with malformation: everything is overvalued, the gains, the losses, the danger; everything is intense, limiting the space for the other activities of the mother, even regarding her other children, which may create feelings of guilt.[23] Gianotti[17] highlights that in cases of heart malformation, this movement is very intense due to the threat represented by the heart; thus the individual with a cardiopathy becomes the center of attention and his/her siblings receive less attention. In agreement with this remark of the author, the feeling of guilt was made evident through Camilla's speech, as she realized she dedicated herself more intensively to Jota's needs and sometime even neglected her other children. Even if in Camilla's case it did not seem that the malformation was the only reason for such disregard, she need to believe the hypothesis that Jota was the one to be blamed so that maybe she could exempt from the responsibility of mother and adult woman, which seemed to be a burden for her. Actually, maybe this was the opportunity for her to show the resentment she felt towards him and the malformation and to express how much he absorbed her: "We ended up taking bad care of her because of him, you know." (3rd AS). Her anger seemed to be quite evident soon after that, when the baby asked for her attention and she scolded him coarsely.

Such projective mechanism of making Jota responsible for something that she could not tolerate in herself shows the overburden that Camilla was carrying in her life and, mainly, within the context of malformation.[24] She did not have psychic or economic conditions to endure that. Maybe that is the reason why she assigned her and her husband's responsibilities to her parents and sisters.

Concerns regarding Jota's life and growth were constantly present in their relational life: "If he feels anything I try to know what it is, I think that maybe I did not give him his medication on time, I start wondering... like that, you know." (4th AS). Here, it is important to think about how it is like to life under constant tension and threat of loss. And since the heart is symbolically considered the organ of life, this threat is even more frightening.[25] The literature points out that the psychism tends to defend itself from these extreme and traumatic burdens by softening or even transforming the situation, with the purpose of avoiding a possible breakdown.[26] This was Camilla's reaction at several moments, as the ones described above, but now she was explaining the reasons for that. She lived worried and terrified with the possibility of losing her son and recognizing that without a continent emotional support was not psychically possible.

It is possible to consider that at the enc of the assessment sessions and realizing that she was building a trust bond with me, she was able to have more contact with this painful reality and, as a consequence, slowly started to have a more active attitude in order to deal with it. Thus, it was possible to observe Camilla's initial movement to start trying to find ways of buying her son's medications:

He is taking two medicines I could buy, you know. Now I went there and manicured for her... and I bought the medicine for his blood pressure... I still have to buy four more. (5th AS).

Such possibility of more closely facing the reality of threat was present throughout the first and second psychotherapy sessions, during which the mother reported severe intercurrent events of her son's health. She was starting to take advantage of the supportive environment of the treatment and my role as a continent for her anxieties and fears.

In short, this first phase, from the first AS to the second PS, was initially characterized by the mother's more partial representation of her son, that is, a more idealized representation that compensated his malformation. Her representations of herself were based on an idea of undervalue and guilt for not being able to provide his son with everything he needed. Feelings of anger and constant tension were prevalent during this phase. Slowly, Camilla was able to express the fear of losing her son, her angers, using the sessions as a continent for helping her to feel and think about her reality. It was possible to observe also the beginning of a more active attitude trying to obtain more resources for her son.

The second phase, which lasted from the third to the fifth PS, involved a maternal representation of a baby that was making progress and had much potential. Camilla proudly pointed out her son's growth:

His clothes are too small! I try to put them on and they keep getting open! His shoes as well... He is getting bigger... he is really big! (3rd PS)

Tell her the great news! A big tooth in your mouth! (4th PS)

This movement seems to be a continuation of the first phase, when she could borrow Jota's risks and her fears of losing him. Freud[27] mentions that once the individual uses the mechanism of isolating the affection to soften the difficulties, the true positive investments can also be reduced. It is like a general anesthesia, that is, you do not get too close to avoid feeling the pain and, this way, love and pleasure are also lost. Therefore, as Camilla approached her reality, her fear of loss and anger she felt about all that, she seemed to be able to have contact with the pride and hope she felt regarding her son. Thus, during this second phase, from the third to the fifth PS, the maternal representations were aimed at a grown baby that was making progress. In addition, Camilla seemed to perceive herself as someone who had a higher maternal value.

The third phase included the gap between the sixth and ninth PS. During this period, the maternal representation of the baby was connected to high risk and vulnerability. Camilla highlighted once more how much Jota requested more attention than a normal child, since he needed constant special care:

He started to have this hoarseness and I took him to the hospital... and the doctors said: "you did the right thing bringing him because he is the kind of child who cannot have anything!" (6th PS)

Along with this statement, she expressed an idea of a defective baby, different from others: "He has a lot of defects! A lot of ... different stuff" (8th PS).

With regard to this label, Schorn[28] mentions that the malformation is a mark for the whole life, an organic and psychic mark. This author draws attention to the difficulty of defining malformation, since it is not a single disease, one symptom, or even a single syndrome. Therefore, it is called "mark" with the purpose of providing a psychic connotation, as if the organic defect would always lead to strangeness[29] or, at least, to a categorization as being "different".[15] This psychic connotation seems to be present in the mother's speech when she says that Jota "has a lot of defects, a lot of different stuff," not defining the heart malformation and showing that this is a big issue in her mind.

Such a burden, added up to Camilla's personal needs, sometimes seemed to paralyze her, as if she hoped that the solutions would come out without her effort. During the sixth PS, when I asked about the catheterism, she said: "The doctor is not willing to do it right now because she wants to do it through the private health insurance plan" (6th PS). Actually, this was a projection of her own desires on the doctor. Due to her needs, she could not leave her more passive infantile condition of

being cared for instead of taking care, and this way, the little girl who lived inside her was anxious because she wanted that her parents paid for a private health insurance plan; in other words, she wanted them to take care of her. Thus, giving up being treated using a private health insurance plan and trying to get treatment from the public health system (SUS) meant that she had to admit that she depended on her own and had to forget some infantile desires. However, such attitude would lead her to face her abandonment, which, at that specific moment, was too much for her to take.

Then, I tried to convince Camilla to face the real risk condition Jota was going through, connecting it to her unconscious desire of being cared for. Here it is important to mention that my continent attitude was essential, because did not work as a superegoic element, which was showing her abandonment regarding her son, but it worked as an assistant ego to help her think about the reasons that led her not to react:

Maybe it's that... you and I had already seen... that there was a part of you in that, you know. Still want that things were like that [through the private health insurance plan]*, and creating false expectations for the hospital team. (6th PS).*

Thus, maybe I was somehow fulfilling that void of the needy girl, giving her a mind to analyze things, at the same time I held her "on my lap", providing her with resources to go ahead. After being able to understand and accept this content, the mother arrived for the seventh session with the catheterism scheduled through the public health system: "I called them every day, you know. That's what I did. Then I got it... on Friday he will have the catheterism" (7th PS). In addition, she showed she was taking active care of Jota, such as not bringing him to the session to avoid distressing him before the procedure.

With regard to the technique used in this situation, Ferro[30] emphasizes the higher importance of the relational field between patient and analyst in comparison with the importance of the material provided by the patient. Therefore, I tried to guide myself by the field built by our minds, perceiving that interpreting the abandonment regarding her son and the possible reasons for that could work as a superego and a more severe ego ideal, maybe generating a paralyzing guilt. Thus, I tried to prioritize another focus, being able to transform, according to Ferro's suggestions, the superego of the relational field. First, being able to offer me as someone who contains and helps to think, I tried to provide space to analyze together with the patient the abandonments or what could generate the overwhelming guilt as something that could slowly be replaced by the desire of being understood and the desire of changing.

Another aspect that could be contributing to Camilla's passivity is the psychic impossibility of being constantly close to her son's high risk, which led her to soften the situation. Such state of tension, added up to all other Camilla's concerns, represented a psychic overburden that impaired her ability to discriminate. Several studies have shown that mothers of children with malformation, when compared to mothers of children without physical problems, have a higher level of stress, depression, anxiety, and low self-esteem,[7,8,17,26] and this seems to be corroborated by Camilla's psychic state. Her constant tension due to the difficulties and to Jota's malformation let her confuse and she could not differentiate the situations and emergencies and was not able to organize the routine of family care.

However, in spite of these obstacles, during this phase, Camilla seemed to be more prepared to face reality. This was evidenced by the fact that, during the eighth PS, she told me she had found out about more complication in her son's heart, she was very sad and afraid, but this did not paralyze her. Instead, it motivated her to want to find out more about what was happening, suggesting a meeting with the medical team responsible for Jota.

Thinking about the mourning phases proposed by Drotar et al.[24] and Moura,[31]which mothers have to go through when they have a child with malformation, we can assume that Camilla needed therapeutic support to leave the denial phase and face the situation, going towards a stage of better reorganization.

Her overburden was too excessive and this was evident during this eighth session. My countertransference feelings were of lack of power and much pain. Such intensity appeared also in Jota, who started to cry while Camilla expressed her fear that he could die. I felt that I needed to translate to him what was actually going on there. Szejer & Stewart[32] believe that what is not said

causes a deeper psychic harm than the explanation, even when this explanation is very painful. And I felt that at that moment; he seemed to be asking me to translate all that strong anxiety of death, and that was what I did, trying to transmit the message into a calm and clear manner:

Mommy is crying, Jota! She is afraid. She is telling us that today in a stronger way. You know. She wants you to get well, but she is afraid! That's why we are here. To talk about these very hard things... but sometimes she doesn't know how you are... isn't that true, Camilla? You are not sure, right? (8th PS)

Jota stopped crying, instead of Camilla, who kept crying while she talked about the situation. And, after I valued the fact that she was able to be there with me to talk about difficult things for her, Camilla, expressed not her fear, but her horror of losing her son: "I can't take it anymore! [crying] So many things happened!... he might die! [about his heart growing large]" (8th PS).

Rajon et al.[33] suggested that the therapist needs to work as a lighting rod for the patients' pains. And, by means of my countertransferential feeling of grief and sadness, I knew I was being this lighting rod, since I was also carrying that burden of suffering. It seemed that my function was effectively being accomplished since the mother asked me to anticipate the ninth PS because the surgery had been scheduled and she was very anxious.

Thus, the third phase, from the sixth to the ninth PS, was characterized by the representation of a fragile, high risk and different baby. The prevalent feelings were of strong fear of loss, sadness, and guilt. The mother's representation on her own changed from a more passive and infantile attitude to a behavior of facing the reality and active search of family and medical support.

The fourth phase lasted from the 10th to the 12th PS. In spite of being a period close to a surgery, Camilla showed a representation of a more active and grown baby ("He is restless! Now, just because he had a lot of teeth, he thinks he is something else!" (10th PS) and also a strong baby showing reaction capacity:

Because when I left home with him[to go to the hospital]*and it seemed that he was coming here,* [for the session]*he was all happy!... Then, when we got there*[at the hospital]*, he had another milk bottle!... They brought him dinner, and he ate... and asked for more!* (11th PS)

During this session, the transferential feeling of trust and well being of the mother projected into the baby was evident, which shows a strong therapeutic bond.

In spite of the fact that the maternal representations involve a grown baby with better abilities, the idea of vulnerability was still present: "Then he started to get better, you know. But all the time he had those things... [blood] saturation, you know." (11th PS). Then, it was possible to observe a more integrated representation of the baby: he could be capable and vulnerable at the same time. However, the idea of a different baby, which had been mentioned before, was still present: "He is completely different! And this vena cava is directly connected to this single ventricle he has, you know..." (11th PS). Considering the study by Trolt[34], who stated that the ideal baby will survive forever in the mother's mind every time she sees a normal child or, when she has to face his child's difficulties, she can remember this image of the child she lost, this way thinking of the difference between the real and the ideal. We believe that the idea of difference in Camilla is related to this aspect.

During this phase, Camilla was very devoted to her son, staying in the hospital all the time with him. She kept being more active also with regard to the search for resources, also looking for help to organize a charity party to raise funds for the medications (12th PS). It seemed that the affective investment in Jota had become more possible in spite of the fear of loss still being present. It is possible to consider that this movement is also related to Camilla's self-esteem, which had increased. She said she felt she had "good milk" to offer him, different from what happened before when maybe she was not investing in him to protect him from her belief in a "bad, spoiled" content. The feelings of guilt now were reverted, at least partially, into attempts to help him. This may also be related to the fact that the mother was receiving "good milk" during the sessions and, therefore, by receiving better food she could offer better food. This alludes to the idea mentioned in another study conducted by me with a group of colleagues[35] involving the intrauterine observation of babies,

where we discussed how much the observer needed to serve as a good belly that supports and feeds the mother, thus providing her with conditions to be a good belly for the baby. There are many layers, skins that serve as continents and nutrients.

In short, this fourth phase of psychotherapy was characterized by a more integrated representation of the child, which started to be seen as capable and vulnerable at the same time. The idea of being a different baby was still present in the mother's mind. Her representations as mother solidified, being related to more activities of search for help to fulfill the needs of her son and much devotion to his care during the hospitalization. The fear of losing her son was still present, but, at the same time, there was hope that he would get better.

The fifth phase of the psychotherapy consisted of the interval between the 13th and the 15th PS. It was characterized by Camilla's important emotional variation. First, she was extremely happy and optimistic regarding her son's progress, which even led to a strong reappearance of the idealized representation of the baby: "He is going to be an air force engineer! He is going to work for NASA... [laughs]" (13th PS). Next, she mentioned that, when she was a teenager, she thought about pursuing this career. The desire that the children fulfill the voids left by the parents has already been discussed by Freud.[36] In *On Narcissism: An Introduction*, the author mentioned that the touching parental love is not anything else than the parent's resuscitated narcissism. Cramer & Palacio-Espasa[7] commented on how the baby can be seen according to an alienating point of view, that is, regardless of his/her true self, serving solely to provide his/her parents' with satisfaction.

However, in spite of having an idealized image of the baby, maternal expectations also mean that she was planning a future for her child, a sign of investment and hope. Camilla seemed to be excited by the way Jota was responding after the surgery: "He is more mischievous now! He put on weight! After the surgery, he started to eat more. Now, the first step is to get pumped legs!" (13th PS). I mentioned that if she was talking about a first step, then it meant that there were other steps after that, with the purpose of reinforcing hope and the need of stimulation. Then, she was showing me how Jota's legs were more stable, and he was trying to walk. Maybe that was our history as well, we were walking in spite of the difficulties. We had many experiences together... I believe that my emotion when I saw him making efforts to stand up came from that, because I remembered seeing him at the ICU 2 weeks earlier. "How much willingness to live!", I thought.

However, in the next week, the supply of electric power was stopped to their home due to non payment. And this metaphorically stopped the supply of Camilla's internal light and her possibility of "seeing." She showed she was feeling like dying, or, in other words, she wanted to receive a lot of attention and to avoid the end of the treatment, which was schedule to happen in some weeks, according to a discussion with the supervision group. It is possible to conclude that, after a recent period of a lot of attention and devotion to her son due to the surgery, Camilla entered a state of emotional exhaustion, which was being overcome by the success of the procedure and by Jota's evident gains. Nevertheless, the lost of electric power might have meant the return of the constant instabilities of Camilla's life: "Now that everything was fine, this happens, I'm tired" (14th PS); it may have reminded her of the fact that she would have to deal with the situation by herself again soon, since her separation from me was going to happen soon.

In short, the fifth phase was characterized by the mother's oscillation between withdrawing from her son and getting close to him again, trying to play her maternal role. The external reality of so many difficulties needed to be faced slowly.

The sixth and last phase lasted from the 16th PS to the post-psychotherapy session. During this phase, the baby was seen as a more active, smart and grown baby:

Much smart now... he is so cute, chubby. He can speak now: "daddy," "piss,", "dad," "mommy" and ... he can crawl now! (16th PS)

But the perception of vulnerability was still present, which is a more integrated representation of the baby, with potentials and weaknesses. The fear of loss was still present, but this did not prevent her from investing in her son in the present:

I think of what I can do for him right now, so that I do not think that in 2 years something will happen... his heart will grow and maybe the results of the exams do not come from abroad... then we have to think of what we can do today, you know. At this moment. (16th PS)

The literature suggests that one of the factors that hinders the stimulation and the investment of mothers in the development of their children with malformation is related to the constant threat of losing them. Thus, they sometimes keep from feeling affection until they are sure that the baby will survive.[37,38] This way, we could consider Camilla's difficulty in investing, since she did not know when and even if there would be more stability and safeness. However, she seemed to be able to learn how to live with the fear without being "anesthetized" regarding her son. She demonstrated by this last comment that if the future was unknown, the present was not, and she was going to fight for the present, acknowledging that her powerlessness was not so current as she used to feel it was.

In the beginning of the 17th PS, while Camilla spoke about her satisfaction of being able to count on her more, Jota started an attempt to crawl, and she proudly said that this was one of his new achievements. It is possible to understand that moment as an expression of a healthier interaction, in which what Camilla was saying about herself – more movement and evolution –, Jota was showing in his behavior. Both had achievements to show, had left stagnation and "were crawling" towards growth.

Maternal representations of her son also involved an idea of evolution, confirmed by the medical assessment:

And Jota is fine. Now his medical visits are being scheduled for every 2 months. He does not need to see the doctor every month because he is doing great! (17th PS)

And such evolution was then followed by the perception and acceptance of his limitations (he would get tired when he moved), which evidenced again the possibility of seeing him in a more integrated manner. Camilla was taking measures to overcome these limitations. Thus, her maternal representations of herself expressed more competence, since she believed she could get a breathing bag for Jota, avoiding that he would get so tired and allowing him to move more (17th PS). She demonstrated a very active attitude in the search for resources for her son.

Chess & Hassibi[39]highlighted that sometimes mothers do not invest in their children evolution as if malformation imposed limitations and failures. This process is called cross effect of disabilities and in such a process limitations may be more closely associated with maternal representations than with the malformation itself. Then, Camilla was not passively accepting Jota's limitations, possibly because of a representation of higher value about her and her son, which led her to invest in his progress, being able to get a breathing bag with the purpose of trying to overcome the respiratory sequelae of his malformation. It is possible to consider the psychotherapy as a symbolic representation of this oxygen that was allowing her to be stronger to react, changing her representation from a disabled baby to someone with potential. According to Kamers & Baratto,[40], the signifier is able to change the body mechanics itself.

In that sense, representations play a special role in the nature of the relationship between the pair and in the way the mother invests and believes in her child. During the second last PS, Camilla showed that she had abandoned an important belief regarding Jota, that he had inherited every bad aspect from her:

There is no chance that something bad from me contaminated him. Things that I have experienced and... then, I think that every child has something of their parents, but... I think that there is not a child that will get just the negative part of what their parents have gone through. (16th PS)

When she got rid of these pathologic projections, the mother started to represent him in a more real, true manner, including potentialities and difficulties. This was evident when she said she knew that that was a calm moment, but the there could be new obstacles in the future: "This is just a period of calmness" (17th PS). Hope seemed to be present in spite of the threat: "When Jota gets really big, we are going to see his doctor to show that Jota got completely cured!" (17th PS).

Camilla's representation of a different baby was still present until the last post-psychotherapy session. Therefore, it is possible to consider that this idea is true and that the fact that it remained present is an ability to see that in order to being able to face this situation in a more harmonious manner. Thus, this last phase was characterized by the maternal representation of a more integrated baby, with potentials and weaknesses. The fear of death was present, but it did not prevent affective and physical investments. The maternal representations of the mother herself involved an impression of higher competence and more active attitudes. Feelings of hope and constant concern were always present in the mother's speech.

With this last post-psychotherapy session, we concluded the treatment recommended for this family. This happened based on the proposal of a short-term parent-infant psychotherapy, which is aimed at changing the maternal representations of the baby by means of decontamination of parasite elements from the mother's internal and external world, making them more adequate to reality. Once such objectives were reached, at least partially, the author, together with the supervision group, concluded that the case should be closed, as the mother was sent to individual therapy. In spite of a significant decrease in the scores on the BDI before and after psychotherapy (from 31 to 11), this individual therapy was really important due to the psychic variations demonstrated by the mother and also due to the uncertainty regarding Jota's clinical progress, who should still undergo several surgeries. Taking this situation into consideration, Camilla could continue to take advantage of the professional support to face this situation and her own material and personal needs.

FINAL COMMENTS

In general, the evolution of the topic "life and growth" during the treatment showed that the mother's representation of the baby changed from being partial (fragile or idealized) to a more integrated representation (vulnerable, but having some potentials). The mother's attitude became more active in the search for resources and information about the malformation. The maternal feelings of fear, anger, and guilt could be more deeply accessed and expressed, leaving more space for feelings of hope.

Based on what has been mentioned above, the benefit of short parent-infant psychotherapy for the context of infant’s malformation seems evident, mainly for the maternal representations of the infant’s development. Thus, we suggest that this technique is increasingly offered to families that have to face such situations. It is necessary that malformation is not treated by the health professionals strictly in terms of its physical and functional aspects, considering that the psychological aspects also need to be treated. As it has been highlighted above, the psychological care in the specific case of this family had a significant impact on the child's clinical picture, since the mother was much more involved with his treatment, thus avoiding the exacerbation of the disease and frequent hospitalizations.

Thus, I hope that Camilla's availability and trust to show us all her pain and to reexperience her primitive anxieties during psychotherapy may be useful for the training of mental health professional that continue to investigate, understand and help so many Camillas and Jotas that receive treatment in our hospitals.

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