A LONGITUDINAL STUDY OF MOTHER-INFANT PAIRS: PSYCHOLOGICAL SUFFERING DURING MOTHERHOOD

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ABSTRACT: This is a psychoanalytical study in the field of Early Detection of Severe Psychopathologies. It proposes a longitudinal study through monitoring of mother-infant pairs in a public institution specialized in the care of pregnant women. The idea is to study how the fundamental bond between mother and child is established, and analyze certain signs of psychological distress within this setting. This research aims to discuss the methodological impasses that arise; to share findings; and to discuss a concept of psychological distress which is typical to this stage of life.

Keywords: longitudinal study; motherhood; psychopathology; psychoanalysis; mental health.

Resumo: Estudo longitudinal de duplas mãe-bebê: o sofrimento psíquico na maternidade. Trata-se de uma pesquisa de orientação psicanalítica no campo da Detecção Precoce de Psicopatologias Graves. Propõe um estudo longitudinal através do acompanhamento de duplas mãe-bebê numa instituição pública especializada nos cuidados à saúde da gestante, visando estudar a construção desse laço primordial e de alguns sinais de sofrimento psíquico nessa configuração. Pretende-se discutir os impasses metodológicos vividos, compartilhar achados e discutir uma concepção de sofrimento psíquico peculiar a essa etapa de vida.

Palavras-chave: estudo longitudinal; maternidade; psicopatologia; psicanálise; saúde mental.

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This is a longitudinal and psychoanalytic study which seeks to contribute to current discussions concerning signs of psychological distress in mother-baby pairs. It focuses on monitoring such pairs from pregnancy to the child's third year, so as to study the establishment of this new and essential bond; the new subjective positions that, as a result, begin to be organized (father, child, mother of a child, mother of three, for example); and certain signs of psychological distress.

This study is part of a larger survey conducted at Pontifical Catholic University of São Paulo (PUC-SP) – Early Detection of Severe Psychopathologies. The latter was carried out following a cross-sectional study model in which single interviews were conducted in general health services offering care to children, such as hospitals, ICUs and pediatrics clinics. This instrument intended to allow the mother-baby bond to freely express itself; all manifestations – both from the mother and from the baby, that is, from the newly established bond – were taken into account for subsequent analysis.

The analysis aimed to identify three signs in the pairs: the presence of eye contact, the presence of the third phase of the pulsional circuit, as well as the presence of organized speech based on the development of an otherness. The absence of these signs was considered indicative of psychological distress with severe psychopathological risk, since the developing otherness and subjectivity may manifest through these linguistic and symbolic signs (LOPES, et al., 2009).

The first two were identified by French psychoanalyst Marie-Christine Laznik in the early detection of autism (LAZNIK, 1997). They are used at the Centre Alfred Binet in Paris, by the group of researchers at PRÉAUT – Prévèntion Autistique[2], and also by pediatricians belonging to the French public system, for the early identification and referral of infants with signs of autism, for necessary intervention so as to prevent aggravation and chronicity.

The lack of eye contact between a mother and her baby, added to the lack of the third phase of the pulsional circuit, i.e., the baby doen not provoke loving gestures from the mother (the baby invites eye contact, kisses) have been shown to be reliable indications of autistic risk, from the baby's third month on: they indicate impasses in the establishment of the pulsional circuit within the mother-baby bond, preventing the construction of the erogenous body, its inclusion in the logic of desire and the construction of the usual communicational and symbolic matrixes.

By saying this we do not intend to suggest an etiological basis for infantile autism, but simply to discuss certain signs of its clinical manifestation. Cases of autism are widely discussed but have not been clearly defined; it is presumably the result of a complex mix of epigenetic factors, as with global development disorders in general.

The third sign, in turn, was considered by this team of researchers (VISANI; RABELLO, 2012; LOPES, et al., 2009), taking into account the discursive quality between mother-baby as indicative of otherness and of the establishment of subjectiveness in this loving bond, established in the logic of desire, since duly established by the pulsional circuit. Based on this premise, we understand that, when the mother's speech does not include the baby as a relevant party, does not recognize it in the context of otherness and of symbolic exchanges, this suggests significant distress in the establishment of the mother-baby bond, as well as impasses in the organization of interlocution positions in this dyad (me-you), impasses in the organization of transitivity and otherness, in the constitution of maternal and paternal functions, of the communicational bond, of ego organization in the child, and may contribute or even determine, as a result, Global Developmental Disorders, F-84, according to ICD – International Statistical Classification of Diseases and Related Health Problems (Version: 1.6c)[3].

2 French autism research group: <http://preaut.fr/>.

3 Source: http://www.datasus.gov.br/cid10/download.htm. Access: jul. 2014.

Using these indicators during the course of the initial cross-sectional study, we found that the signs described for the early detection of psychological distress in the mother-baby pairs in general health institutions were reliable. However, we were surprised by a significantly higher incidence of pairs revealing other signs of psychological distress, with less serious – but more frequent – consequences, leading the team to carry out this study.

Current epidemiological studies find that psychological disorders in children are equivalent, in Latin America and the Caribbean, to between 15% and 21%. However, among these, severe childhood disorders (F-84, for example) are equivalent to around 5% to 9%, and are therefore rare when considered in general health service and rare compared to a larger group of other psychological distress conditions in young children. Finally, we also know the relevance of this data, since psychological distress in early childhood may jeopardize the development and the subjective life of a child, as well as pleasure in the bond of this child with his educators (FEITOSA, et al, 2011; PAULA, et al., 2007; LAURIDSEN; TANAKA, 2005).

The described finding, added to this picture, led us to broaden the spectrum of psychological distress during childhood to be studied. As a strategy, facing the new problem posed, we considered moving the research's methodological approach from cross-sectional to longitudinal, so as to monitor these events over a certain period of time – also understanding that longitudinal monitoring would allow better psychoanalytic listening compared to previous cross-sectional studies.

ABOUT THE METHOD

Scott Menard indicates that a longitudinal study is defined both by certain conditions for data collection and by methods of analysis used in research: data is collected over two or more periods of time, and analysis must involve some comparison between them (MENARD, 1991).

We sought in literature longitudinal studies of mother-baby pairs oriented by psychoanalysis,[4] and we realized that, even in the group focused on studying this population, there was considerable diversity in the methodology, objectives and theoretical framework within the psychoanalysis universe (Klein, Winnicott, among others).

As for the method, certain studies strictly use psychoanalytic listening, either in the usual psychoanalytic setting or in institutional settings focused on health (GUEDENEY; LEBOVICI, 1999; LEBOVICI, 1987; WENDLAND, 2001).

Based on this definition, we must consider that the psychoanalytic clinic usually establishes longitudinal research and a classic case study, like many found in the psychoanalytic literature, and is, since Freud, important analysis and compilation material for research.

Other studies, however, associate the psychoanalytic approach to experimental procedures. This is the case of important research conducted by Margaret Mahler, Fred Pine and Anni Bergman in order to study the process, which they called "Separation/Individuation" (MAHLER; PINE; BERGMAN, 1986). The authors monitored the mother-baby pairs through psychoanalytic listening and experimental observation, from birth to five years old, aiming to find out more about the process by which this primordial connection and ambivalent paths governing necessary separation is carried out. The authors highlight the attempt to establish an appropriate balance between free and floating psychoanalytical observations and a fixed experimental design, however, they mention the methodological difficulties that can result from this, pointing out that the procedures used in this work "are subject to serious criticism from both sides" (MAHLER; PINE; BERGMAN, 1986, p. 31), i.e., both from psychoanalysts and experimentalists.

There are also researchers who had undergone psychoanalytic training, such as John Bowlby and René Spitz, who associated psychoanalytic knowledge to ethology and the experimental method, carrying out

[4] Researchers Bruna Amoroso Pastore and Flávia Horta Hungria collaborated with this research.

important studies on different contingencies of the mother-baby bond, on the conditions inherent to attachment and separation (BOWLBY, 1952/1988; SPITZ, 1954/1993). Spitz described phenomena such as hospitalism and anaclitic depression in young children, among other unique conditions that problematize the paths that make up healthy separation within this bond, with consequences for the care of a child in the bond with his mother, in various health institutions.

As for the goals that define the many studies on psychoanalysis in this field, we found longitudinal studies exploring various aspects of the mother-baby relationship, among which we must emphasize the frequent and relevant use of the Bick Method for baby observation by many psychoanalysts.

Esther Bick, bringing together the results of several observations, described important signs of psychological distress in early life, such as self-calming procedures and adhesive identification; her observation method still guides numerous works to the present day (BICK, 1961, 1964, 1968).

We also found researchers who used longitudinal studies in order to develop reliable tools to identify signs of distress in mother-baby pairs. These guidelines aim to promptly offer care to those showing signs of psychological distress. Among these, we highlight the aforementioned research by the PRÉAUT group in France, which inspires our research through Marie-Christine Laznik's contributions, and the *Multicenter Research concerning the Clinical Indicators of Risk to Child Development*[5], Brazilian research which is nationally coordinated by Professor Maria Cristina Kupfer, from University of São Paulo (USP), and brings together 31 clinical risk indicators – IRDI, and is available to early childhood professionals.

Thus, we found various studies that use different psychoanalytic theoretical references, and they all show their potential contribution to the study of this field.

The main common point among them is consensus concerning the relevance of studying the primordial mother-baby relationship, because of its central role in the constitution of the human psyche, as well as the early signs of psychological distress in mother-baby pairs, determining the importance of comprehensive attention to early childhood health and maternal suffering, so as to avoid the aggravation and chronicity of initial psychological distress into severe psychopathologies.

This research, in order to contribute to this field of studies, conducted its work in partnership with the Hospital Municipal Maternidade e Escola de Vila Nova Cachoeirinha "Dr. Mário de Moraes Altenfelder Silva," an institution that has been sensitive to this field through those responsible for this partnership: the Coordination of the Neonatal Clinic and the Coordination of the Psychology Sector.

This is a reference hospital in the care of high-risk pregnancies, of childbirth and of the early stages of the mother-baby pair, offering specialized care to pregnant women referred by several Basic Health Units of the city of São Paulo's Northern region.

We heard pregnant women receiving prenatal care in this hospital, seeking to find out more about the contingencies of the constitution of this primordial bond, from the beginning of pregnancy to the third year of the child's life. In the initial contact with these pregnant women, following a routine medical prenatal check-up, they were informed about the research that was going on in the next room, where psychological listening was offered. They were informed about their freedom to participate or not in any stage of the process, and if they showed interest in doing so, they were presented an instrument for ***free***, prior and informed ***consent***, duly signing it.

Next, they were invited to talk about their visits to the hospital; their return visits were scheduled at the same dates of their medical appointments, when these pregnant women would be able to present themselves

[5] Cf. KUPFER, M. C. M. Pesquisa multicêntrica de indicadores clínicos para a detecção precoce de riscos no desenvolvimento infantil. *Revista Latinoamericana de Psicopatologia Fundamental*, v. VI, n. 2, São Paulo, 2003, p. 7-25 e KUPFER, et al. Predictive value of clinical risk indicators in child development: final results of a study based on psychoanalytic theory. *Revista Latinoamericana de Psicopatologia Fundamental*, v. XIII, n. 1, São Paulo, 2010, p. 31-52.

to the researchers or not, as they wished. However, these return visits became a major problem for the continuity of research, because, due to institutional dynamics, changes would commonly occur in the scheduling times of prenatal consultations, in many cases making longitudinal monitoring difficult.

After the birth of the child, however, continued monitoring was scheduled, according to the preference of the family: at the hospital itself, at the Basic Health Unit where the baby received pediatric monitoring, or in the family home. In none of the cases was it possible to monitor a case up to the third year of a child's life, due to specific situations in each case.

Periodically, meetings were held by this team of researchers with the representatives of the institution who established this partnership, to discuss methodological procedures, results, impasses and possible reformulations, based on what experience was presenting.

In this unusual setting, this psychoanalytic research used listening as defined by Freud – which, guided by the free association of the speaker and by the floating attention of who is listening, values the experience of the unconscious. It takes into account, to this end, the field of transference experience where speech is organized, transference with the institution and with the researchers, as well as the demands that led pregnant women to the researchers' room, following medical consultation. Thus, it takes into consideration the field of language and of drive, where discourses and demands that reveal the unconscious experience are constructed, in the form of repetitions, misunderstandings, among other symptomatic productions (BIRMAN, 1994). Such subjective productions are, therefore, privileged by the listening of the one who stands in the position of researcher in this project. Whether within the scope of research, or of clinical practice, psychoanalytic listening should also be considered a methodological tool, respecting the basis and the ethics that so define it, since Freud.

Based on this guidance, we take care to avoid any interpretative hastiness, favoring the construction of meaning by whomever is speaking. This longitudinal study experience will be problematized based on the same criteria, although experienced in the externality of the usual field of psychoanalysis and with a specific population: mother-baby pairs that are being established.

PSYCHOANALYSIS AND MOTHERHOOD

Based on the knowledge accumulated by psychoanalysis, we know that motherhood and the mother-baby bond are complex constitutional processes which are not instinctively secured, either from the maternal side or from the side of the newborn child (BADINTER, 1985). They are not natural responses, but a unique development arising from a complex symbolic transmission and transgenerational order, in which motherhood begins to support itself based on the logic of desire, given the symbolic game established in the history of that family, that society, according to its filiation, in which ancestral customs are updated in the confrontation with current experiences.

Freud (1933[1932]/1996), in his study of femininity, points out that the baby is part of a subjective place that is unique to his mother, determined by transgenerationality and, within that, by its unique experience facing castration anxiety, when it is introduced into the logic of oedipal triangulation and sexual difference. To Freud, motherhood has an important place in the elaborations of women facing such distresses, configured as a possible female response when she understands the place of the child in the series of phallic substitutes. Thus, we understand that motherhood has an impact on the female psyche.

From early childhood, women (as well as men) are faced with difficult enigmas about herself (or himself), about male and female sexuality, about motherhood, about the body, about babies and about the world of relationships.

Thus, when she herself experiences motherhood, a woman is referred to previous psychological dramas in her history – and even prior to her history, involving endless elaborations. Through the transitivity of relationships, especially primordial relationships, the woman places herself as one who has transgenerational

knowledge (and anxieties) that will serve as the subjective plot for the composition of new subjectivities in construction: father, mother, child, mother of several children or of one child, in a given family framework.

On this, Jacques Lacan brings the idea, in his 1938 "Family Complexes", of an eversion which occurs specially in the breastfeeding situation (LACAN, 1938/2008).

> Thus constituted, the imago of the maternal breast dominates the whole life of a man... she may be able to saturate herself in the eversion of the situation that she represents, which is only strictly carried out in motherhood. In lactation, in the embrace and in contemplating the child, the mother, at the same time, receives and satisfies the most primitive of desires (...). (LACAN, 2008, p. 24).

The identificatory power that sustains the mother-baby bond reveals the "eversion" suggested by Lacan, who puts together in a single scene the mother to her baby, the mother to herself and, at the same time, the baby to its mother, in itself. This overturn nurtures a nursing mother with the care received (and the distresses experienced) to be transmitted in this new care of the baby, in this identification game. Thus, it can also confront mother and baby with the emptiness marked by the helplessness that has been experienced.

Currently, several psychoanalysts study pregnancy and the mother-baby bond and make important contributions to knowledge concerning the elements involved in this field. Julieta Jerusalinsky points out that the penis-phallus-baby equation presented by Freud and phallic pleasure, described before, do not exhaust the size of the mother-baby bond and the pleasure in maternity (JERUSALINSKY, 2009). She suggests that pleasure in transitivity, that is, in this exchange of places and positions, through identification processes, can be an alternative pleasure to expected phallic pleasure.

Regina Orth Aragão emphasizes the work that is imposed on the mother's psyche during pregnancy, pointing to important psychological reshuffling in the psychological universe of the mother's representations, in order to build a new representation for herself in the relationship with the new baby (ARAGÃO, 2007).

In this sense, it is worth remembering Monique Bydlowski's contributions, when she points out that pregnancy engenders a particular state in a woman's psyche, a condition she call *Psychic Transparency*, which is characterized by relaxation of repressions, allowing fragments of pre-consciousness and unconsciousness to surface to consciousness. She points out that pregnancy and thw psychic transparency that accompanies it revive, for many women, the memory of their origins, and thus emotions, conflicts, knowledge and primitive anxieties pertaining to her first bonds are reactivated (BYDLOWSKI, 2002). The representations and phantoms that dominate this period may, in turn, acquire materiality with the arrival of the child, turning into knowledge, but also at risk of creating impasses in the mother-baby bond.

The findings of the longitudinal study that we present here reaffirm the sense of complexity and psychological density in maternity and in the establishment of the mother-baby bond.

When listening was offered to pregnant women in the described prenatal clinic, many wanted to bring their subjective experiences to this research. In the uniqueness and complexity of their speeches, they revealed anxieties and conflicts, in this process, which they did not want to express to the doctors during the consultation, minutes earlier. When asked about this, they sometimes revealed fear of being reprimanded because of the conflicts and bad thoughts they were having regarding their health and their babies' heath, because of their attempted abortions or attempts to threaten their health or even their own lives. Other times, they felt that the doctors would not be interested in psychological details that had no relation with physical health. In this context, they sometimes told doctors about situations that were important in terms of medical information, such as the self-inflicted falls or abortion attempts. Thus, the fact that doctors were not informed about these women's psychological distress placed them next to the knowledge required for proper clinical reasoning, revealing the inseparability of physical and mental health, determining the need for a health professional and system capable of accommodating the complexity that defines the health of human beings and, in this case, the complexity of the pregnancy phenomenon.

Other pregnant women who were not experiencing such serious episodes, in turn, told daily life stories followed by significant memory lapses and signs of distress that had to be considered.

But could we consider these signs evidence of an initial psychopathological configuration in this mother-baby bond? Or were they signs of conflicts that would be elaborated during the process of building their new subjective positions?

These issues were the focus of attention in the proposed longitudinal monitoring.

ABOUT THE MATERNAL ANGUISH THAT WAS FOUND

Since we understand that clinical practice is paramount, excerpts from the speech of the women who chose to participate in this research will be presented to enhance this discussion – those who became emblematic of a certain psychological dynamics also presented by other pregnant women, thus being considered worthy of analysis and discussion.

Ana, a young pregnant woman – 17, suffering from hypertension, already the mother of a three-year-old child. She was interviewed following her first prenatal visit to the hospital. Invited to speak, she said she thought she was "about 8 months' pregnant, but she didn't know, since each person said something different"; "she was there to see if all was well with her child, to know how many months' pregnant she was, when the baby was due, whether it would be a natural or caesarean birth, to get things solved once and for all." She justified not having had prenatal care before by saying that "at the basic health unit they didn't want to treat her because she had high blood pressure, and she should already have had her first visit to the hospital, but the doctor was missing on the day." Whatever the aspect of her pregnancy that was considered, knowledge and responsibility were placed on another, and so was neglect. Ana was very late to her next appointment; meeting with the researcher was impossible, and the next scheduled appointments after that were incompatible.

Beth, pregnant for the first time, 6 months' pregnant, said she was surprised and anguished because she was expecting twins. She committed certain lapses, saying she was "there to take care of her health and for the unborn baby to be born well," referring to the babies as if they were one. On the date of her next appointment, Beth said she "didn't want to talk right now;" she was waiting for a second medical exam that day; she looked worried and said that she might be hospitalized.

In both cases longitudinal monitoring was not feasible; these pregnant women were heard only once.

Cida, in turn, was monitored until the child was eight months old.

At her first interview, she said she was "distracted and very happy, since her pregnancy had just been confirmed." Her gestational age was calculated at two months. She referred to the pregnancy as "a dream coming true." She also referred to a previous pregnancy, ectopic, which had to be interrupted, reporting suffering because of this. Cida was just about to begin treatment to get pregnant when she spontaneously became pregnant with this child.

In the following interviews, she told us about several family problems, including the deaths of an uncle, a cousin and a family friend, saying "she still hadn't been able to think about the pregnancy, or had had time to enjoy this moment."

During follow-up, doubts as to her ability as a mother came up. When she was around 7 months' pregnant, she said, "they say the mother feels if the baby is boy or girl, but I don't know, I don't feel anything." She went on to say that "if it was a girl, they'd choose the name of a cousin who was very sweet and intelligent." If it was a boy, "she'd use the name of her brother, murdered four years ago." She also said that this "was her husband's suggestion and that her father thought it would be a beautiful tribute."

The child was a girl and was in fact given the mother's cousin's name, Rafaela.

Over the same period, close to seven months' pregnant, Cida felt strange to feel the baby move at certain moments. She said she felt physically unwell, and how difficult and what a sacrifice in terms of health

pregnancy was: she developed hypertension, culminating in imminent eclampsia and premature cesarean section.

The child was hospitalized in the ICU for over a month.

In general, we saw few signs of enthusiasm from this mother, despite the fact that she initially described pregnancy as a major achievement. She disqualified her place as a mother. She repeatedly spoke about her problems, difficulties and sacrifice.

After birth, we met this pair three times.

In the first meeting, when the baby was still hospitalized in the ICU, the mother said she was coming to see it every day. She was nursing her daughter, helped by the service's speech therapist to promote breastfeeding. Rafaela suckled a little, stopped, suckled again. The mother spoke little, both with the researcher and with her daughter, but at times talked to the baby and sometimes spoke for her. Cida said that Rafaela "was gaining weight every day, only a little, but she was."

The second and third meetings took place during the child's consultation in the premature clinic. In these, the father was also present.

At the second meeting, the parents were quite quiet, but Cida said that Rafaela "was not being breastfed, that her milk was not enough and that her daughter would not suckle." Cida gave the baby a bottle and seemed happy to hold her daughter on her lap. Rafaela opened her eyes, looked at her parents at times, complained a little and then fell asleep.

In the third meeting, the mother was more talkative; she said "her daughter was smart, liked to talk and eat, and was like her grandfather in this – her father." She said that "life changes so much with child," and that, to her, "everything was new." Rafaela, very well-looked after and tidy, was on her father's lap. Her mother picked her up, but soon the baby leant towards her father and returned to his lap. The child made eye contact, vocalized when she was spoken to, smiled, but more so towards her father. This was mentioned by her mother when she described her daughter's strong connection with her father, and that she always paid attention to the signs of his arrival home.

Signs of conflict as to the desire to have a child were a common element in four pregnant women, each in their uniqueness. Here we discuss two of them.

Denise, three months' pregnant in the first interview, stated that "she did not intend to get pregnant" and that she had "taken the morning after pill, but to no avail." She already had two daughters from her first marriage and the bond with the baby's father was described as minor.

She lived with her daughters in her parents' house and said, many times, that "her family was having a hard time accepting, that there was a fight when they learned she was pregnant." She also said several times that her greatest difficulty was in relation to her father, who "only found out when she was 4 months' pregnant, and was very angry, but later accepted."

Denise repeated that, before telling her family, she "felt as if she had committed a crime and was hiding the body." At the beginning of follow-up, she stressed these family conflicts. She said she was calmer after her family accepted her pregnancy.

At approximately 8 months' pregnant, she began to speak mostly about her concern for the health of the baby, her anticipation of the birth and her fear of the pain of childbirth.

She sometimes talked about the child's father, but so as to little include him, revealing disappointment and disqualifying him, saying, for example, that "he was not there when she needed him most, when she told her father about the pregnancy" and that "she did not want him around, since her daughter, still in her belly, did not need him."

Also in this final period of pregnancy, Denise said, a few times, that she "turned into a difficult and moody person when she is pregnant, finding herself the ugliest woman in the world and not wanting to see anyone." But she also pointed out that "having begun to talk about it helped her feel better."

We only saw Denise once after the birth of her child, at a medical appointment at the hospital, without the baby. On that occasion, she said she was "one hundred percent better," chose not to continue participating in the research and brought several photos of her daughter so that we could get to know her that way.

In the other case, we highlight signs of intense pregnancy conflict as to the desire to have another child. Elisa was married, had two children, a girl of 11 and a boy of 9. The pregnancy was unexpected, and was discovered when Elisa went to her gynecologist to cauterize a wound in her cervix.

In the first interview, at 3 months' pregnant, she said she "did not accept it well." Later on, she said that when she learned she was pregnant she hit her belly and threw herself from a ladder, trying to abort. At an interview at 5 months' pregnant, she said that she "appeared to be pregnant at certain times and at other, not." But she also said she had "begun to feel the baby move and then thought she was indeed pregnant."

During her monitoring, we supposed there had been some appeasement as to her conflict, and a movement for the preparation of a possible place for the child was revealed. The pregnancy gradually became more concrete to the mother, especially, as already mentioned, with the baby's first movements and, later, by visualization of the child – a girl – through ultrasound examination images.

The images helped towards the psychological realization, with greater stability, of the existence of this baby to the mother, allowing her to even fall in love with it. Around this time, Elisa began to assign characteristics to her daughter. At the end of the pregnancy, she complained great deal about physical discomfort and about how hard it was to carry out certain activities, simultaneously expressing that she wanted the baby to be born soon.

After the birth of the child, some time passed before Elisa met the researcher, since some institutional definitions were necessary to monitoring the cases outside the hospital.

After that, we met the pair at the basic health unit where the child was taken to pediatric consultation. Caroline, the small baby, was active, made eye contact, smiled, took her toy to her mouth and, according to her mother, used to do a lot of "cute stuff" to please her father. Elisa, in turn, said she was going through a difficult period, full of irritation, anxiety and hypertension crises following the birth of her daughter, as well as difficulty to take care of her, needing help from her family.

She referred to this as a time that had passed, saying "everything's already well." At our next meeting, however, she made a request for attention, declaring that she needed help.

We considered how to receive this request, established within this complex research space in psychoanalysis, since its inevitable intervention and the construction of a transference relationship with the researcher offering listening is known.

After many discussions with the research team, care was offered, after giving her the option to continue with the researcher who accompanied her, or to change to another member of staff, or even to another person or institution.

The mother chose the researcher, explaining that the latter "already knew her since her daughter's pregnancy."

This request, as well as the fact that this pregnant woman had mentioned that she felt better after having started talking, made an important issue emerge: while researchers in psychoanalysis, what is our place?

The boundaries between research and intervention seem tenuous in this field. The researcher's listening does not differ from psychoanalytic listening in its ethical foundations and may, even in the context of research, have interventional effects and effects as to the subject's construction of knowledge about themselves (COSTA; POLI, 2006).

We believe, therefore, that this is not a methodological difficulty, but a specificity and richness of research in psychoanalysis, in which the researcher cannot claim neutrality, if neutrality can in fact exist in some other kind of research work.

Returning to our case: the treatment was carried out over a short period. In it, Elisa told us mostly about conflicts with her own mother.

She felt she had been set aside by her mother in comparison to her sisters, although she was, according to herself, the only daughter who liked her mother and helped when she could. She complained of her mother's contempt; her mother had refused to help her in difficult situations during her life. Even in this very period, her mother had made little of her suffering, saying that she was being "finicky." This contempt was accentuated especially after her parents separated, when she was 14. Since then, her mother used to say that Elisa was a lot like her father, and that she should go live with him. Along with the topic of her relationship with her mother, she also spoke of thoughts that had begun during Caroline's pregnancy, of disease and death concerning herself, her husband and children, thoughts that were accompanied by fear; she was sometimes unable to leave home.

The care we had been offering was prematurely interrupted by Elisa, thus establishing the threshold for intervention. In the interruption, she mentioned an improvement and the difficulty to come to the sessions because she had gone back to work, also saying that "working, she didn't have time to think stupid things." This phrase was used repeatedly when referring to the bad thoughts.

During the period this pair was monitored, Caroline showed adequate motor development, good social contact, interest in the environment and toys. However, Elisa said that the daughter yelled a lot and that she wanted to be in her mother's arms all the time. She also had recurrent and important episodes of infection, allergies and rashes.

After a while, once again, Elisa sought care, when her daughter was hospitalized due to an infection. Soon after this hospitalization was over, we met the mother and child again. Elisa spoke of her intense concern for the health of the child, of her fear that the baby would get sick and die, and also about how difficult it was to wean her.

The suffering of this pair and the need for intervention were evident, but the interruption of care by the mother happened again, this time in a definite way.

We would also like to quickly address an aspect of another case that we monitored. This was a pregnant woman who was having her fourth pregnancy, Fabiana.

This woman had three daughters from her first marriage. The baby, a boy, was the first child of her current husband.

Fabiana, in the second interview, at 8 months' pregnant, presented significant suffering, saying that she "was afraid to feel, after the baby's birth, what she felt when her two younger daughters were born." She said she "had had postpartum depression, had cried a lot and had had evil thoughts; after the birth of her youngest daughter, she even saww herself throwing the child out of the hospital window." In addition, she said she isolated herself and just wanted to sleep, and that she had been like this until about a month after delivery. She had not received professional help regarding this issue in either of the two periods.

Also in this interview, Fabiana said that she "wanted to talk about it, since she was afraid that it would happen again," stating that "there are mothers who do stupid things after delivery." However, this concern had not been addressed so far in her prenatal care with her doctor.

After the baby – Mateus – was born, only phone contacts were initially possible; in them, Fabiana said she and her son were well and that she was not having those thoughts.

When the baby was three months' old, we held the first meeting with the pair in the basic health unit in which Mateus was monitored by the pediatrician, following medical consultation. Fabiana said they had found that the child had anemia, also saying that "he had jaundice at birth and that she had had high blood pressure, because she was nervous about the situation." She said that "the baby nursed at her breast for just a few days and then stopped." She said that, "after giving birth she did not feel ill, but felt a bit anguished for a few days; I should have been happy, but I was not."

She described her son saying he was “nice, slept well, and nursed at the bottle, was smart, talked to her, and was already a good companion.” During the interview, Mateus made eye contact, smiling, and playing with his hand, bringing it to his mouth.

Other meetings took place in the family home. Fabiana had no complaints, and seemed well. Mateus, in turn, showed adequate motor development, good social contact, with eye contact, smiles and vocalization towards other people. The pair let this research when the child was 6 months old, because they left the city.

ANALYSIS AND FINAL CONSIDERATIONS

This is one among many other psychoanalytic longitudinal studies in the field of the subjective organization of the mother-baby bond. It proposes the monitoring of mother-infant pairs, from pregnancy to the third year of the child’s life, understanding that this is a useful method to find out more about the paths through which this primordial bond is established, as well as the psychological distress that results from it.

We have known, since Freud, that the conditions for a woman to mother a baby are organized from the early days of her childhood, in the identification bond with her mother, as well as in the differentiation from the latter, in the organization of her broader subjectivity, marked by the female condition, by oedipal development and by transgenerational features. We also know that these conditions are updated by current affective, social and family experiences.

To begin listening to mother-baby pairs from pregnancy, however, was new to this group of researchers. After several discussions and studies on the collected material and on the methodological impasses experienced, some formulations were organized about:

1. The psychological configurations identified as indicative of psychological distress;
2. A mental suffering concept that is unique to this stage of life;
3. The suggestions arising from this experience for offering care.

- CONCERNING THE PSYCHOLOGICAL CONFIGURATIONS IDENTIFIED AS INDICATIVE OF PSYCHOLOGICAL DISTRESS

In this initial work, we categorized five signs of psychological distress observed in these mother-baby pairs during pregnancy:

a) maternal separation from the pregnancy process, with allocation of knowledge and responsibilities;
b) maternal denial of the baby, or of one of the babies when between twins, during pregnancy;
c) low libidinal investment or low pulsionality addressed to the baby, to maternity and to the symbolic construction of the baby in the maternal psyche;
d) depressive states and abortion attempts;
e) e. fear of ideas and of impulses that put the baby’s life at risk.

Thus, we separated certain settings suggestive of psychological distress found in this research.

Among the surveyed pairs (even if they are pairs during pregnancy), anguish facing the elaboration of intense transformations established in the body, the psyche and everyday life was configured as commonplace. The complex subjective movements determined by this condition inevitably lead to difficult elaborations in a short interval of time.

During the process accompanied by listening, we found, in general, a quick and healthy reinterpretation of suffering experienced about the pregnancy experience and about the symbolic and narcissistic place given to the baby, the child’s father and herself as a mother.

Some scholars have highlighted, a long time ago, this condition marked by intense and rapid physical, social and psychological changes during pregnancy as a salutary process (RAPHAEL-LEFF, 1997; BRAZELTOM; CRAMER, 2002; MALDONADO, 2002). They even highlight certain phases experienced by women during the psychological experience of pregnancy.

Maldonado (2002) describes, for example, during the first trimester of pregnancy, hypersomnia as preparation of the organism and the psyche, through resting to face these transformations. Raphael-Leff (1997) describes women's concern to adapt to new physical and emotional sensations, seeking new equilibrium. In this process, they begin to experience fantasies about their "real" pregnancy status, ambivalence about being pregnant or not, rapid emotional changes, marked by a sense of unreality and even rejection of their new and strange state.

The second trimester of pregnancy reveals sharper characteristics of their pregnant condition. Maldonado highlights "the impact of the first fetal movements" (MALDONADO, 2002, p. 41) and the roundness of their shape. The woman begins to admit sharing her body and realizes that the baby, in a way, is independent and out of her control. Pregnancy begins to be felt as a more realistic experience. The author also highlights important changes in the pregnant woman's bodily scheme and the weight of the irreversibility of this process in her life.

With the arrival of the third trimester of pregnancy, the bodily changes are even more intense; many women feel clumsy, swollen and exhausted, and feel the need to slow down, already preparing for the baby's arrival to the contexts of the home and of social relationships.

- CONCERNING A CONCEPT OF PSYCHOLOGICAL DISTRESS THAT IS SPECIFIC IN THIS STAGE OF LIFE.

Analyzing this experience, through interviews and the study of the mentioned authors, we understand this rapid movement of resignification as a healthy sign of the pair that is being subjectively established, as opposed to stagnation and to the restricted resignification found in clinical cases with greater risk of becoming chronic psychological suffering.

Some mothers found more fertile ground than others to carry out their elaborations with the necessary flexibility to realizing their new condition, finding a more or less generous offer of dialogue, so that their elaborations might move towards new directions, allowing the resignification of their lives, their bodies and their relationships and emotions.

We also realized the importance that listening offered by researchers had for those who were lonelier or who could not find peace of mind to say what they were thinking or living – whether to health care professionals, family members or companions. We realized that dialogue, when it recognizes its troubles and accepts its unique paths towards development, contributes significantly to the mental health of this pair and, therefore, to their general health.

The mothers who were lonelier and were facing greater conflicts were those who needed to talk, but who had less courage to reveal their troubles. This silence often brought mother and baby closer to a significant risk to their physical health and even to their life, since, by not revealing their depressions, their anguished impulses and the reality of their conditions and need for care to doctors in general.

- CONCERNING SUGGESTIONS ARISING FROM THIS EXPERIENCE FOR THE PRACTICAL CARE OF THIS POPULATION

We highlight, based on this longitudinal study, the importance and the interventional potential, and even preventive potential, that listening to the initial signs of distress may have to both mother and baby.

However, the anguish, the signs of suffering and, in general, the size of the subjectivity seem to have little acceptance in traditional prenatal care, and also in the monitoring of children and their families in health care

from early childhood, which gives priority attention to the intense transformations in the strictly organic aspect.

The findings of this study point to the anguish and suffering that were expressed within a specialized institution for the care of this population, when listening was offered to the mother-baby pair during pregnancy by researchers – listening that is not part of everyday care practices in this institution, which are restricted to clear cases of physical and psychological suffering that are sent on to the team's psychologists.

This fact makes us think how many other pregnant women in a condition of mental suffering pass silently through care institutions, as if the subjective elaborations that determine the construction of their roles as mothers and the symbolic construction of the babies in the subjective universes of those mothers were not relevant. We also know about the difficulties experienced by healthcare professionals to best offer attention to this suffering. Thus, we understand that the decision to offer this attention is not solely their responsibility, but of an entire care policy for pregnant women that enables this listening to suffering by health professional, from the moment of their professional training, in the management of their professional practices and in the valuation that this data offers to those who assess their work.

Thus, this study reveals aspects that showed the need, already known by many, to broaden the concept of maternal health and the health of the mother-baby pair beyond the usual medical parameters, taking also into account their subjective life and psychological distress, avoiding the chronification and aggravation of suffering that can determine unhealthy bonds in the formation of the new family configuration, as well as in the process of subjectivity and instrumental development of the child.

The Brazilian Ministry of Health, in its guidelines on Mental Health in Primary Care, has already pointed out that:

> To begin with, we understand that mental health is not separated from general health. And so it is necessary to recognize that the demands of mental health are present in several complaints of patients who come to health services, especially primary care. It is up to the professionals to understand and intervene on these issues.[6]

We consider that the findings of this research can contribute by offering subsidies to expand the concept of service and care to the mother-baby pair from pregnancy, including in this care a warm and welcoming approach that contributes to the organization of the subjective dimension that will sustain the bond that is being organized between mother and baby, and that is crucial to the constitution of a subject in a child.

A service that welcomes mother-baby pairs, in this delicate and decisive primordial phase, has an important role in early detection and intervention as to this quality of suffering, if available and attentive to listening to the impasses that can be configured in this bond.

In this sense, we intend to make these findings become gains, by proposing an increase in interdisciplinary clinical listening in the organization of specialized services for the care of pregnant women/mothers and their babies; services that take these issues into account, understanding this initiative as an action that promotes health and revalidates the principles of the Brazilian Unified Health System (SUS*)*. We thus take up once again some positions presented by the Brazilian Ministry of Health as to mental health care in primary care:

> To pay attention to mental health actions that can be performed in the context of the territory of the teams, we intend to draw attention to the fact that mental health does not necessarily require work beyond that already demanded of health professionals. It is, above all, that these professionals incorporate or enhance

[6] Source: http://bvsms.saude.gov.br/bvs/publicacoes/cadernos_atencao_basica_34_saude_mental.pdf (p. 11). Access: jul. 2014.

> care skills in mental health in their daily practice, so that their interventions are able to consider the subjectivity, the uniqueness and the user's view of the world in the process of full health care.[7]

Thus, participation in care is always necessary, identifying risks and needs, as well as creating effective clinical interventions that may exist in the case of mother-baby bonds in pregnancy, possibly even by the offer of a voluntary group of pregnant women who is willing to also hear the anguish experienced in this process, perhaps identifying those who need special listening. This is a suggestion among many that can be created by the teams.

We know that contemporary society has withdrawn the special attention and care which was traditionally offered in all social groups, Eastern or Western, to pregnant women and mothers in general – in which feminine wisdom accumulated by generations were transmitted as power to new mothers, in which small girls closely participated in the care of a baby and of the bond in formation.

In this way, we also want to discuss our academic training – still grounded in a strong biomedical perspective –, which understands that health professionals' work is restricted to anatomic and physiological reasoning, based on scientific evidence.

Finally, to complete the discussion of this research experience, we must reiterate the contribution of longitudinal studies to this research field, allowing a qualitative analysis of complex processes through which the organization of maternity and the mother-baby bond is established, noting that certain signs psychological distress, in pregnant women, when isolated, may give rise to misunderstandings about mental health in this context of life.

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[7] Source: http://bvsms.saude.gov.br/bvs/publicacoes/cadernos_atencao_basica_34_saude_mental.pdf (p. 11). Access: jul. 2014.

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