Motherhood and Early Interaction in a Schizoaffective Patient: The Story of a Long-Term Psychotherapy

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Pregnancy is a challenging time for the patient with psychosis, the fetus, the psychotherapist, and the team treating the patient. Little is known about being a parent with psychiatric illness and how to manage this clinical situation. This paper is the sequel to a previously published case study that described the process of psychotherapy with a schizoaffective patient (See AJP 62/2, 35-49). The patient became pregnant and gave birth to a boy. This paper reports the psychotherapeutic process of the patient during pregnancy, the child's early years, and over ten years after childbirth. The process of psychotherapy is discussed.

KEYWORDS: motherhood; mother-infant psychotherapy; psychotic mother; schizoaffective mother

INTRODUCTION

The process of deinstitutionalization has had unexpected consequences on the sexual and reproductive lives of people with severe mental illness. Patients with severe mental illnesses, such as schizophrenia or other psychotic disorders, aspire to a "normal" life in the community. As Miller and Finnery (1996) pointed out, the impact of deinstitutionalization has been particularly significant for women, who had fewer and shorter hospital stays than men with the same diagnoses: women were more sociable, more likely to date, to cohabit, and finally to engage in a sexually active life (Miller & Finnery, 1996). Consequently, the proportion of severely mentally ill people who are parents has been reported to be

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increasing, although it remains lower than in the general population (McGrath et al., 1999; Oyserman et al., 2000).

Women with psychotic disorders have more children and a more active parenting role than do men with similar diagnoses (Test et al., 1990). In a study of patients with psychosis in London, 63% of women, but only 26% of men, had at least one child (Howard et al., 2001) and in Australia, McGrath and colleagues found that 59% of their female patients were parents, compared with 25% of men. However, losing custody of a child is a frequent problem encountered by patients (Coverdale et al., 1989). Kumar et al. (1995) reported that 50% of mothers with schizophrenia were discharged from the hospital after giving birth without their babies, and Howard et al. (2003) found that 48% of mothers with schizophrenia and their babies were supervised by social services after discharge.

Little attention has been paid by adult psychiatry in research and service development to the fact that a severely mentally ill patient can be a parent (Howard, 2000). Yet it seems that motherhood, childcare, parenting, and having a partner have an impact on the course of women with schizophrenic and schizoaffective disorders during the first postpartum year (Bosanac et al., 2003). Moreover, the general assumption that psychotic patients are alone or with their parents and do not have families of their own, are based on stereotyped expectations, as are the services offered (Oyserman et al., 2000; Diaz-Caneja & Johnson, 2004).

Experiences of being a mother with a severe mental disorder have been examined in a few studies in the United States, Australia, and the United Kingdom. Most of the mothers studied reported great joy, fulfillment, and a sense of confidence in their parenting skills, but also described stress due to economic difficulties, lack of social support, fear of relapse, fear of children being stigmatized by the illness, and fear of losing custody of the child (Mowbray et al., 1995, 2001; Diaz-Caneja & Johnson, 2004). Additionally, women reported difficulties in combining medication and the concentration needed in caring for children. Mothers worried about the impact of their illness on the mental health of their children (Diaz-Caneja & Johnson, 2004). When interviewed, most women made it clear that they felt strongly involved in motherhood and did not want to relinquish their parental rights, although the rate of custody loss is high (Miller & Finnerty, 1996).

In the interviews, the women also commented on adult mental health services and professionals. Patients were mostly satisfied with the mental care they received, but also described it as failing to acknowledge children, motherhood, and the practical difficulties of adhering to treatment and

taking care of children. Attending appointments and using mental health services was challenging since there are no facilities in adult mental health offices for children (Craig, 2004; Diaz-Caneja & Johnson, 2004; Lagan et al., 2009; Solari et al., 2009). Moreover, the prejudices and negative attitudes of mental health professionals often were the main obstacles for pregnant patients in seeking help. In a study by Joseph et al. (1999) women reported that their pregnancies were mostly perceived by others as a calamity, while Nicholson and colleagues (1998) emphasized the negative assumptions of professionals, relatives and significant others. The professionals' ignorance and the patients' fear of losing custody of their children were obstacles to providing appropriate help. Additionally, mentally ill mothers experienced that adult psychiatry professionals were not interested in their family lives and experiences of parenting. Furthermore, when children were in foster care, the pain and worries of mothers were totally ignored by professionals (Diaz-Caneja & Johnson, 2004). Finally, the mothers' experiences were that help was only provided in periods of crisis during psychotic relapses and that the collaboration between mental health professionals and child protection agencies or child guidance was poor (Diaz-Caneja & Johnson, 2004).

CHALLENGES IN TRANSITION TO PARENTHOOD AND EARLY INTERACTION

Transition to parenthood is a transformation process occurring during adult life, implying integration of new knowledge, changes in roles, changes in identity, and changes in patterns of behavior (Benedek, 1959; Anthony & Benedek, 1970; O'Neill & Ruddick, 1979). Parenthood requires adjustment to a new role in society and to a new place in the family (Lydon et al., 1996; Hackel & Ruble, 1992; Kalmuss et al., 1992). Thus, the process of transition prepares the parent to respond adequately and sensitively to the infant's developmental needs.

The first stage of this transition process for women is pregnancy. Pregnancy is described as a developmental task with maturational phases. In the first stage, before the movements of the fetus are perceived, the pregnant mother goes through several processes, including changes in her body and strange bodily perceptions, such as feet and belly swelling, morning sickness, changes in her self-image and readjustment of her identity, and changes in emotional states, such as overreactions to minor incidents, inappropriate oversensitivity, and heightened emotionality and anxiety. The second stage of pregnancy is initiated by the perception of fetal movements. The expectant mother's concentration is divided be-

tween the demands of the external world and her growing attention toward what is happening within her. She elaborates fantasies and representations about the infant, sometimes communicating with him/her, and she reassesses her relationship toward her own mother. The third stage, during the last trimester, is labeled by concerns for the growth of the infant and concerns about labor and giving birth (Raphael-Leff, 1991).

Parenthood as a new state of inner life in the adult is related to the inner world of the newborn through emotional commitment and attachment. The concept of attachment bond and attachment system (which includes behavioral, exploratory, and emotional systems) introduced by Bowlby (1969/1977) and developed further by many researchers is central (Zeanah et al., 1993; Seifer et al., 1996). The representation of self as a mother is highly influenced by one's own childhood experiences and mental health (Fraiberg, 1980; Slade et al., 1999). The mother's representations of her unborn child (Benoit et al., 1997) or the mother's representations towards her attachment figures (Fonagy et al., 1991b) predict the quality of the infant's attachment pattern. Moreover, Fonagy and Target (1997) have suggested that the relationship between attachment processes and the development of the capacity to envision mental states in self and others is a key determinant for the organization of the self. The development of "reflective functioning", which emphasizes the ability to anticipate and to mentalize, starts in early infancy; this function may develop through life and later plays an important role in parents' sensitivity in understanding the needs of their developing children.

The process of adjustment to motherhood and to the early mother-infant relationship can be affected by several risk factors, such as mother's own painful childhood experiences (Fraiberg, 1980), the quality of the couple's relationship, a lack of social support (Belsky, 1984), and finally, by maternal mental illness (Gjerdigen & Yawn, 2007; Glover et al., 1999; Oates, 1997; Rich-Edwards et al., 2006; Zeanah et al., 1997).

This paper is the sequel to a previously published case study in which a schizoaffective patient was successfully treated in psychotherapy between 1991 and 1997 (Schmitt et al., 2008). The patient became pregnant in July 1997 and gave birth to a boy in February 1998. Here we report on the patient's psychotherapeutic process during her pregnancy, the years following childbirth, and the first ten years of the child's life.

CASE VIGNETTE

We described the patient, Priscilla, her background, and the psychotherapeutic process in detail in Schmitt et al. (2008). After this intensive

psychotherapy the patient continued to see her psychotherapist to prevent relapses. In 1995, she met a male patient (diagnosed with a bipolar disorder) and they married. They moved in together in a pleasant suburb. During a follow-up session in July 1997, Priscilla announced that she was pregnant.

When Priscilla said she was pregnant, the first reaction as a therapist was a kind of panic. Though Priscilla had made great progress in monitoring her feelings and controlling her life, at the time, the psychotherapist (FS) did not feel confident in her patient's capacity for parenting. Priscilla's husband was 50 years old and and had been severely mentally ill for more than 30 years. He had a 34-year-old son from a previous marriage. Priscilla was 40 years old, and she was still under heavy medication. However, they wanted the baby and Priscilla refused abortion because she was very religious. The therapist chose a pragmatic solution; psychotherapy had to progress step by step, concentrating first on pregnancy by helping the patient to deal with the changes in her body and in her inner life, and second by differentiating the perceptions linked with her pregnancy from psychotic perceptions.

At the same time, several options about the baby's future had to be explored. Priscilla could give the baby up for adoption and, then, the psychotherapy would focus on working through loss and sorrow, or the baby could stay with his parents and, then, various forms of help had to be provided for the family. During the whole pregnancy, the psychotherapist saw Priscilla twice a week and she never missed an appointment. During the entire pregnancy Priscilla was given the same medication as before, zuclopenthixol depot 200 mg every two weeks in the form of an injection, 20 mg citalopram × 1 once a day by oral route, and lorazepam by oral route l mg × 3. (cf. Schmitt et al., 2008). The pregnancy was monitored as is usually done in Finland by visits to the local prenatal clinic. The first ultrasound scan was a strong experience: Priscilla was fascinated by the movement of her baby, but she was also sad because her husband was not at all interested. From the early stages of pregnancy, Priscilla had vivid fantasies and representations of her baby. The baby would make her more alive, or the baby would make her more like her therapist, or the baby would give a meaning to her fight against the illness. Finally, motherhood would give sense to her life.

In her mind, the baby-to-be had several meanings: he was a very small angel growing in her womb, but later on, he was like a monster, who wanted to destroy her. After the second trimester when she was more concretely in touch with her baby to be (who was moving in her womb),

he became more like a stranger or an alien she was afraid to meet. She was very excited but also very apprehensive by the idea of being a mother. She wanted very strongly to be a mother and she had some short periods of high idealization. Sometimes she was so afraid that she wanted to give the baby up for adoption. She was ambivalent but vividly able to describe her inner world and to speak about the baby as a distinct person. Priscilla prepared the crib and all that was needed for taking care of a newborn.

At the beginning of 1998, the psychotherapist gathered a multidisciplinary team including a psychiatrist, the social worker from the Child Protection Agency, and the midwife in charge of the patient. The team started to prepare for the delivery by organizing, besides individual psychotherapy, some meetings with the staff of the maternity ward. Additionally, the team had three meetings with the staff of the psychiatric intensive ward to anticipate procedure in the case of psychotic breakdown. Priscilla was angry with her psychotherapist: she felt that the therapist took the baby's side against her. Many individual psychotherapy sessions were devoted to this issue. Only two weeks before the delivery, Priscilla suddenly told her psychotherapist that she was happy the therapist was on the side of her baby. She wanted the therapist to swear that she would always stay with Priscilla's family until the child turned 18 years old so that she could be his defender. "Against me, if needed", she added. The same day she asked the psychotherapist to be with her for the delivery because her husband did not want to be there, and she wanted to have somebody nearby. During the pregnancy the relationships between Priscilla had with her relatives improved tremendously. The psychotherapist organized a network meeting where the relatives and professionals could share their views, concerns, and readiness to help with the patient and her husband.

February 25, 1998 was an ice-cold and beautiful day with a lot of snow. Priscilla called her therapist early in the morning and we met in the hospital. It was a long day. Priscilla went through the whole delivery process without painkillers because she thought it was God's will that women suffer and she wanted to feel what was happening to her. The psychotherapist was there, holding her hand, taking care of her along with the midwife. Priscilla was brave. The delivery was rough, she screamed furiously. At 5 p.m. she gave birth to a perfect baby boy with a 10 Apgar score. The psychotherapist withdrew and watched them: the baby was lying peacefully on his mother's breast. Priscilla was diving deep into the eyes of her baby and gazing at him while tears of joy and pain ran onto her pillow. During the preparation time with the staff of the maternity ward, the therapist had agreed with the midwives, that if the delivery were to go

successfully, the baby and his mother should be left alone together for some time. Mother and child were left alone together for half an hour, while the psychotherapist and the midwife were in the next room ready to help. After that, the psychotherapist helped the mother to have a shower (this is not strange in Finland since the psychotherapist had also been trained in her youth as a nurse), and the baby was washed by the nurse. The next day the psychotherapist went to the hospital to visit them. The mother took her newborn in her arms and introduced the psychotherapist to him: "look sweetie, this is Florence. You need to know her, mummy likes her very much. Without her, you wouldn't be here". The baby watched carefully and the psychotherapist introduced herself to him. Finally, Priscilla put the baby in her psychotherapist's arms and said: "I'm sure you will be good friends".

Priscilla wanted to try to be a good mother to her baby but the psychotherapist was still worried about a possible postpartum psychosis or depression, and was anxious about how the mother and child would cope after being discharged from the hospital. According to Finnish Law, the social worker from the Child Protection Agency assessed the situation. This assessment was made in collaboration with the same network that had been invited previously; mental health professionals, social services, relatives, the patient, her husband, and the baby, given the name Tom.

Several decisions were made: someone (a relative or a family assistant/home helper from social services or a friend) would spend two to three hours every day with the family, providing concrete help such as cleaning, cooking, and teaching Priscilla baby rearing. The psychotherapist, FS, would make four home visits a week and carry on the psychotherapeutic process. Once a month the network's members would gather for a joint meeting. This setting was to be continued for the first year postpartum.

When Tom was one year old (February 1999), new plans were made with the network. Tom went to a day-care-center for 4-hours each day, the home helpers visited the family twice a week, the psychotherapy continued twice a week in the home visit context, and the network met every two months. This was done for two years from 1999 to 2001.

When Tom was three years and six months (August 2001), he started to attend the nursery school, which was very close to the daycare center. During his time at the daycare center one nurse was cared for him all the time. Later on, when Tom joined the kindergarten group, he could see her every day in the school's yard. The home helpers were the same two women who had started working with the family from Tom's birth. In contrast, the psychiatrist and social worker in charged, sometimes as often

as three times a year. The network's members met four times a year. When Tom went to the kindergarten, the psychotherapy frequency changed, with the psychotherapist seeing them once a week until the end of 2001.

Since January 2002, the psychotherapist has seen the family every third week for a two-hour session in their own home, and this will continue for the next ten years. The home helpers visit the family only once a month. The relationships the patient has with her relatives no longer need any support from the professionals, and the professionals'/relatives' network meetings are held only once a year. In 2009, Tom is an eleven-year-old boy: he is a well-developed and happy child, who is doing very well at school. He has good friends, plays and reads a lot, rides a bike, and enjoys life. He likes to paint and he builds model planes. He spends one weekend a month with his aunt and her family, and one day a week with another relative, his uncle, grandparent, or cousin. He is more "sporty" with his relatives than with his parents.

Both parents are severely mentally ill and every two weeks, they are given medication by injection. During these eleven years, both parents have once been in hospital for a few days. Tom spent this time with his aunt and grandmother.

DISCUSSION

This therapeutic process has been as demanding and moving as the first part of Priscilla's psychotherapy. These years of work have invoked strong feelings and humility. FS has been trained in family therapy on an advanced level with a special focus on children, and has also been trained as an individual psychotherapist (with a psychoanalytic framework) for adults. The knowledge of the psychotherapist in the field of infant psychiatry was limited and, therefore, the therapist attended a continuous training (including 18 months of baby observation) in early interaction and parent-infant psychotherapy.

Pregnancy is a challenging time. Not only does the fetus develop and mature inside the womb of the mother, but the mother too, undergoes a process of growth and change (Raphael-Leff, 1991). When FS listened more to pregnant mothers during her training program she realized how "normal" Priscilla was, how humble, frank, and sincere she had been when describing her experiences of being pregnant.

As a result of adjustment, motherhood is seen as a new mental state affecting the self of the adult. Winnicott (1956) described the concept of maternal preoccupation, which implies a transformation in the mind of the mother, while Fonagy and Target (1996) argued that parenthood trans-

forms the mind and the mental state of the adult, who is occupied by "holding the infant in mind". Stern (1995) described the concept of "motherhood constellation": the psychic structure of the mother to be is going through a process of total reorganization, which lasts from a few months to two years. For Priscilla, this process of transition and adjustment was successful; both psychotic breakdown and depressive reaction were avoided. Furthermore, the power of the motherhood constellation (Stern, 1995), the transformational power of learning from the baby, as well as the mutuality and reciprocal nature of the infant-mother dyad carried Priscilla's psychic development further. In addition, the integration of her mind continued in an unexpected way, which challenged the therapeutic team's prejudices. Motherhood enhanced the patient's mental health in a new way. For the first time in twenty years, during spring 2002, Priscilla who had been a journalist, started to write articles for a newspaper and was paid for her work.

After the baby was born, it was natural to use home visits as the psychotherapeutic setting since winters in Finland are cold, distances are great, and the psychotherapist was used to making house calls. Later on, several publications supported the idea that home visits are helpful (Stern, 2006; Zeanah, 2006). During the first three years of life, the infant is going through tremendous developmental changes on a biological, emotional, cognitive, and social level, including acquisition of new skills such as walking and speaking (Stern, 1985; Zeanah et al., 1997). The period of infancy is a time of rapid changes in development. During the first three months postpartum, Priscilla concentrated on keeping her baby alive. She gave bottlefed Tom because she was not allowed to breastfeed due to her heavy medication. In a few days she learned to hold her baby in a comfortable and pleasant position, close to her breast. She enjoyed it very much. After having given the bottle, she would lie on her bed with the baby resting on her chest. Once, during a home visit, she asked her psychotherapist to come closer to her, and she remembered what it was like when she was psychotic and the therapist was close to her in the seclusion room. She sang to her baby the songs her psychotherapist had sung to her in the seclusion room of the psychiatric ward. This was a very special moment, because the therapist (who was born in France) sang French songs that Priscilla did not know, and Priscilla invented Finnish words for them. She spoke softly and kindly to her baby, telling him what she was doing. She told her psychotherapist what the baby was doing, how he was watching her face, or watching his father. She wanted the psychotherapist to watch how her baby was smiling or to listen to how he was

babbling. We were watching, waiting, and wondering—without knowing at this time, that this was in fact a technique used in mother-infant psychotherapy (Muir, 1992).

During the first year of Tom's life we spent an hour four times a week observing the baby, just looking at him and talking about what he was doing. Later Priscilla asked me: "What does that mean? What does Tom want me to understand?" She was trying to understand the signals and behavior of her baby, as her psychotherapist had tried to understand her when she was psychotic. She used some sentences that approximated those the psychotherapist had used to comment on Priscilla's long and painful silence during the first six months of psychotherapy. Priscilla was sensitive, nonintrusive, nonhostile; she was appropriate and consistent in her behavior and especially talented at vocalization and using her voice to calm or stimulate the baby.

Tom was a fantastic baby. He was very expressive, responsive, easy to make happy, had a good self-regulation and an easy temperament. He slept and ate well. He enjoyed company and singing. He was always healthy, had no otitis, no flu, and he also developed well on each level. It seems that everybody who meets Tom likes him because he is verbally very talented and physically a beautiful child, with red hair and a charming smile. He also has his bad days, temper tantrums, and a strong will. and he can show a large scale of feelings, which he is also able to name. This process of telling stories about what is happening and trying to describe inner states (feeling, fantasies, thoughts) has been the core of psychotherapy with the mother and her child. It was a kind of continual reflecting, thinking aloud together. Two minds joined to keep a third one in a narrative envelope. As a result, Tom is talented in describing his ideas, feelings, and enjoys stories.

When Tom learned to walk, Priscilla needed help to structure him, and she is still looking for the right balance between emotional connection, protection, and autonomy. Setting limits was challenging because she felt she was too aggressive toward her child. On one hand she needed to understand the role of limits as protective measures, but on the other, she needed to be validated in allowing her child to try to climb or run. For the child (and his parents) the transition from being home to going to a half-day daycare-center went without any problems. The second transition from being at a daycare-center to going to nursery school took place easily. The third transition from nursery school to school also succeeded well. However, every transition was accompanied by a high level of anxiety, a sense of loss, a feeling of losing control. Therefore, besides regular psychotherapy sessions at home, the patient was allowed to call her

psychotherapist during the transition crisis. The main job of the psychotherapist was simply to provide a calm container and serene confidence in the course of events.

In contrast, and unfortunately, the father was not really interested in his son. He always said that a baby was a woman's business and that he was waiting for Tom to start walking and talking. FS tried very hard to integrate him without success. The hardest task for the psychotherapist was to manage father's jealousy toward his son. He was also continuously in competition with the child for Priscilla's attention. It is still a hard task to keep him in a good mood. The father's lack of involvement remained a big problem. However, this distance could also be interpreted as the father's coping strategy against his destructive jealousy and the wish to protect his son from it.

Many authors have emphasized how the fear of losing custody of the child is affecting mothers with mental illness either by inhibiting them from seeking help or making them hide symptoms and difficulties in child rearing (Diaz-Caneja & Johnson, 2004; Lagan et al., 2009; Nicholson et al., 1998). This fear is wise and realistic: there is evidence of mother-infant disturbances in a dyad with a mentally ill mother that can last through the cognitive, emotional, social and behavioral development of the child. For instance, lack of eye contact or stimulation, difficulties or inabilities in picking up cues from the infant's behavior, psychotic symptoms sucha s delusions, hallucinations, which place the baby at risk of being incorporated into (including being perceived as a source of persecution). All these difficulties, combined with poor social support and poor compliance with treatment, can increase the risk of severe neglect, abuse, even infanticide (Hipwell & Kumar, 1996; Hipwell et al., 2000; Seifer & Dickstein, 1993; Snellen et al., 1999). In our case, the issue of losing custody had been broached from the first moment the pregnancy was mentioned. Over the years a strong attachment was woven between the patient and her psychotherapist. The patient had a long experience of safe holding that allowed her to approach even difficult and painful issues. Additionally, the psychotherapist was never afraid to confront the patient with reality. However, the main idea was to turn fear into a resource rather than into a threat. The question was "how could fear help us to make good decisions and to keep alert in our efforts to support mothering and early interaction between mother and infant"? Moreover, "taking the child away" was never used as blackmail to force the patient to act according to the professional's will. The relationship between the family/relatives and professionals was strong, respectful, and honest.

The stigma associated with mental illness has been described as creating problems in disclosing problems or being in contact with the neighborhood or of being afraid of the children being bullied at school (Diaz-Caneja & Johnson, 2004; Nicholson et al., 1998). Therefore, this issue was openly discussed during family sessions, and Tom was prepared to face questions about the strange habits of his parents. Once, a child teased Tom about his mother's use of medication. Tom listened a while and then said to this boy: "for illnesses there is medicine, but unfortunately not for stupidity". Tom was eight years old. Some information was given to Tom's teacher, and once Priscilla and her psychotherapist gave a lecture to the teachers at Tom's school about mental illnesses and how to recognize symptoms of distress in a child at school.

Diaz-Caneja and Johnson (2004) described how mothers [with mental disorders] interviewed about adult mental health professionals, noted that the providers, besides having strong prejudices about the patient's capacity of being a parent, often ignore the difficulties encountered by the patient in adhering to treatment and failed to acknowledging their parenthood. Additionally, collaboration between adult psychiatry, child psychiatry, and child protection agencies is poor and help is provided only in times of crisis (Diaz-Caneja & Johnson 2004). During the early 1990s, colleagues had condemned Priscilla as a "hopeless case", but the psychotherapist challenged this opinion. However, when Priscilla became pregnant, the psychotherapist had prejudices about her ability to be "a good-enough" mother. Challenging the prejudices led the therapist to learn more (as stated above) and to maintain a position of learning from the patient. Additionally, a change in paradigm and two moves were made: firstly, a move was made from the individual approach (of individual psychoanalytic psychotherapy) to the family approach, and secondly, a move from the patient perspective to the parent perspective, i.e. the mental ill patient is seen primarily as a parent. The focus is not on fighting against a mental illness, but on supporting parenthood and parenting. However, this paradigm shift was formulated afterwards when considering the treatment process. Furthermore, this shift was found to be extremely powerful in many other settings (Schmitt et al., 2007).

Solari and colleagues recently published (2009) a synopsis of recommendations for the nonpharmacological management of severely ill mothers during pregnancy and the postpartum period. We agree with this comprehensive treatment plan, although Solari and colleagues failed to address the question of compliance and the question of integrating the efforts of many professionals involved in the treatment. To achieve a

fruitful collaboration between the patient and the psychiatric team is challenging, as is patient adherence to treatment. It seems that one key to understanding our successful work is the strong attachment between the therapist and the patient, an attachment achieved during the patient's individual psychotherapy (described in the first paper, see Schmitt et al., 2008). Continuity and presence—even in good times—leads to the best prevention of crisis.

The mothers in the study by Diaz- Caneja and Johnson (2004) emphasized the importance of a "consistent keyworker with whom she had felt able to establish a trusting relationship" (p. 478). "They had felt well supported by social services as they had been allocated a consistent worker who listened to their concerns and appeared committed to supporting them in continuing to look after their children" (p. 478). In this fragment of Diaz- Caneja and Johnson's article the words "keyworker", "trusting relationship", "consistent", "committed" are crucial. It seems that the "keyworker" is a kind of "good-enough mother" for the patient and provides over the time through his/her attitude of caring a "working-model of being-with" (Bolwby, 1969). Studies on differences in patterns of attachment, as well as the systematic exploration of mother's childhood experiences and how they may help predict the infant-mother relationship, show the intergenerational continuity of caregiver-child relationship patterns (Fonagy et al., 1991b; Greenberg, 1999). Maternal mental illness can impact negatively on a child's life, especially when an insecure attachment is formed between mother and baby (Craig, 2004; Hipwell et al., 2000). In Schmitt et al. (2008) we described how secure attachment in therapy enabled Priscilla to tell the therapist her story. She (Priscilla) was intelligent and her insight ability was good enough for psychoanalytic psychotherapy. Priscilla and the therapist developed a fruitful companionship and a strong therapeutic alliance over the time (Schmitt et al., 2008). In the bosom of this relationship, Priscilla was able to learn a new model of being—with, and a new internal working model of self and relationship, and was thus able to develop a secure attachment toward her baby (see also Fonagy et al., 1991a). A rhetorical question may be formulated: does a strong attachment between a patient and her therapist predict a good attachment between the patient and her baby? This needs to be studied.

Both parents are retired and are at home, the father still somehow peripheral. The child is doing very well. As we know from the literature (Guth et al., 1993) and clinical experience, there is a considerable amount of evidence that familial, and indeed genetic factors, are in direct etiological importance in affective disorder (reviewed by McGuffin & Sargeant,

1991), in the bipolar patient (Taylor, 1992) and in schizophrenia (e.g. Owen et al., 1988). Research often focuses on psychopathology (Gamer et al., 1977a; Gamer et al., 1977b; Snellen et al., 1999; Hipwell et al., 1996; 2000). However, research on resilience challenges deterministic views. In a study by Kauffman and colleagues (1979) on children of mothers with psychosis, the authors tested and individually interviewed a subgroup of outstandingly talented and competent "high-risk" children. They were then compared with a control group of children whose mothers had no psychiatric illness. The six most socially and intellectually competent high-risk children were strikingly more competent, creative, and talented than the six highest functioning control children. They more often reported having a best friend and had extensive and positive contact with an adult outside the family. Another important variable in the prediction of high social competence among children at high risk is a warm relationship with the mother. However, nothing is known about the further development of these children. Longitudinal and prospective studies are needed to identify risk and protective factors.

Protective factors have been the subject of child psychiatry research. In this field of research, resilience has been seen as a process in which several protective factors (good neighborhood, at least one healthy and good relationship, friends and peers, one significant other, school, the capacity for dreaming and imagination) are interwoven with a robust temperament ([genetic characteristic] Rutter, 1985, 1996, 2006a, b, c). Then, the resilient child, by being exposed to risk factors, develops strength and resistance to stress. Tom seems to be a resilient child, and the psychotherapeutic work involved several dimensions (individual work on the intrapsychic level, family work, social work, and network) which enhanced protective factors. However, we really do not know the final outcome of this work. It would be interesting to write the follow-up of this case when Tom is a young adult.

SUMMARY

This paper focused on motherhood in a patient with a schizoaffective disorder. The core of the treatment was to build a strong therapeutic alliance in which compliance with medication and elaboration of mental processes could be achieved. Pregnancy and motherhood are a time of crisis in the life of women. For the schizoaffective patient this crisis threatens the deepest level of functioning and challenges attachment patterns. Comprehensive treatment including psychosocial support, medication and psychotherapy is able to protect the baby to be, the early

relationship between mother and baby, and the development of the child over time in this high-risk family. However, the commitment over years of the same psychotherapist also seems one of the most powerful tools.

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