ARTICLE

MOTHERS' EXPERIENCES OF MOTHER-INFANT PSYCHOANALYTIC TREATMENT—A QUALITATIVE STUDY

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ABSTRACT: As part of a larger research project in Sweden, a qualitative study investigated mother-infant psychoanalysis (MIP). Earlier, a randomized controlled trial compared two mother-infant groups. One received MIP, and the other received standard child health center care. Previous articles have reported long-term effects: MIP-group mothers were less depressed throughout a 3-year posttreatment period, and their children demonstrated better global functioning and psychological well-being (Winberg Salomonsson, Sorjonen, & Salomonsson, 2015b). The present study's objectives were to describe the mothers' experiences of MIP and deepen the understanding of the MIP process. Six months after treatment started, all mothers were interviewed. Transcribed interviews of 10 (of 33) MIP-group participants were randomly selected and analyzed in detail. Thematic analysis was used on the interview data. Two main themes emerged: (a) transition to motherhood and (b) relationships with the infant and family. MIP facilitated mother-infant relationship development and familial relationship development and clarified mothers' views of how their personal histories were connected with their motherhood experiences. Mothers reported that the analysts had succeeded in balancing the mothers' own needs and those of the infant. Their accounts of therapy matched the published descriptions of MIP.

Keywords: mother-infant psychotherapy, mother interviews, thematic analysis

RESUMEN: Como parte de un proyecto de investigación mayor en Suecia, un estudio cualitativo investigó el sicoanálisis madre-infante (MIP). Primero, un ensayo controlado al azar comparó dos grupos de madre-infante. Uno recibió MIP y el otro recibió el cuidado estándar del centro de salud infantil (CHCC). Artículos anteriores reportaron efectos a largo plazo: las madres del grupo MIP eran menos depresivas a lo largo de un período de 3.5 años de post-tratamiento, y sus niños demostraron mejor funcionamiento global y bienestar sicológico. Los objetivos del presente estudio fueron describir las experiencias de las madres del MIP y hacer más profundo el conocimiento del proceso MIP. Método: seis meses después que comenzó el tratamiento, todas las madres fueron entrevistadas. Las transcritas entrevistas de 10 de las participantes del grupo MIP (de un total de 33) fueron seleccionadas al azar y analizadas en detalle. Se usó un análisis temático de los datos de las entrevistas. Resultados: surgieron dos temas principales: (i) la transición a la maternidad y (ii) las relaciones con sus infantes y la familia. Conclusiones: el MIP facilitó el desarrollo de la relación madre-infante y el de la relación familiar y clarificó los puntos de vista de las madres de cómo sus historias personales estaban conectadas con sus experiencias de la maternidad. Las madres reportaron que el análisis había sido exitoso en cuanto a equilibrar las propias necesidades de las madres y las de su infante. Sus recuentos de la terapia coincidieron con las descripciones publicadas de MIP.

Palabras claves: sicoterapia madre-infante, entrevistas a la madre, análisis temáticos

RÉSUMÉ: Faisant partie d'un plus grand projet de recherche en Suède, une étude qualitative s'est penchée sur la psychanalyse mère-bébé (MIP en anglais, P.M.I en français). Un essai contrôlé randomisé a déjà comparé deux groupes mère-bébé. L'un des deux groupes a reçu une P.M.I et l'autre a reçu des soins standards du centre de santé infantile (CHCC). Des articles précédents ont fait état d'effets à long terme : les mères du groupe P.M.I étaient moins déprimées tout au long d'une période de 3,5 années après le traitement, et leurs enfants ont fait preuve d'un meilleur fonctionnement global et d'un bien-être psychologique. Les objectifs de cette étude-ci étaient de décrire les expériences du P.M.I des mères et d'approfondir la compréhension du processus P.M.I. Méthode : Six mois après que le traitement a commencé toutes les mères ont fait l'objet d'un entretien. Les entretiens transcrits de 10 participantes du groupe P.M.I (sur 33) ont été sélectionnés au hasard et analysés en détail. Une analyse thématique a été utilisée sur les données de

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l'entretien. Résultats : Deux thèmes principaux ont émergé : (i) la transition à la maternité et (ii) les relations avec le bébé et la famille. Conclusions : La P.M.I a facilité le développement de la relation mère-bébé et le développement de la relation familiale et clarifié les vues des mères de la manière dont leurs histoires personnelles sont liées à leur expérience de la maternité. Les mères ont dit que les analystes avaient réussi à faire équilibrer les propres besoins des mères et ceux du bébé. Leurs descriptions de la thérapie a correspondu aux descriptions publiées de la P.M.I.

Mots clés: psychothérapie mère-bébé, entretiens de la mère, analyse thématique K

ZUSAMMENFASSUNG: Im Rahmen eines größeren Forschungsprojekts in Schweden untersuchte eine qualitative Studie die Mutter-Säuglings-Psychoanalyse (mother-infant psychoanalysis = MIP). Zuvor verglich eine randomisierte kontrollierte Studie zwei Mutter-Säuglings-Gruppen. Eine Gruppe erhielt MIP und die andere erhielt eine Standardversorgung durch Kindergesundheitszentrum (CHCC). Bisherige Artikel berichteten über langfristige Effekte: MIP-Gruppen-Mütter waren während einer 3.5-jährigen Nachbehandlungsperiode weniger depressiv und ihre Kinder zeigten ein besseres globales Funktionsniveau und psychisches Wohlbefinden. Ziel der vorliegenden Studie war es, die Erfahrungen der MIP-Mütter zu beschreiben und das Verständnis des MIP-Prozesses zu vertiefen. Methode: Sechs Monate nach Beginn der Behandlung wurden alle Mütter interviewt. Transkribierte Interviews von 10 MIP-Gruppenteilnehmerinnen (von 33) wurden zufällig ausgewählt und detailliert analysiert. Mit den Interviewdaten wurde eine thematische Analyse durchgeführt. Ergebnisse: Zwei Hauptthemen ergaben sich: (i) Übergang zur Mutterschaft und (ii) Beziehungen zum Säugling und zur Familie. Schlussfolgerungen: MIP förderte die Entwicklung von Mutter-Kind-Beziehungen sowie die familiäre Beziehungsentwicklung und klarifizierte die Ansichten der Mütter, wie ihre persönlichen Vorgeschichten mit ihren Mutterschaftserfahrungen verknüpft sind. Die Mütter berichteten, dass es den Analytikern gelungen sei, eine Balance zwischen den eigenen Bedürfnissen der Mütter und denen des Kindes zu schaffen. Ihre Beschreibungen der Therapie entsprechen den veröffentlichten Beschreibungen der MIP.

Stichwörter: Mutter-Säuglings-Psychotherapie, Interviews mit Müttern, thematische Analyse

抄録: スウェーデンの大きな研究プロジェクトの一部として、質的研究で母-乳幼児精神分析 (mother-infant psychoanalysis MIP) を調べた。以前に、ランダム化対照試験で二つの母-乳幼児グループが比較された。一方が MIP を受け、他方は標準的な子ども健康センターの治療 (child health center care CHCC) を受けた。先の論文では長期の効果を報告した: MIP グループの母親は、治療後 3.5 年間を通して抑うつが少なく、その子どもはより良い全般的機能と心理的な幸福を示した。この研究の目的は、母親の MIP 体験を記述し、 MIP 過程の理解を深めることだった。方法:治療開始 6 か月後、全ての母親はインタビューを受けた。 MIP グループ参加者10 人 (33人中) の文字起こしされたインタビューがランダムに選ばれ、詳細に分析された。主題分析がインタビューデータに使われた。結果: 2 つの主なテーマが現れた。 (i) 母親になること motherhood への移行と (ii) 乳児および家族との関係だった。結論: MIP は母–乳幼児関係性の発達と親しい関係性の発達を促進し、母親が自分の個人的な歴史がどのように母親になることの体験につながっているのかについての母親の視点を明確化した。母親は、分析家が母親自身のニーズと乳児のニーズのバランスを取るのに成功したと報告した。母親たちの治療の説明は、出版された MIP の記述と合致した。

キーワード: 母–乳幼児精神療法, 母親面接, 主題分析

摘要: 作為瑞典一個較大研究的一部分, 這定性研究調查母嬰精神分析 (MIP) 。此前, 一項隨機對照試驗比較兩個母嬰組。一個接受 MIP, 另一個接受標準的兒童保健中心護理 (CHCC) 。以前的研究報導長期的影響: MIP 組母親在治療後的 3.5 年時間內抑鬱程度較低, 她們的孩子表現較好的整體功能和心理健康。本研究的目的是描述母親的 MIP 經驗, 並加深對 MIP 過程的理解。方法:治療開始後6個月, 所有母親接受訪問。作者隨機抽取 10 名 MIP 組參與者 (33 人中抽取), 詳細分析她們的訪談轉錄。研究採用專題分析訪談數據。結果:兩個主題出現: (i) 過渡為母親, (ii) 與嬰兒和家庭的關係。結論: MIP 促進了母嬰關係和家庭關係發展, 並闡明母親對個人歷史與經歷的聯繫的之看法。母親報告說, 分析人員成功地平衡了自己和嬰兒的需求。她們對治療的看法符合已發表的 MIP 描述。

關鍵詞: 母嬰心理治療, 母親訪談, 專題分析

ملخص: هذه الدراسة الوصفية جزء من مشروع بحثي كبير في السويد وتناولت التحليل النفسي بين الأم والرضيع (MIP). في البداية قارنت تجربة عشوائية مجموعتين من الأمهات والأطفال. تلقت أحد المجموعات معالجة تحليل نفسي (MIP) وتلقت المجموعة الأخرى رعاية صحية معتادة في مركز رعاية الأطفال (CHCC). أظهرت المقالات السابقة تأثيرات طويلة المدى: الأمهات من مجموعة (MIP) كانوا أقل اكتئابا على مدار 3 سنوات ونصف بعد فترة العلاج وأظهر أطفالهم أداء كوني أفضل ورفاهية نفسية أعلى. الهدف من الدراسة الحالية هو وصف تجارب الأمهات في معالجة التحليل النفسي بين الأم والرضيع (MIP) وتعميق الفهم لهذه العملية. التجربة: تمت مقابلة شخصية مع كل الأمهات بعد ستة أشهر من بداية المعالجة. وتم تفريغ 10 مقابلات عشوائيا من واقع 33 مقابلة وتحليل المحتوى بالتفصيل باستخدام تحليل المواضيع. النتائج: ظهر موضوعان أساسيان من خلال التحليل : 1)الانتقال إلى الأمومة و 2)العلاقة مع الطفل الرضيع ومع الأسرة. الاستنتاجات: إجراءات (MIP) سهلت تطور علاقة الأم والرضيع ونمو العلاقات الأسرية وأوضحت كيفية ارتباط رؤية الأمهات لتاريخهم الشخصي بتجارب الأمومة لديهم. وقد أبدت الأمهات أن المحللين قد نجحوا في الموازنة بين حاجات الأمهات وحاجات الرضيع. وتطابقت أراءهم عن برنامج المعالجة مع التوصيف المنشور لبرنامج (MIP).

كلمات مفتاحية: العلاج النفسي بين الأم والرضيع- مقابلات الأمهات – تحليل المواضيع

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Pregnancy, delivery, and parental care of her newborn infant are critical experiences in a woman's life, and they challenge her psychological well-being (Cowan & Cowan, 2000; Osofsky & Osofsky, 1980). Pregnancy might be viewed—similarly to puberty or menopause—as a period of crisis that involves important biological transformations and parallel psychological changes (Benedek, 1950; Blos, 1962; Notman & Lester, 1988). In all these periods, several new, specific, adaptive tasks confront the individual—often diametrically opposed to the central tasks and functions of the preceding phases (Bibring, Dwyer, Huntington, & Valenstein, 1961). In the new situation, many mothers experience problems in their parental role and ask for psychological help. They are worried about the infant's situation and symptoms in areas of sleep, crying, nursing, colic, mood, and regulation of activity and affects. Some mothers experience difficulties in bonding with their infants and fear that these difficulties will obstruct their contact with the infants (Brockington, 2004; Klier, 2006). If they feel depressed, anxious, and insecure in their abilities to function as mothers, these feelings may indeed have negative effects on the infants (Field et al., 1988; Field, 2002; Reck et al., 2004). In addition, infants with functional problems may trigger vicious circles in the mother-infant interactions (Hagekull, Bohlin, & Rydell, 1997; Puura et al., 2013).

Special healthcare units usually deal with these types of problems; in Sweden, they are called *child health centers*, which are placed throughout neighborhoods in which families live. Child health center care (CHCC) supports almost 100% of the families (Blennow, Lindfors, & Lindstrand, 2010). This healthcare service is well-organized, and it prescribes a series of scheduled visits with nurses and pediatricians. For example, CHC nurses offer home visits within 1 week after discharge from delivery wards. Because hospital care after delivery has become briefer during the last decades, the CHCs have a greater responsibility for discovering problems and providing advice and support on issues such as breast-feeding and infant care (Barimani, Oxelmark, Johansson, & Hylander, 2015).

If such emotional problems, which we summarize under the term *baby worries*, become more profound, special treatments for mothers and infants are offered. Apart from pharmacological treatments introduced during the last decades, such as selective serotonin reuptake inhibitor drugs, several psychotherapeutic methods have been developed. Usually, they proceed from psychodynamic theory integrated with infant research and attachment and intersubjective theories. These therapies seek to improve communication between mother and infant. Sometimes, as in the Marte Meo method (Hedenbro, 1997), therapists use video-recorded parent-infant interactions to comprehend what transpires between mother and infant. A similar form of dialogue (without videos) is used in the Watch, Wait, and Wonder intervention (Cohen et al., 1999; Lojkasek, Cohen, & Muir, 1994).

MOTHER-INFANT PSYCHOANALYSIS

Psychoanalyst Johan Norman developed mother-infant psychoanalysis (MIP) in the 1990s (Norman, 2001, 2004; Salomonsson, 2007a, 2007b). MIP is based on psychoanalytic theory applied to young children. Sessions occur with infant and mother together. The therapist receives and emotionally processes within him- or herself the infant's distress and communicates it back to the infant in a form that he or she can assimilate. The aim is to liberate the infant's distressing affects, which are assumed to be expressed in symptoms such as whining, sleeping and feeding problems, mood disturbances, and attachment problems. As the mother witnesses the infant-therapist interaction, she will understand more about the links between her baby's affects and symptoms. This experience, it is further assumed, will enable her to resume maternal care. The therapist also tries to generate a dialogue with the mother and pay close attention to her self-esteem, which is often unstable. It also is important to take into consideration the mother's feelings of guilt, depression, and insufficiency.

In MIP, the frequency and the treatment duration are adapted to the (a) mother's and infant's needs and pathology and (b) mother's motivation and opportunities for continuing therapy. In general, four sessions per week is desirable, according to the originator of the method used. It was originally used for infants up to 18 months. MIP is taught and developed at the Infant Centre of the Swedish Psychoanalytical Association (www.psykoanalys.se). All psychoanalysts in the present study belonged to this group. Each week, they discuss their MIP cases with colleagues and supervisors during seminars.

A randomized controlled trial (Salomonsson & Sandell, 2011a, 2011b) investigated the results of MIP; 80 mother-infant dyads were randomized to either MIP or CHCC. This will be called "the infant study." After 6 months, for the MIP mothers, significant improvements were found on self-reported depression, observer-rated mother-infant relationships, and maternal sensitivity, and—on a marginally significant level—self-reported maternal stress. About 3 years after MIP, the "follow-up study" was launched when the children were 4 years old (Winberg Salomonsson, Sorjonen, & Salomonsson, 2015a, 2015b) (Figure 1).

The follow-up study showed that compared with the CHCC group, the MIP mothers were less depressed throughout the entire posttreatment period, and the MIP children demonstrated better global functioning and psychological well-being. These results indicated that MIP had the potential to improve mother-infant mental health.

Most investigations of MIPs are case studies (Baradon, 2005; Belt et al., 2013; Downing, Burgin, Reck, & Ziegenhain, 2008; Keren, 2011) or quantitative outcome studies (Cohen, Lojkasek, Muir, Muir, & Parker, 2002; Cooper, Murray, Wilson, & Romaniuk, 2003; Hayes, Matthews, Copley, & Welsh, 2008; Letourneau et al., 2011; Murray, Cooper, Wilson, & Romaniuk, 2003; Ravn et al., 2012; Robert-Tissot et al., 1996; Santelices et al., 2011; Winberg Salomonsson, Sorjonen, & Salomonsson, 2015a, 2015b). However, studies using qualitative analysis have become more common (Cramer, 1998). Some studies have used qualitative analysis to investigate changes due to therapy (Paris, Spielman, & Bolton, 2009); the present study also took the qualitative route to better comprehend mothers' experiences of MIP treatment.

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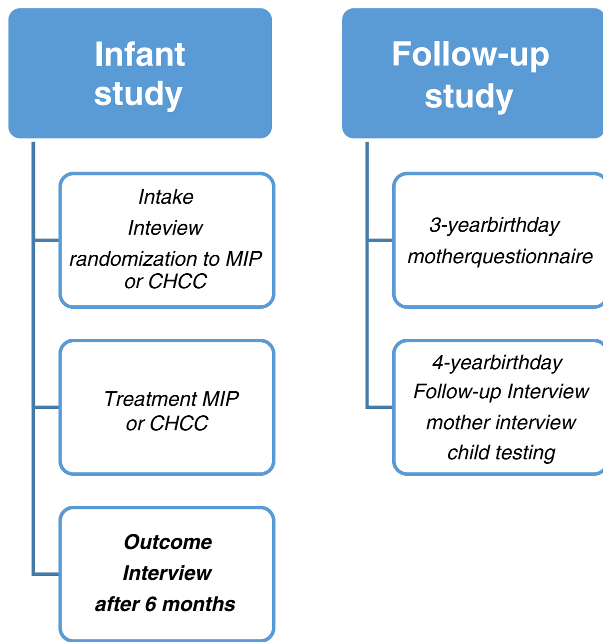

FIGURE 1. Design of the infant (mother-infant psychoanalysis; MIP & child health center care; CHCC) and the follow-up studies.

AIMS OF THE STUDY

The present study's objectives were to (a) describe participants' experiences of MIP and to (b) deepen the understanding of the therapeutic process in MIP.

METHOD

Data Collection

In the infant study, mothers were interviewed with their babies before randomization (*intake interview)* and treatment start, and 6 months later when treatments were terminated (*outcome interview*, see Figure 1). Thirty-three mother-child dyads in MIP treatment remained during the entire project period. For the present study, transcribed interviews with 10 mothers were randomly chosen with the help of a random number generator on the Internet and then analyzed in detail (Bryman, 2016).

Interviews lasted 1 hr and were conducted by the researcher (BS), an M.D. and an experienced psychoanalyst who initiated the project. He used a semistructured format (Bryman, 2016), which was expected to generate spontaneous emotional expressions and also to enable systematic data collection. The interviewer was the same for both the intake and outcome interviews. His questions were posed in an order that suited the present situation because it was important to follow the study participants' lead to understand their experiences of MIP.

The interviewer's questions were based on an implicit agenda that covered various areas. The mother was asked about (a) changes in the family, such as divorce, unemployment, and illness; (b) how she had experienced the results of MIP and her contact with the therapist; (c) what had emerged during sessions and the ways in which the therapist implemented MIP; and (d) any thoughts she had about how the baby might have experienced the sessions. If the mother expressed doubts or uncertainties, the interviewer probed deeper into such issues to uncover latent ideas about MIP.

Participants and MIP Frequency

Concerning the 10 mothers in the present study, the following data were collected during the intake interview (see Figure 1). The mothers' mean age was 34 (range = 27–42); 8 of them were first-time mothers. The fathers' mean age was 35 (range = 30–43). All mothers lived with the fathers. The mean delivery week was 40 (range = 36–42). Seven participants delivered vaginally; 3 had cesarean sections. Breastfeeding lasted 5 months (range = 1–10). Mean birth weight was 3,600 g (range = 3,020–4,800). The infants were between 8 and 15 months ($M = 11$ months during the interview). There were 4 girls and 6 boys.

One participant had a physical affliction that did not interfere with her ability to care for her infant. Six participants had experienced mental disorders in adulthood, mostly depression. One reported anxiety, and another reported an eating disorder in the past. One participant had depressive symptoms and an eating disorder during adolescence. The participants' major complaints and reasons for seeking help were (a) difficulties in bonding with the baby, (b) problems with nursing or sleep, (c) baby crying, (d) worry that the baby would become sick or die, (e) uncertainty about being a mother, and (f) conflicts with the father. In addition, they frequently had guilt feelings about not being a good mother. Many participants were stressed and anxious and felt depressed. They usually felt very lonely—even if they had good access to other family members and friends.

MIP

Frequency of treatment varied between one and four times per week ($M = 2.6$). The number of sessions varied between 7 and 64 ($M = 40$). These figures are similar to the entire MIP group of 33 mothers—except for the number of sessions, which was less (i.e., 29).

Data Analysis

The present study used thematic analysis (TA; Braun & Clarke, 2006, 2012). TA enables identifying, analyzing, and reporting themes within data. A theme captures an essential aspect of the data. The present study used inductive coding (i.e., data were coded without trying to fit results into a preexisting coding frame), and the identified themes were then linked back to the data (Patton, 1990). In this process, movement back and forth is needed throughout the analysis phases. Open Code software (ICT, 2009)

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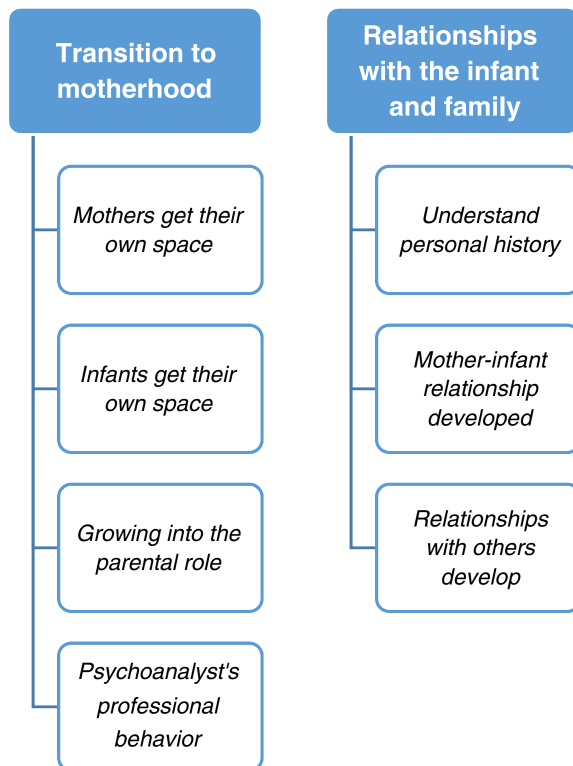

FIGURE 2. Mother-infant psychoanalysis (MIP) and transition to motherhood and relationships with the infant and family.

was used for coding because it enables researchers to create and organize codes and themes and to go back and forth in the material.

The present study applied Braun and Clarke's (2006) description of the TA phases. In Phase I, *familiarizing with data*, a research assistant transcribed verbatim the video-recorded interviews. When uncertainties emerged during transcription, the first author compared the transcripts with the original video recordings. We also read and reread all data. In Phase II,*generating initial codes*, many codes were constructed and analyzed—based on their similarities and dissimilarities—and then categorized into subcategories. Phase III, *searching for themes*, resulted in categories for various areas, as described later (see Figure 2). Phases IV and V, *reviewing, defining, and naming themes*, resulted in two main themes. In Phase VI, *final analysis*, the analytic narrative (with illustrative examples) was formulated.

Ethical Approval

The Regional Ethical Review Board in Stockholm approved the study (Document No. 2009/1334-32). Mothers were told that they could leave the study at any time and that their decision would not affect the treatment. Video recordings were made only with their consent.

RESULTS

Of the 10 participants, 5 mothers were very positive (50%), and 4 were mostly positive (40%) toward MIP. One mother (10%) was critical. In the entire group of 33 participants, 16 (48%) were very positive, 12 (37%) were mostly positive, and 5 (15%) were critical. Thus, the results are similar between this study group and the entire group.

The present study's analyses yielded two main themes: (a) transition to motherhood and (b) relationships with the infant and family. The first theme refers to various aspects of how the woman develops a maternal identity that also allows her to recognize the infant as an individual in his or her own right. The second theme refers to her relationships with the infant, the father, and the important figures in her early life—above all, her own mother. This section explains the main themes and subthemes and displays quotes from study participants.

MIP and Transition to Motherhood

Mothers get their own space. Study participants said that the psychoanalyst provided them with a space of their own; that is, they were given opportunities to deal with problems such as anxiety and depression. They appreciated the MIP sessions and described them as a process that was, unlike other interactions in their daily life, exempt from time pressure and moralizing. Even though other people physically surrounded the mothers, they felt isolated and alone with their problems. The psychoanalyst provided another kind of interaction, which helped them manage these feelings.

Some participants described how they were trapped in a vicious circle with their thoughts. MIP sessions provided the means to work through the problems and exit such circles. They reported that the psychoanalyst asked questions, made suggestions, and thus helped them see things in a new light and become aware of their own motives:

> She [the analyst] can sometimes reverse my argument. She doesn't influence me, but she makes me think "Why did I think like that?" She helped me open up some things within myself . . . . She did not say it out loud, but she is very skilled in asking questions that make me find out things for myself.

The psychoanalyst was perceived as someone willing to take the time to listen and comment on mothers' situations. Sharing thoughts, feelings, and problems was valuable; although for some it was a painful process, such as when having to face one's self and past and present life situations:

> I didn't accept any help, either, from the outside, but I . . . it was pretty lonely, I wouldn't let others in, it was just me and the boy . . . . To attend sessions with A [analyst] helped me understand how I isolated myself. And that was pretty tough to see.

In many cases, MIP promoted opening up, talking through things, and deepening communication about emotional

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experiences. This implied that participants also could express ambivalence toward being confronted with distressing feelings and experiences. They both wanted to come in contact with their own feelings and felt it was hard to express them in analysis:

> . . . Put words on things perhaps. You are kind of forced to, when explaining to another person. I mean, then you see it yourself.

Although participants felt that they received a lot of space, some said that time was a problem; they felt that MIP took too much time and that it was difficult to fit into the time slots:

> . . . Often it was like that, almost every day. Had a hard time with it. Had no strength. It felt like it was a bit too frequent. I was tired and it felt like a project to go there every day. It was so early.

Other participants wanted more frequent sessions:

> It had certainly been easier if we had seen each other more times a week. You kind of have time to talk, and the next day, you continue where you left off. After a week, you sort of lose that.

Infants get their own space. When the mother came for MIP, she was usually so anxious or depressed that she found it difficult to understand her infant's emotional situation. She rather focused on the infant's distress symptoms and feared their consequences (i.e., that the child would die). Participants described how they were initially puzzled that the psychoanalyst made direct contact with the infants. Later, they thought that this helped the infants develop and also become more involved in MIP:

> Anyway I wondered how much she could achieve by talking to him for 5–10 minutes. Talk, yes . . . but then she came up with such good ideas.

The analysts' focus on the infants helped participants see them as individuals with their own personalities. Consequently, some mothers reported that they had started to relate to their children in a new way. Often, they observed how her infant took part in MIP and showed interest and curiosity when the psychoanalyst directly addressed the infant. For example, the infant looked with interest at the psychoanalyst and responded with sounds and gestures such as moving closer to or further from the analyst. The mother reported that the infant seemed to comprehend aspects of the communication. Even if the infant did not catch the lexical meaning of the analyst's words, she or he seemed to understand that what the psychoanalyst conveyed was important:

> She talks to her as well, looking at her, observing. I think that's good, positive. I didn't think that an infant could be such an independent person, that you could communicate so seriously.

The psychoanalyst communicated directly with the infant, for example, about how the infant reacted when the mother was sad or worried. Sometimes, mothers worried that when they did not feel well, their children were affected. It then became important to be able to see how the children reacted and responded.

There also was criticism of the infant focus (i.e., some participants experienced that they did not get enough space and help with their personal problems). One participant looked for help from another therapist, whom she had contact with previously. There, she experienced a better support for herself:

> It was not quite as I had imagined . . . . There was so much focus on the boy . . . . I suppose I felt a need to talk about my feelings. I had thought that I would talk more about myself. He (the child) is doing fine; I'm the one with the problems.

Growing into the parental role. Through the analyst, participants got help to resolve their problems, develop, and gain new insights into their maternal role. In general, psychological problems had existed earlier in life, and now they resurfaced in the new situation. Some participants said that the most important thing was that they got help to feel better themselves and that way, the child also would benefit:

> I think this is the kind of stuff that has huge significance for my parental role. In this way, it was enormously significant for the girl . . . but I really don't think she's the reason for the problem, I had problems before she arrived.

Participants described the postpartum period as difficult. They even had trouble remembering that earlier period (i.e., at the time of the first interview) when they were so worried and stressed. Concerns that the child would die were prevalent. In MIP, they could eventually link their own stress to these anxieties about the child, and the concern decreased.

Although the children sometimes still screamed or showed distress in other ways after MIP, the participants now could better cope with the situation. Several mothers described themselves as ambitious—with a great need for control. They had the notion that there was only one correct way to be with a baby and were afraid of making mistakes. They were helped by the treatment to relax and diminish the control mentality.

One mother expressed that she felt more joy and confidence in the future when her depression eased. She also reported that she had developed on a personal level in that she had matured and grown into parenthood. Some mothers said that they had become more courageous, daring to speak up and assert themselves:

> It's a very big difference now . . . . I feel positive, have confidence in the future—I'm happy. That's how it is. I wasn't really like that before. I have become much more mature.

Psychoanalyst's professional behavior. The psychoanalyst was frequently described in positive terms, and participants expressed great confidence in the analyst. They liked and trusted the analyst, whom they perceived to be compassionate, warm, and listening:

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Soft and listening. She is a little bit like, well not a mother, but something similar. Not a mother-figure but a bit like a mother can be.

Participants said that they managed to relate and verbalize their problems with an outsider who *guided without control*. The psychoanalyst was perceived as a skilled, experienced professional who maintained appropriate objectivity.

A few participants indicated that the situation was uncomfortable because the psychoanalyst was perceived as scrutinizing and critical—rather than as a participant in the discussions. Eventually, this professional attitude was considered more meaningful:

That's odd, you are talking about such personal things, and yet you don't know anything—nothing about the other person. She has a professional role when you sit and talk.

Some mothers were critical of the psychoanalyst and the MIP method and said that it was sometimes difficult to openly express this criticism. One mother described how she had wished for more control and direct advice:

To my taste, I would have been happy if A was more controlling. I like it when you say "What you're doing is no good!" So I have mixed feelings.

There also were doubts that MIP had been important for the mother's development, for her transition into her maternal role:

I do not see the therapy as harmful anyway . . . . it's a bit difficult . . . . I don't know . . . . it's been good but . . . maybe . . . I don't know if it's just the therapy that has made the situation better.

MIP and Relationships With the Infant and Family

Understand personal history. Most participants talked about problems in their relationships with their parents—especially with their mothers. During MIP, they began to look at their personal histories in a new way. Some accepted that they would go on living with their history—it would not change—and they worked to relate to it in another way. Some felt that through motherhood, they now understood their mothers in a deeper way and thus achieved better relationships with them. Others expressed grief about how relationships with their parents had been earlier and that they could not be repaired. Such feelings could emerge especially when a mother had traumatic childhood experiences with her own mother:

. . . I have accepted how it has been, how life was then. It is there and will always be, it will never be different, but it still belongs to the past.

Several mothers saw a risk of transferring old patterns to their infants. In a few cases, mothers discovered how their relations to their infants directly repeated their mothers' behavior toward them during their childhood. One participant described how she was tormented by shame when her child cried while they took a walk. During MIP, she recalled how her mother was embarrassed when her children screamed in the supermarket. This participant came to understand in MIP how she had reenacted a pattern and from where her feelings of shame emanated. This insight gave her the means to break the pattern.

Mother-infant relationship developed. The mother-infant relationship developed during MIP, and participants described (a) how they interacted more with the infant and (b) their need to move outside the closed common space at home.

Some participants said that initially they had difficulties getting in touch with their infants. They felt rejected when the infant turned away from the breast or bottle or had sleeping difficulties. They became irritated and even wished the babies away or handed them to the fathers. Participants often expressed guilt about these feelings.

Yes, it has been a journey. Back and forth. A little up and down. A lot of black stuff I must say. But our relationship was strengthened a lot since we started going to A . . . . We have a completely different way of communicating. I feel more confident that she thinks I'm okay as a mother.

Sometimes the psychoanalyst helped them understand what caused the infant's dissatisfaction (e.g., that the infant wanted to breast-feed longer or wanted to quit eating). This way, participants understood more clearly what the infants were signaling with their cries—whether it was despair, anger, or sadness. Some participants said they received help in developing routines for their infants. Consequently, the infant settled down more easily in the evening, began to eat regularly, and so on.

. . . to have gone to A and worked to get her calm, that has been good. We have looked into her temper. It's important that she can relax, find quiet moments, be alone, like now. To feel safe, how to do that. Suddenly I feel that it's starting to pay back.

Some mothers described a desire to move out of the closed common space, implying that they experienced being too closely linked with their infants. Becoming more independent in relation to the infant then became a task in treatment:

Such a difference. Now it feels okay to want to have some time away from him [the baby].

Several mothers were afraid of leaving the infant. During treatment, they were able to link such separation anxieties to childhood experiences:

You live so closely together, day and night, everything is together . . . . In my own past a great many things have happened making it difficult for me to let go of her.

Sometimes MIP coincided with external situations that triggered separation anxiety, for example, when it was time to wean the baby. Several participants described how they increasingly allowed the father to enter into a relationship of his own with the baby—especially when it was time to reenter the workforce. Some

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mothers also received help to reflect on concrete situations, such as when they wished to stop breast-feeding earlier than the child desired or when they enrolled the child in a daycare center at a very early age.

Many study participants described ambivalence toward the infants. Some had a great need to control the baby. This was addressed repeatedly in treatment.

> I thought that when she screamed so much, maybe she was afraid. I didn't want to leave her because of her fears. But A said that when she cried in her office, then she didn't scream out of fear. A said she was probably angry. I have begun to distinguish between when she is afraid and when she is angry.

Participants described how this development in the relationship with the child helped them feel more warmly toward their children. They also experienced that the child had become calmer, happier, and more harmonious during MIP:

> Maybe it's me who became more calm . . . . In the beginning when he screamed, I had no idea what he wanted. But now, when he has eaten and slept, he is satisfied.

From having been afraid of the strange environment of MIP sessions, the children became more secure and open. Several mothers pointed out other causes that contributed to improvement in the infant, such as the passage of time and the child's development. The children gradually matured, and mothers experienced them as less vulnerable. Some children started walking and others started talking during MIP. By developing these skills, they could express themselves, become less frustrated, and feel better. One mother described how she now had fun with her child, and they played and laughed together.

Relationships with other people develop. The period with their infant did not meet the participants' expectations, which was why they were looking for help. Relationships with partners, family, and their parents had been negatively affected during this period. This issue came up regularly in MIP, and the mothers were encouraged to accept that not everything turns out as expected. Many mothers brought up their family situation, with changing roles:

> I think the whole atmosphere in the family was—maybe not changed—but affected . . . the relationship between my husband and me, which is so important for our two daughters. Yes, the entire atmosphere in the family became better. Including my relationship with him.

In some cases, a sibling participated in MIP; in others, the mother used MIP to get the analyst's help in matters concerning an older sibling's problems.

> . . . about things at home. I did so once when we had great problems with the big guy. Then I talked with her and got advice about it.

Several mothers did not talk at all about changes in the relationship with their partner. Those who did often felt that MIP helped them see and process that relationship. The partner relationship deepened. The balance between the parents changed, and the partner participated more in childcare:

> It's become so much better. My husband is much more calm and focused on things that are important. He probably feels more that we're a small family.

These positive changes were partly due to the child's age, the mother's stopping breast-feeding, and a conscious effort from the mother. She was able to open up and, in several cases, describe how she included her partner:

> It's much better. We have been able to talk about it a bit, my partner and I. I felt very much alone during that time.

DISCUSSION

There exists today several quantitative studies of various mother-infant therapy modes, most often in the form of randomized controlled trials (Cohen et al., 2002; Cohen et al., 1999; Lieberman, Weston, & Pawl, 1991; Mulcahy, Reay, Wilkinson, & Owen, 2010; Ravn et al., 2012). In general, they have shown beneficial effects for the index treatment on some or several outcome measures. When it comes to understanding the therapeutic mechanisms behind these effects, we have had to rely on traditional case reports (Baradon, 2005; von Klitzing, 2003; Watillon, 1993). Another methodology of understanding the therapy process and the participants' experiences is the qualitative study. One may, for example, analyze interviews with participants and therapists or recorded therapy sessions. Such methods are increasingly used in psychotherapy research (Barros, Kitson, & Midgley, 2008; Carlberg, Thorén, Billström, & Odhammar, 2009; Lilliengren & Werbart, 2005; Palmstierna &Werbart, 2013).

As for MIP, the method investigated in this article, traditional case reports that also address various theoretical topics have been published (Norman, 2004; Salomonsson, 2014). The advantage of case reports is that they allow an in-depth insight into one specific case and contribute to developing the clinical theory underlying the therapeutic method. The drawback is the restricted external validity and the subjectivity of the author, who is generally the therapist. A qualitative study collects a group of patients who are interviewed about their treatment experiences. This procedure increases the external validity and allows for greater objectivity because the researcher, the interviewer, and the therapist are not one and the same person. The drawback is that the fine-grained clinical process cannot be investigated with the same accuracy. To our knowledge, qualitative analyses of mother-infant therapy modes have not been published. Apart from our interest in extending research on MIP treatment by using yet another methodology, we wanted to investigate if a qualitative approach might be applicable to this patient cohort.

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In this project, we chose a double approach by interviewing both mothers and therapists. The present study reports on analyses of interviews with 10 mothers who participated in MIP. An upcoming article will present analyses of the interviews with their therapists. In both studies, data consisted of transcripts of interviews made by another researcher after treatment completion. The analyses in this study yielded two main themes: transition to motherhood and relationships with the infant and family.

In our search for similar themes that appear in the parent-infant therapy literature, we would like to bring out Stern's (1995) concept of "the motherhood constellation," which consists of four main themes. The *life-growth theme* is about the mother's capacity to maintain the life and growth of her baby while the *primary relatedness theme* deals with her engagement in the baby to assure the baby's emotional development. The *supporting matrix theme* comprises the necessary support systems, preferably the partner. Finally, the *identity reorganization theme* is about the transformation of mother's self-identity. Our first theme highlights the mother's transition to motherhood; it comprises establishing a space for herself and the baby as well as growing into her parental role. This theme seems to coincide with Stern's life-growth and identity reorganization themes. Our second theme, relationships with the infant and family, is very similar to the primary relatedness and the supporting matrix themes.

Undoubtedly, this period in life is stressful for mothers, when anxiety and depression may be elevated. Homewood, Tweed, Cree, and Crossley (2009) reported that depressed mothers with newborns were overwhelmed by responsibility for their infants and became emotionally fragmented when attempting to meet the infants' needs. This led to a vicious circle with negative self-evaluation. Mothers' expressed needs for professional help in this difficult situation are well-known (Barimani et al., 2015). Pregnancy and motherhood is thus a period of great changes, and the transition is associated with mothers' responses to these alterations and the ways in which they integrate new circumstances into their lives (Kralik, Visentin, & van Loon, 2006).

Participants in the present study often felt helpless and bad as mothers. They constituted a care-intensive group with previous and present emotional problems. Several participants said that they received help by having access to a trustworthy professional person, the therapist, whom they could address freely about problems such as anxiety, stress, and depression. They were thus able to develop their maternal role and perceptions about their children. In contrast, some mothers reported that they received too little focus on their personal difficulties and felt that the therapist's focus on the baby was made at the expense of addressing the mother's problems. Their present precarious situation may have contributed to the reports by those mothers who did not understand why the psychoanalyst turned to the child. They signaled that they lacked a focus on their own problems. But for those mothers who eventually understood the benefits of this approach, treatment helped them grow into their role as a mother. For them, MIP thus seemed to contribute to the transition to motherhood.

The originator of MIP, Norman (2001) used the term *maternal receptivity* to indicate how the mother comes to understand, with the help of the therapist, the baby's signals and emotions. This term can be read as equal to *sensitivity*—a more commonly used term in this context (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003; Biringen, Robinson, & Emde, 1998). Norman's (2001) idea was that by increasing the mother's receptivity, it was possible to "bring the hidden parts of the child into the emotional relationship with the mother" (p. 98). In other words, by turning to the baby, the analyst could help the mother perceive her child's emotions and how they linked with various behaviors.

Many participants said that the psychoanalyst turned to the child. Actually, when describing the therapy process, their emphasis was rather on their personal development. They often described how they received help for themselves. One may assume that the mothers were able to develop increased sensitivity toward their children only to the extent that the analyst also addressed their own problems. The mothers needed the analyst's direct help to increase their sensitivity toward their infant, not only via the child. Without this help, it seemed difficult to establish a better bonding between mother and child. One conlusion is thus that the analyst's technique should balance the needs of mother and infant.

When a woman becomes a mother, her relationship with her own mother becomes more salient. This applies both to the mother as an external, real person and to her as an internal object (Hinshelwood, 1994; Klein, 1940).The impact on parenthood of the parent's history was described by Fraiberg, Adelson, and Shapiro's (1975) through her concept "ghosts in the nursery:" "In every nursery there are ghosts. They are visitors from the unremembered past of the parents" (p. 387). The internal mother figure had great importance for the woman's capacity to handle this new situation of being a mother. Benedek (1959) emphasized that

> the mother's ability to receive from her child is strongly affected by the confidence which the mother herself has incorporated into her mental structure while receiving from her own mother. Her patience and motherliness are derived from the developmental vicissitudes of primary identifications with her mother. (p. 394.)

Identification with mother is thus described as important for developing the ability to take care of the infant.

Participants frequently talked about their relationships with their mothers. Sometimes, MIP helped them perceive their mothers in a new way; in a few cases, they described how they could even break destructive transgenerational patterns. Furthermore, when these patterns were clarified and worked through, the relationship with the child could develop in a new and more optimal way.

It has been shown that establishing a good mother-infant relationship and attachment is of crucial importance for the child's development. Problems in this area have been traced to future attachment difficulties for the child in toddlerhood (Erikson, Sroufe, & Egeland, 1985) and in adolescence (Lyons-Ruth, 2008). Regarding the theme "mother-infant relationship developed," the mothers reported various issues. Some felt that they had been too close to

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the child while others felt estranged and remote from the child. Both situations made it difficult to (a) get to know the child, (b) understand who the child really is, and (c) empathize with the child. We conclude that the therapists' focus on the baby helped the mother to better achieve a healthy distance to the child, in parallel to optimizing the relationship. This was reflected in such expressions as "I didn´t think that an infant could be such an independent person, that you could communicate so seriously" or "We have come so much closer now."

Anxieties about the infant's well-being were prevalent. Many mothers were afraid of sudden infant death syndrome, which they had read about on the Internet. Some mothers reported that after therapy, they were able to link such fears to their own feelings of shortcomings and of not being good enough as a mother. Participants required of themselves that they should love their children and had strong guilt feelings when they experienced other emotions. Parker (1995) contended that mothers need to accept ambivalent feelings toward their infants to be able to separate from them. One recurrent finding in this study was that the analyst helped the mother to realize and accept such ambivalence.

The partner relationship is exposed to many changes during pregnancy and the first period with a newborn. These changes may affect the couple's relationship—usually with a decline in marital satisfaction (Belsky, Lang, & Rovine, 1985). Mothers reported that they felt alone with the child and had problems in communicating with their partners. Many participants claimed that MIP enabled them to clarify their relationships with the partner.

All mothers had emotional problems, usually in the form of stress, anxiety, and depression, and many had a painful history during childhood or adolescence which was brought to life now that they had become parents. Most of them expressed that during therapy, they developed in their maternal role and their relationship with their children. Those mothers who were critical felt that they did not get enough attention. It is possible that the mother did not give herself the opportunity to receive the help that was offered; she felt lonely and isolated and had difficulties in opening up to another person. Another possibility is that her own problems were so great that the treatment should have been primarily focused on her. Perhaps it also would have been helpful if the mother had received a description and explanation of how MIP was supposed to work—and why. If so, she would have had a better opportunity to develop a sense of meaning and coherence of the therapy procedure.

Methodological Considerations

Concerning the question whether findings in qualitative analysis are trustworthy, concepts linked to qualitative research are often used (Guba & Lincoln, 1994). The present study applied the concepts of credibility and dependability to describe various aspects of trustworthiness (Graneheim & Lundman, 2004).

Credibility. To deal with how well the themes represent the data, the two authors worked independently with the data until agreement was reached; quotations from the transcribed texts further illustrate the study's credibility.

Limitations. The present study was limited to women of childbearing age; the reason is that only mothers and infants received MIP. Information concerning fathers' problems and interactive contributions might have added valuable information.

Strengths. The mothers entered the study with various problems and perspectives; this contributed to a variety of treatment experiences. The amount of data was sufficient for fulfilling the research objectives.

Dependability

Dependability was considered substantial because one interviewer interviewed all study participants and used the same guide for questions.

Limitations. Multiple interviewers might have gained new insights and influence follow-up questions. The first author and the interviewer are psychoanalysts, and their allegiance (Luborsky et al., 1999; Markin & Kivlighan, 2007) must be taken into account.

Strengths. To minimize allegiance effects, an interviewer's guide was developed (Salomonsson & Sandell, 2012), and the present study's analyses are described in detail. The interviewer did not analyse these data. In the coding procedure, another research team member, who is an experienced psychologist but not a psychoanalyst, participated with the two authors.

In this study, we only explored experiences by mothers participating in MIP and not from those who did not receive this kind of treatment; the reason was that the specific aim of the study was to deepen the insight in mothers' experiences of MIP rather than comparing experiences of two treatment forms. Future studies could compare interviews with patients participating in various therapy forms, including CHCC and mother-infant therapy.

Conclusions and Clinical Implications

Motherhood is a major life transition that significantly affects a woman's identity. The transition to motherhood requires adjustments to new roles and growing demands. The mothers in the present study had "baby worries;" that is, difficulties in their maternal role and experienced problems in relationship with their children. Many mothers found it beneficial and useful that the psychoanalyst talked to the mother *and* the child and understood both their needs. MIP appears to have been helpful for them to achieve closer relationships with their children. Some mothers were dissatisfied because they did not feel that they received enough focus on their personal problems. This finding has bearings particularly for those mothers whose needs for emotional support are substantial. For them, a modified technique should preferably be used to ensure that they get more attention and space to express themselves.

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This observation makes us conclude that the analyst needs to be receptive to the mother's needs. Consequently, both the mother's personal requirements and the child's needs must be fulfilled.

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