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Traumatic Birth and Early Bonding, a Case Study*

Rose-Angelique Belot[1], Magalie Bonnet[1], Almudena Sanahuja[1], & Camila Taunay[2,**]

[1]*Laboratory, Bourgogne/Franche-Comté University, Besançon, France*

[2]*Clinical Psychology Department, University of Brasilia, Brasília, DF, Brazil*

ABSTRACT – Motherhood can be a major developmental crisis. But what about when the birth also includes traumatic elements? Physical, moral and psychic suffering make the mother unavailable and disrupt the first mother-baby bonds, the quality of holding and handling. A state of tension in the mother and the baby can be so intense that it can result in a real state of personal and relational crisis, difficult to control. The presentation of a detailed case study shows the intensity and extent of these movements. Listening and careful observation of the mother and her baby reveal how a particular attention work allowed the mother to name the state of crisis and dissolve it.

KEYWORDS: birth, trauma, early relationships

Nascimento Traumático e Impacto Sobre os Primeiros Vínculos, um Estudo de Caso

RESUMO – A maternidade pode ser uma grande crise de desenvolvimento. Mas o que acontece quando o nascimento também inclui elementos traumáticos? Sofrimentos físicos, morais e psicológicos tornam a mãe indisponível e perturbam os primeiros vínculos mãe-bebê, a qualidade do *holding* e do *handling*. Um estado de tensão na mãe e no bebê pode ser tão intenso e vir a resultar em um verdadeiro estado de crise pessoal e relacional, difícil de conter. A apresentação de um estudo de caso detalhado mostra a intensidade e a amplitude desses movimentos. A escuta e a observação atenta da mãe e do seu bebê revelam como um trabalho de atenção específico permitiu à mãe nomear o estado de crise e dissolvê-lo.

PALAVRAS-CHAVES: nascimento, traumatismo, relações precoces

Despite the societal and family idealization around motherhood, welcoming a baby is not always easy. Parents often have to deal with multiple and particularly intense psychological tasks. Indeed, giving birth leads to significant psychic reorganizations and arouses memories of the future parents' own childhoods and histories, inevitably causing them to question everything relating to life and death (Belot, 2014). The intensity of the events experienced, from pregnancy to birth, the meeting with the baby, the sudden nature of the birth, having to deal with the unknown in several respects and across very different levels, all recall the mother's own intrapsychic conflicts and her own childhood (Bydlowki, 2007).

This arduous psychic work can be made more complex by the actual birth process, with the occurrence of unpredictable events leading to shock, violence, an inability to psychically metabolize the experience, and trauma (Prat, 2008).

While we do not overlook the role, place, and psychic difficulties of the father in such circumstances, our discussion will focus on the mother's experience of childbirth, on how it impacts the early bonding process, and on how it can even destabilize it completely.

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** E-mail: camila.taunay@gmail.com

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THE CONCEPT OF TRAUMA

First, we should recall that the etymology of the term "trauma" comes from the Greek "trauma" (τραύμα), meaning a physical wound. Laplanche and Pontalis (1967) define it as an event characterized by "its intensity, the subject's inability to respond adequately, the upheaval and the lasting pathogenic effects it provokes in one's psychic organization" (p. 499). Even when there are no complications, childbirth may be associated with some form of trauma that can be described as ordinary (Belot, 2019) in so far as the psychic apparatus is overwhelmed by the resulting excitement and is unable to contain it. Freud showed, very early in his discoveries of psychic life, that to assimilate excitement, the psyche must be subjected only to small amounts of it. Later, Bion (1962) shed light on individuals' own psychic capacities to transform their "own raw sensory experiences" into detoxified and then assimilable elements which would allow them, little by little, to develop their own apparatus to "think unthought thoughts". The psychic apparatus therefore plays a major role and is at the center of the possibilities of regulating and processing the excitement emanating from the mother herself when she is confronted with the major event that is childbirth. Moreover, her own psychic forces are directed toward her baby to process successfully the archaic projections of an immature baby with neotenous features.

What, then, happens when childbirth generates trauma? What additional difficulties weigh on the psychic life of the mother and how do they impact on early bonding? We will begin by examining how the post-birth phase, outside a traumatic context, unfolds.

LATEST DEVELOPMENTS ON THE RISKS OF "TRAUMATIC" BIRTH

While childbirth is a particularly intense and unique event, both physically and psychologically, many women fear it and perceive it as inescapable and are often not without misgivings. Giving birth may appear both more valued and more expected than the childbirth process itself, because while the first is synonymous with finally meeting one's baby, the second involves unprecedented violence (Candilis-Huissman, 2010). Childbirth involves dealing with the unknown at all levels, especially for first-time mothers. Moreover, it also involves a fair amount of unpredictability due to the maternal and fetal risks that may arise. It is worth remembering that a quarter of the women who gave birth in the 20th century died in childbirth (Bydlowski, 1997).

Childbirth is also a moment characterized by the presence of particularly contrasting emotions, positive emotions but also negative ones that are neither admitted nor recognized, and which are therefore not considered legitimate by the mother herself. Childbirth is also associated with great physical and psychological vulnerability for women (André et al., 2010).

While Freud and Rank focused on birth trauma from the baby's point of view, in 1969, Winnicott spoke of birth as being traumatic for mothers and described childbirth as a moment filled with violence and one that induces a state of stress (Rank, 2016). Winnicott was therefore already conscious of the "ordinary" maternal trauma dimension, whatever the outcome and course of childbirth (Winnicott, 1990).

Our literature review reveals similar findings. Creedy et al. found that the recollections of 33% of women on the childbirth process had traumatic overtones (Creedy, 2002). The studies by Montmasson et al. reported that 22% to 48% of women described their childbirth as a traumatic experience (Montmasson et al., 2012). Moreover, 6% of women reported experiencing post-traumatic stress disorder after childbirth (Denis & Callahan, 2009).

Childbirth may be associated with particularly destabilizing and hostile events and can lead to the perception of a death threat for oneself or for one's child and/or an attack on one's physical integrity. Such experiences can lead to traumatic reactions. Bydlowski (1997) suggests that encountering a vital danger, either in reality or in one's imagination – and the psychic commotion that ensues – can favor the emergence of a particular mental state that may be described as traumatic.

The experience of childbirth, overwhelming in more ways than one, also highlights the condensation of themes around birth and death that are closely associated with this moment of life. In addition, how the delivery unfolds, the meeting with the baby, the adaptation to this new being, and the consequences of adjusting to life with a new baby are only some of the unknowns and the multiple inherent aspects that the mother, indeed both parents, must manage during this period.

Faced with this potentially traumatic event, specific defense mechanisms emerge, such as the body-psyche split and emotional dissociation; in the long term, these may provoke post-traumatic stress (PTSD). Individuals may find themselves invaded by a state of shock or psychic paralysis, which may be accompanied by an excessive production of cortisol and adrenaline. The available literature suggests that more than a third of women have PTSD ten weeks after giving birth (Ayers, 2009). According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), symptoms of initial post-traumatic stress lasting more than one month after giving birth led to PTSD, and the prevalence rate lies between 1% and 3% (Ayers et al., 2016).

It should be noted that PTSD can also occur belatedly in a woman who showed no initial signs of acute stress. (Smid et al., 2009).

Left untreated, a traumatic experience associated with childbirth can evolve into generalized anxiety, addictive behavior, or even dissociative PTSD. There is a strong correlation between PTSD and postpartum depression (Montmasson et al. 2012).

There is a lack of studies on how birth trauma affects early mother-infant bonding. Those studies available have focused on specific issues such as the consequences of postpartum hemorrhage (Candilis, 2011; Courtaux et al. 2020), or on the trauma that parents experience when faced with the premature birth of their child. For instance, the study by Muller-Nix (Muller-Nix, 2009), focusing on prematurity and the parental experience, revealed that PTSD was a major risk factor influencing early bonding; mothers who had lower sensitivity had a particularly controlling personality. In terms of preterm birth, Kersting's study (Kersting, 2004) also highlights the fact that the traumatic aspect of the parental experience has received little attention and that this trauma considerably hampers the mother's meeting with her child.

A study involving 200 mothers focused on the perception of pain and control during childbirth. It revealed that the quality of mothers' early relationships with their babies was lower among those mothers with a negative experience of childbirth (Chabbert & Wendland, 2016). The authors suggest that it is important to consider negative, or even traumatic, experiences of childbirth to better assess the impact of such experiences on early mother-baby relationships. In the same vein, one study has shown that professionals who succeed in establishing interpersonal relationships with women during and after childbirth help to minimize and reduce the traumatic impact of these experiences because they play a key role in influencing the sense of security perceived by these women (Lyndon et al.,2018).

Even though antenatal classes are provided free of charge, only one third of women attend the seven sessions proposed. These sessions help future mothers to change their perceptions of childbirth, promote control over their bodies, allow a different bodily and psychic commitment, promote the emergence of positive perceptions, and help the future mothers to prepare for certain potential complications, even if childbirth is always a singular experience, dependent on its context, and always unpredictable. Naturally, it relates to singularities in terms of experience and support, but also to the singularity of the psychic life of each mother and the support she receives, both during and after the traumatic event.

The intensity of potentially traumatogenic scenarios is insufficiently described and known. It is also worth mentioning that professionals know that a delivery that has been successful from a somatic and gynecological perspective can still be experienced as a traumatic event by the woman, even though it may not be traumatizing for other women who experience more complicated and difficult childbirths. These aspects are crucial and therefore the factors that prevent trauma and/or its elaboration must be further investigated and considered in future research to enable professionals to act effectively.

This traumatogenic dimension also affects the father, the family, and perinatal professionals, and can have repercussions on future maternity projects (Gottvall & Waldenström, 2002). All these studies relate to very specific births with very specific psychic phenomena that are felt as an attack. However, we believe that birth trauma can also lead to quite deleterious repercussions for early bonding, as we will show through the detailed presentation of our case study. The intensity of the stress experienced, the attacks against the mother's body, and the pain led to a more or less severe psychic unavailability. Before addressing these aspects, it seems necessary to consider the issues that revolve around the "classic mother-infant encounter" in a context where delivery was without complications in order to assess the complexity and the challenges involved when a mother meets her baby for the first time.

THE COMPLEXITY AND THE CHALLENGES OF THE MOTHER-INFANT ENCOUNTER IN THE ABSENCE OF TRAUMATIC EVENTS

In contact with the "real" child and immediately following the birth, a mother cannot yet enter into a phase of personal psychic reorganization. On the contrary, her hypersensitivity – which allows her to adjust to the needs of the newborn – prolongs the previous phase of disorganization. The "primary maternal preoccupation" phase (Winnicott, 1969) makes it possible to absorb the shock of separation due to birth and allows the mother to follow the path of libido regression with her baby. This period, however, is one of great fragility at the psychic level because the mother is in a phase of identification that is both regressive (in order to identify with her baby from the first days of its life) and anticipatory: she must perceive the needs of her child and comfort her infant's sense of existence; this is a major aspect that helps to reduce the mother's encounter with primitive anxieties such as annihilation or dismantling.

The sudden change in responsibilities and social status also weakens both the mother and the father. They are now responsible for life, for a being to whom they have just given birth. There is also a change in future generations and new psychic challenges. Indeed, the birth of children "pushes" generations forward and gives a glimpse of other unknown chapters of life. Despite the psychic resources available to the subject, the mother and the parents, these data always

remain unknown and cannot be predicted before the woman concretely faces them and experiences them. In any case, the encounter with the baby, which is disturbing at all levels, also requires adequate psychic work to succeed in stemming and containing all the emotions and the effects of varying intensity, which are very present, but which differ depending on each woman.

The encounter with the baby brings back to the mother's mind everything in her childhood and in her relational past (Lebovici, 1983; Manzano et al., 1999). The baby's concrete presence and the essential care required reopens certain conflicts and processes that the mother experienced in her own childhood (Racamier, 1979). While certain facets of the maternal experience have not been sufficiently elaborated from a psychic perspective – and nor have the representations associated with its effects been analyzed – this experience, which is still unknown, involves various levels of splitting and constitutes an ideal breeding ground for this splitting (Debray & Belot, 2006; Mellier & Belot, 2010). Other, more tangible elements are associated with the concrete difficulties that the mother experiences, such as containing the baby's crying, her emotional expressions, and satisfying all her baby's needs, which correspond, naturally, to additional inevitable tension. The success and quality of the effect attunement (Stern, 1989) with her baby requires the mother to adopt her own reflective thinking, define her motives, succeed in identifying with her baby, and regress in order to learn gradually how to find her bearings in her new functions as a mother, as well as succeed in getting to know her baby, be able to adjust to her needs, and therefore be mentally available.

This case study is a detailed presentation on how the experience of childbirth can not only lead to a catastrophic mismatch between mother and child, but also create dire repercussions for early bonding. In other words, this in-depth description illustrates how birth trauma can impact the psychic work that a mother must undertake to adapt to her infant's needs. In this case, the ability to enter in the "primary maternal preoccupation" phase was gravely compromised and impacted both mother and child- mentally and physically.

METHOD

The case study method is an integral part of qualitative research methodologies. Widlöcher (1990) argues that "The unique case lends itself to an authentic scientific approach" (p. 385). It allows observation and in-depth description, and sheds light on the clinical richness and specificity of the functioning of individuals' psychic apparatus, making it possible to generalize certain psychic functioning present in other subjects. Indeed, qualitative methods advocate the highlighting of the subject's own subjectivity in order to allow an in-depth analysis of the data and make it possible to explore new avenues of reflection. It is therefore a rather relevant method in our study which involves a very sensitive subject, i.e., the perinatal period.

Participants

This case study was selected from a study on early bonding, on the postpartum period, and on somatization in babies (aged between one and four months). A total of 26 women participated in the study; they were not seeing a therapist, had no initial psychic disorders, and had recently become mothers. The clinical group comprised 13 women who were pediatrics patients. Their babies had several somatic symptoms such as sleep difficulties, feeding difficulties, and digestion disorders, with no identifiable organic cause. The control group comprised 13 women and their babies – without somatic symptoms – who were met in a day-care center.

Therefore, one baby and his family were selected from the 13 cases under pediatric care. Tristan was the first child of Mr. and Mrs. B, 32 and 33 years old. They both worked in the medical sector. The baby Tristan was 1 month 8 days old. He was hospitalized for gastroesophageal reflux disease, daytime and overnight sleep disorders, and an unexplained state of agitation, accompanied by intense crying. There was no identifiable organic cause. Tristan was also a very alert child whose growth in height and weight was satisfactory.

Instruments

The study primarily involved several semi-structured interviews, some of which lasted more than two hours "at the baby's bedside", according to the observation method drawn from Bick (1964).

Procedure

All ethical principles were taken into account and all participants signed written informed-consent forms. At the time of the study, French law did not require the researchers to obtain approval from an ethics committee for this non-interventional study. The presentation of the case below is from the cohort belonging to the clinical population.

The data was collected from eight encounters between the researchers and the family, each one lasting 2 to 3 hours. These were clinical research interviews in the context of somatic expression of the baby. The meetings took place in the hospital room where the child was hospitalized for pediatric care. Mother and child were always present during these interactions. The researchers made themselves available to the mother and the baby in order to successfully listen to them, receive raw elements of their experiences, observe their interactions and affective attunement (Stern, 1989).

RESULTS

Clinical situation – Mrs. B and her son, Tristan, 1 month 8 days

First encounter with Mrs. B[1]

The first meeting with Mrs. B took place in the cubicle of the hospital ward where her son had been admitted two days earlier. The mother was a pretty slender woman with none of the plumpness of motherhood. In an uninterrupted stream of words, she expressed her distress, her general state of fatigue, her lack of sleep, and all the feelings that she was struggling with: her fear of going mad and her guilt because, according to her, her child had been suffering for a long time and no pediatrician had been able to help him. She found it difficult to come to terms with the idea of leaving him alone, out of her presence, in the pediatric ward. Although she acknowledged the good will of the hospital staff, she also criticized them. This first interview was quite long, lasting for more than an hour and a half.

History of pregnancy and birth

Forced to be on bed rest from the sixth month, Mrs. B had gained a lot of weight, 21 kg. During the last month of pregnancy, she had experienced constant and particularly sharp pains. The doctor spoke of the possibility of a caesarean section. Mrs. B responded that this did not frighten her. She said that anesthesia did not scare her and that she also thought she would lose weight faster and it would be easier to get her former life back.

Having still not delivered her baby 10 days after the estimated delivery date and with no contractions, the decision to perform a caesarean section was taken to avoid fetal distress. Given that the epidural had no immediate effect, the doctor was forced to perform general anesthesia.

When she awakened, Mrs. B explained that she guessed, rather than actually saw, that her husband was holding her baby and presenting him to her. Her awakening was particularly difficult and her vision was blurred. She quickly asked her husband whether her child had any malformations and was worried about his state of health. The analgesic effect of the epidural then set in, paralyzing her legs and her entire bust, up to her armpits.

Six hours later, she was still in the recovery room and in severe pain. She called out. The caesarean section and the intensity of the pain she felt would require powerful analgesics for two days. Over the next days, she still suffered significant abdominal pain following the caesarean.

The encounter with her baby

Speaking of her child, Mrs. B specified: “I thought he was just as I had wanted!” His physical appearance corresponded to all her wishes: “he had this image of the baby that you see on TV, round, big cheeks, and no hair.” Without explaining it clearly, Mrs. B had always wanted to have only one child, preferably a boy: “It’s because it’s... everything for him... I don’t want to share the love. I actually think that’s it. It’s that I want to give him everything and don’t want to have to share between several [kids].”

But the pain, the postoperative discomforts and the infusions prevented her from caring for her baby as she wished. At the same time, she confessed her apprehensions. “That’s for sure, I was very afraid of caring for him, well, like all mothers…. Well, I certainly felt awkward, uh... even with a medical background, at that moment, I didn’t know what to do... I was lost”.

During breastfeeding, Tristan was unable to latch properly and Mrs. B was advised to wear a nipple shield. Everyone had a different opinion, which made her lose her patience. She learned that one night, without informing her beforehand, the nurses had given Tristan baby formula in addition to breast milk because he was screaming. She decided to stop breastfeeding abruptly. Despite Mrs. B’s initial desire to feed her baby, breastfeeding therefore ceased. She said: “I was lost, I didn’t have much guidance about feeding babies…/… I was all alone, I had a stomach ache, I was scared of washing him…”

Tristan began crying a lot from the third day after his birth. Disappointed by the contradictory advice and opinions given at the maternity ward and by her son’s feeding, Mrs. B wished to leave as soon as possible and to seek the advice of a pediatrician working elsewhere. The pediatrician she saw advised her to feed her son with a specific infant formula and to continue breastfeeding to wean him progressively from breast milk. At home, and for the first 15 days, Tristan screamed and cried continuously. He would sleep very little during the day. The pediatrician’s visits continued, and the formula was changed several times, eight in total.

In three weeks, Mrs. B had lost 14 kg. Her main fear was the fact that her son was agitated and she was unable to calm him down by herself. She was afraid of being unable to care for him alone. During this period, she remembered: “I had hit rock bottom, we were always arguing with my husband because people who don’t sleep and who don’t eat, well, they argue. I went to my mother’s for a week because I said to myself: No more, enough, this kid, I can’t stand him anymore, nobody can stand him …/… I need a break. If, really, I’m not able to take care of him, if I really piss him off, or I don’t know, well, he’ll be in the experienced arms of Grandma who is patient and then we’ll see.” This decision suited her because it allowed her to stay close to her child.

1 The observation and clinical encounter were performed by R A Belot.

She herself felt unable to wash him, change him, or give him his bottle: "I didn't want to do anything anymore, but I was there" (implied: next to him). "I got to a point where, as the time for giving him his bottle approached, well, I was scared, because I would say to myself: 'Oh, he's going to cry again afterwards, and this, and that...' "

During the first days at her mother's house, Mrs. B slept a lot and got her appetite back. She said that she was better able to care for her child but without ever feeding him at night because she was afraid. During the day, she never fed him on her own: "I needed my mother to be by my side, in case things went wrong". When she could no longer bear to hear him cry, she would place him in the arms of her mother or her aunt and leave the house. She left her mother's house after a fortnight. As she still felt insecure and lacked serenity in the face of her child's crying, Mrs. B requested that he be admitted to pediatric care, convinced that his restlessness and condition required specific care.

She acknowledged that the situation in the hospital improved somewhat. Her child cried less and managed to sleep for several hours without interruption. Despite nursing several grievances against the hospital staff, their presence and the fact that Tristan was hospitalized reassured her.

The hospital staff noticed that Tristan was more agitated when his mother was present.

The father regularly visited his hospitalized son. The healthcare professionals noted that his behavior was the opposite of that of his wife. They thought that he was calm, made social contact easily, and was conciliatory. Mrs. B, however, was viewed as aggressive and plaintive.

The couple met with the doctor in order to clarify and review the situation, but neither the appointment nor the doctor's comments reassured Mrs. B.

Epilogue

After 2½ years, I unexpectedly met Mrs. B at the hospital. Tristan's development was positive. He was a flourishing child whose height and weight were satisfactory. However, he had a slight avoidant restrictive food intake disorder that could have been associated with his early weaning and with the post-birth context dominated by fear and anxiety.

Mrs. B and her husband were still together and the crisis appeared to be in the past. Mrs. B had resumed her professional activity and her life seemed more peaceful.

DISCUSSION

During the first encounter with Mrs. B in the department where her son was hospitalized, I quickly abandoned the idea of talking to her about my research studies because what she urgently required was sympathetic listening and special attention. It was essential to listen to her, to receive her particularly difficult experience, and to listen to her total incomprehension concerning her son's tears and his expressions.

A state of crisis

While there are many interesting points to discuss, we will focus on the difficulties around the birth, the pain intensity, the psychic collapse, the unavailability, the weakness of the mother as a protective shield, and the excess of excitation which is common around childbirth, but which may be increased by the circumstances and the experience of the delivery.

Mrs. B's situation reflects a genuine state of post-delivery crisis and shows the intensity of the changes experienced in her own psychosomatic balance at several levels. One may even speak of a true psychosomatic revolution given that this birth deeply destabilized the previous balance and profoundly modified Mrs. B's usual psychic and bodily processes.

When we met her, she was quite agitated, appeared particularly "overwhelmed", and expressed the intensity of her anger and rage because she was unable to create a serene relationship with her baby from their first encounter. We then questioned her experience, which led to the creation of a space in which she could "deposit" that experience.

Birth trauma

After a birth such as Mrs. B's, how can the bond between mother and baby be created when the former is in the recovery room following a caesarean section performed under general anesthesia? Vagueness and a floating sensation dominated; pain, fear, and the fact of not having seen one's child represented multiple difficulties that made the encounter with the child particularly difficult. When she learned that a caesarean may be required, Mrs. B was not at all alarmed. Thinking positively, she considered that this operation would allow her to lose weight more quickly and to resume her sporting activities and her "former" life. Her view of a caesarean section and its effects was completely false. But how could it be otherwise? Before experiencing such an operation, no woman can understand the difficulties that this may involve in terms of pain and other challenges, including movement. Similarly, Mrs. B was unaware of what babies required in terms of care and attention.

Everything that she reported about her delivery implied trauma: the epidural did not work and the need for more invasive general anesthesia prevented her from welcoming her baby properly, from seeing him and establishing a positive and committed relationship with him from the start. Everything was blurry when she awoke. A considerable

part of her experience had already been taken away from her. Moreover, the intensity of the pain that followed her awakening meant that she was completely unavailable. In addition, the delayed onset of anesthesia prevented her from regaining complete control and mobility of her body. The need for post-operative analgesia was an additional difficulty, exposing Mrs. B to violent and unbearable pain which made it harder for her to regain her strength and to experience a positive encounter with her baby. One must consider the magnitude of the attack on her body following the cesarean section and the complications that followed delivery. She found herself alone and quite helpless and was faced with the intensity of her experience and her impossibility of coping with it even as she described herself as "a fighter".

A difficult encounter and specific concerns

Physical pain had a great impact on the experience surrounding the birth and the meeting with her baby for the first time, inevitably making her unavailable on a psychic and relational level. Mrs. B had a cesarean delivery which went wrong, required general anesthesia, and led to the paralysis of her body and unbearable pain whose calming would require powerful analgesics over several days. The intensity and delay in recovery deeply affected both her strength and her vital energy.

Although unexpressed, we can also reflect on Mrs. B's particularly negative experiences with regard to how this birth made her feel. To what extent did she feel unconscious aggressiveness toward her baby? Childbirth is at the origin of multiple complications that she did not foresee, and nothing occurred in an expected, predictable, or serene manner. In this context, which is rather difficult from different points of view, how can a mother be physically and mentally available for her baby? How can the meeting with the newborn for the first time unfold?

Mrs. B told us that she feared her son's crying and confided that she was afraid to care for him. What drove these fears? Her psychological and physical unavailability? Or the fact that she challenged the need for a course to acquire the required skills, for a real encounter, with trial and error, with her baby, rather than relying on innate knowledge?

These first mother-infant relationships were marked with pain from the outset, and with bodily and psychic trauma. How can a mother care for her baby while she herself is still in pain and is psychologically and emotionally unavailable? Similarly, when Mrs. B confided that she was "afraid to wash him...", it was clear that she found it difficult to care for her baby's body, perhaps because of her experience with her own body which had been particularly affected by the c-section and was painful. We believe that there is a juxtaposition of mother and baby, because of the experience of birth and an absence of differentiation of bodies in this period. Tristan, until recently, was not separate from his mother's body. This is an interesting and new avenue that may help to shed light on the nature and importance of maternal projections in the postnatal period.

Mrs. B particularly dreaded any expression of crying and pain in her child. But what of her own suffering? How was it taken into account? She was in despair and felt absolutely helpless after awakening from her operation, and in the days that followed. Similar to her baby, she felt immature and distressed. Amrhein (2012) suggests that, although Hilflosigkeit "is often translated as distress", this term literally means "a narrow passage, a feeling of abandonment, powerlessness, loneliness, disarray, dramatic deprivation of material means, destitution, without recourse" (p. 44).

It is clear that both mother and baby experienced absolute destitution for different reasons, and that neither of them could be rescued. Mrs. B confided that, "at that moment, I didn't know what to do. I was lost". She rushed out of the maternity ward because she said she was not receiving the expected help.

She seemed to have particularly strong feelings of insecurity and was still being affected by the traumatic events experienced. Mrs. B appeared to be in a "flight" position in relation to motherhood. Seeing a psychologist, immediately after birth, would certainly have allowed her to express her intense suffering and to begin the psychic elaboration of that suffering. This would have allowed her to meet her child differently, because she would have been relieved of the weight of her personal suffering and her traumatic experience.

Mrs. B said that her child's appearance satisfied her at once because it corresponded to her desires and her representations. Without knowing why, she wished for only one child, a boy. Could this reflect an unconscious desire for a fusional and exclusive relationship?

Her words – "I want to give him everything and don't want to have to share between several [kids]" – reflect a desire for a fusional and exclusive relationship, which may seem "trivial" at the very beginning but which, in our opinion, is already a sign of Mrs. B's "all or nothing" relational style. This shows the intensity of her desires, and her lack of flexibility, which may both affect how she reacts to the unexpected.

This exclusive type of relationship may also correspond to a need to "make up for lost time" because of the lack of relationship during the first days with her baby due to her intense pain. While Mrs. B maintained an exclusive type of relationship with her son, she was unable to provide the reassuring, soothing, and protective gestures expected of mothers at this age. Tristan was more alert on the third day after his birth, as is usually the case for all babies, and he displayed behavioral difficulties from the start, crying a lot. However, his mother decided to stop breastfeeding abruptly and this became an additional difficulty in early care. Indeed, he was deprived of his mother's breast and of this closeness which is particularly important in terms of sensations and providing a physical and psychic container.

Specific projections

We believe that, because of her fear of going mad, her belief that her son had been long-suffering, and that no pediatrician had succeeded in relieving him, Mrs. B's reaction was the projection of her own uncontained and silent state of distress, and a genuine state of madness seized her following the delivery of her child. There was a phenomenon of mutual co-identification (Belot et al. 2002) where Mrs. B's own suffering was unconsciously projected onto her child. Indeed, we refer to projection because Tristan calmed down once hospitalized and the hospital staff noticed that he would become agitated when his mother was present. Before being admitted, he would doze off for only five minutes and then wake up screaming. After six days of hospitalization, the healthcare professionals observed that Tristan would sleep for long periods of time, for several hours, in the morning or afternoon, without waking up. His mother's agitation was contagious and was echoed by her son.

Destabilization of the common defense mechanisms

During the interviews, Mrs. B showed us the intense rage that she still felt. She saw herself as a tough fighter, with a strong personality, who took on many things. She could not bear the thought of being depressed and failing in her new role as a mother. She said that it was usually "through force" that she succeeded in overcoming challenges. We believe that she took upon herself all the violent events associated with the delivery, without any psychic elaboration. With these events in the past, she accumulated aggressiveness and hatred. Nothing in her life seemed positive. Her son cried a lot and she was unable to relieve him. The pleasure associated with meeting this child, despite the fact that she found him to her liking, was absent. From her story, her postpartum mental state, and what she described of her relationship with her child, Mrs. B used character defense mechanisms, such as flight, to face anxiety and helplessness, which were difficult to express, and she had the constant feeling of "being unable to get through it". She fled the maternity ward as quickly as possible; this particular reaction relates to the traumatic experience. The maternity ward was thus perceived as being the place of "all dangers".

There were many other character defense attempts: abrupt cessation of breastfeeding, a hasty departure to her mother (a saving solution because the latter acted as a container and Mrs. B was able to rest) and the hospital readmission of Tristan. The stay at her mother's was cut short because Mrs. B still showed as much destabilization and "flight"-type behavior, which drove her to get outside the house to avoid her son's cries. She said that, at her mother's house, "I didn't want to do anything anymore, but I was there". She also spoke of her complete inability to care for her son and of her need to take a break. While the opposition character trait was clear here, other depressive elements and a desire to flee were present as well: a classic response to trauma.

Failure in receptivity, containment, holding, and handling

The childbirth experience was accompanied by challenges in acting as her own container and, as a result, as a container for her baby. Her psychic apparatus was saturated and she had a vulnerable protective shield.

The lack of holding and handling (Winnicott, 1960) made Tristan feel agitated and her mother, who was unavailable, was unable to calm him. Moreover, this agitation made Mrs. B feel more keenly the vulnerability of her own protective shield.

She responded to her son's agitation with the defensive mechanisms she usually used (character, behavior) rather than in a regressive manner. During our first meeting, Mrs. B was holding Tristan at arm's length in front of her and forcing him to listen to her even though he was only one month old.

She constantly and rapidly changed positions, preventing Tristan from finding a comfortable position or settling into a steady one; on the contrary, these changes increased his tension. Her desire to care exclusively for her child was also thwarted because she was forced to ask for help. The implementation and recognition of her maternal skills had failed: not only was she unable to soothe her child by herself, but she also feared his crying, and felt helpless when faced with his behavior. Given his age, Tristan did not allow her to gain recognition, especially in her role and function as a mother.

Mrs. B's psychic apparatus appeared to be overwhelmed. She seemed to struggle with transforming her baby's raw experiences and with containing all his manifestations, including his crying. Her capacity for maternal reverie (Bion, 1962) was also affected, as was the transformation of beta elements into alpha elements.

Difficulties in acting as a container for her baby may have also been accentuated by her own lack of holding, which she recalled from when she herself was a baby. Naturally, her own psychic unavailability during the childbirth, and being forced to deal with this traumatic experience, made it harder to identify with her baby and to identify his needs. We believe that these difficulties are at the heart of the problem relating to the relationship forged.

We can also evoke the particularly strong early emotional contagion where both mother and baby are "exasperated" at failing to find serenity, comfort, and pleasure in being together in order to gradually get to know each other. Welcoming a baby always has an impact on the functioning of different women's psychic apparatus. In addition to accepting regression, the women must also succeed in identifying with their babies. Indeed, to be able to identify with one's child, mothers must be able to access both the passive position and regression. However, the common defense mechanisms

are already destabilized by the "motherhood" situation and even more so by birth trauma. Despite staying for only 15 days, going back to her mother's home provided her with a container and placed her in a position where she herself occupied the place of a child requiring her own mother to act as a container.

Contagious and paralyzing anxiety versus life-saving attention

We noticed that the intensity of Mrs. B's anxiety and her agitation during the interviews appeared to be contagious and capable of "paralyzing" our capacity for thought. She still placed herself in a position of control and was unable to put herself in a state of receptivity sufficient to welcome her baby, to discover him, and to seek to understand his expressions (as is the work of all mothers). Instead, the hospital and our interviews acted as containers, allowing her to evacuate her aggressiveness, rage, and anger. During the study, I was able to help Mrs. B to gain awareness of how observing her son could help her to identify better how she could meet his needs. During an observation session, she saw how attentively her son listened to her. I then pointed it out: "Look, he's soaking in your words". Indeed, positioned in her arms, Tristan showed considerable interest in his mother and was looking at her intently. Such shared moments allowed the mother to find peace and serenity, to relate better to her child, and to succeed in engaging in a positive interaction. Paying specific attention to this mother and listening to her attentively also allowed the psychic elaboration of the traumatic experience. During the half-days spent with both, while Mrs. B shared her story and her experience, calm moments fell into place between the mother and her baby. Tristan managed to fall asleep in his mother's arms, making her gain confidence in her maternal abilities.

This clinical situation presents a situation of birth trauma in which the ability of the mother to care for her baby was compromised (Winnicott, 1960). Tristan appeared to lack containment because his mother was unavailable and particularly stressed when faced with the demands of a baby, with her own inability to regress sufficiently and to identify with Tristan's primary, archaic needs.

Birth trauma considerably hampers the psychic work that a mother must undertake against the raw projections of her baby, which are physically and psychically immature. However, because of their immaturity, babies must rely primarily on maternal psychic processing capacities. These must be effective and must remain so, despite the intensity of the underlying experience.

The arrival of a baby requires specific care from the mother, such as a capacity for maternal reverie and the activation of her alpha function (Bion, 1962), in order to succeed in deciphering the archaic needs of the baby who is still immature.

CONCLUSION

The intensity of the psychic reorganizations that the woman, and then the mother, must experience and absorb during pregnancy, childbirth, and meeting one's baby is such that, if there are complications during delivery, both mother and child are subjected to a significant overflow of excitation. The transition to motherhood always involves profound upheaval, especially in primiparity, as this is an aggravating factor because it increases the need to face the unknown, from all points of view, both in terms of the mother, the encounter with her baby, and the development of her maternal skills. This detailed case study shows precisely what can happen when childbirth is aggravated by a traumatic experience that is left unaddressed. In fact, in the case of our participant, an explosive cocktail was formed and all the predominant excitations that were left untreated intensified the difficulties. The complicated delivery considerably destabilized the mother's first meeting with her baby and subsequent early bonding. This bonding was painfully impacted by the mother who was mentally and physically unavailable. Therefore, this manuscript points to the e existence of a different temporality, a hiatus between the need to restore a psychic balance and recover physically and the possibility of being attentive to one's baby. It is also a question of being able to come to terms with one's own experience of "becoming a mother". The closeness of an event experienced as dangerous condemns, in a way, any possibility of investing energy in an object, even if that object is one's own child. In this type of experience, the result of this work points to a vulnerable narcissism and an encounter with the object that is both laborious and painful.

Therefore, only psychic work can help to stem or contain all the emotions and effects of varying intensity according to the individuals. Moreover, information from professionals is fundamental, as is the presence of psychologists close to mothers, including in the delivery room. Owing to the significance of the "birth" event and the emotions it generates, especially in cases of birth trauma, it seems important to analyze further the specificity and the highly singular nature of this event and how it impacts on early bonding. This is a major issue that influences the quality of the links established with the baby in the postpartum period, an essential aspect that affects his or her future as well as the quality of family and parental life.

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Erratum

In the article "Traumatic Birth and Early Bonding, a Case Study", with DOI number: 10.1590/0102.3772e39403.en, published in the journal *Psicologia: Teoria e Pesquisa*, 39:e39403, in the first page:

Where it reads:

***** This manuscript as a part of a master's degree dissertation in the Clinical Psychology and Culture program of University of Brasilia.

****** This research is part of the CAPES PRINT project entitled: Clinical Psychology and Culture: Interventions and Professional Training.

It should read:

***** This research is part of the work of Rose-Angelique Belot, visiting professor and international author with a scholarship for the CAPES PRINT project of the Clinical Psychology and Culture Program entitled "Clinical Psychology and Culture: Interventions and Professional Training".