Early preventive work with parent-child interaction offers unique opportunities for change. Pregnancy is a time of psychological change during which first representations of the baby, oneself as a parent and the relationship are formed (Slade, Patterson, & Miller, 2007). Positive imagination, fantasizing and thinking about the child pave the way to actually meeting the real baby. Daniel Stern (2004) has used the term “motherhood constellation” to refer to the emergence of a new psychological structure comprising representations of past attachment relationships, and baby and self in relation to the baby. The motherhood constellation is formed during pregnancy and infancy and serves to sensitize mothers to the needs of the baby. As a psychic organizer, this constellation will determine a new set of action tendencies, sensibilities, fantasies, fears and wishes. Maternal depression and related psychosocial stress may reduce the capability of entering into the motherhood constellation and the related capability of interacting and mentalizing about the future relationship.

Theraplay During Pregnancy

The relationship between the parent and the child begins to form long before birth. Pregnancy is a period in which the representations of the baby and oneself as a parent begin to emerge along with the actual perceptions of the growing fetus. This experiential relationship between the fetus and the mother is comprised of the 1) actual perception of being pregnant with bodily changes and symptoms, 2) feeling the movements of the fetus and 3) gradually developing a feeling of mutually interchanging dialogues between the baby and the mother, for example, by gently pushing tummy and baby kicking back. According to Margareta Broden (2011) the relationship with the child develops gradually during the course of pregnancy; the first trimester is focused on building the maternal identity, the second the imaginary relationship with the baby, and the third preparing for the actual child. Thus, many intervention models have found the second trimester to be optimal for focusing on perceptions and related images of the baby or assessing maternal representations and reflective functioning.

Ann Jernberg, creator of Theraplay, developed a specific assessment for the prenatal relationship, The Prenatal Marschak Interaction Method (Jernberg, 1982, 1988). This was based upon Marianne Marschak’s original Controlled Interaction Schedule (1960), a structured observation of parent-child interaction. In the Prenatal MIM specific tasks are used to assess the mother’s capability of actually perceiving the child as a separate entity with his/her own perceptions and feelings. Thus, the Prenatal MIM uses tasks such as “Sing to your baby” or “Tell your child about the people he/she will meet after birth”. The actual procedure of asking the mother to think about the child and to enact the embodied relationship resembles the theoretical models derived from mentalization theories focusing on pregnancy (Slade et al., 2007). Prenatal reflective functioning has been defined as the capability of positively imagining oneself as a mother, handling normative ambiguous feelings towards the pregnancy, and the overall ability to perceive the fetus child and oneself as having multiple feelings and perceptions.

Pregnancy is a unique phase that asks the mother to envision unknowns outside her understanding of herself, her spouse, and her situation. Optimally, women can maintain a positive set of expectations and fantasies and have the ability to engage in reverie. Various forms of reverie serve as a playspace or intermediate area where the future mother is playing with the idea of becoming a mother (Slade et al., 2007). I have particularly emphasized the meaning of pleasurable reveries as making room for the baby and serving as preparation for the primary maternal preoccupation usually happening after birth.

Reflective functioning during pregnancy consists of the overall ability to take into account both the maternal and child states of mind. However, given that most of this thinking is imaginary (without the possibility of grounding one’s mentalizations in...
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seeing or perceiving the baby’s actual reactions) it is important to be aware of this difference between reality and fantasy. Furthermore, pregnant mothers are likely to imagine their relationship in a self-serving way, feeling that she will be a good and competent mother. However, clearly the mother resides within a specific set of circumstances where she can place her feelings in the context of the kind of person she is in this variable and transitory state of pregnancy. It is also crucial that the mother has the capability of having multiple emotions, often ambiguous and complex, in mind simultaneously. This includes understanding that other people around her might have multiple and changing emotions. Finally, the self-reflective expectant mother can anticipate the multiple ways in which she and her child’s mind will both meet and not meet (Slade et al., 2007).

Slade developed the Pregnancy Interview, to assess and pull out all these qualities of prenatal reflective functioning. In our Pregnancy Theraplay this interview is used together with the Pre-natal MIM to pull out both maternal reflective functioning and the actual relationship with the baby before proceeding to actual Theraplay sessions. In Pregnancy Theraplay, mother and the therapist engage in reflective discussions about the pregnancy, motherhood, and relationships with the baby in hourly sessions for about 10 weeks. In line with Slade (ibid) the focus of these discussions is to 1) give space to imaginations (“What kind of mother I want to be”), 2) deal with ambiguity related to pregnancy (“What kind of positive/negative feelings/thoughts have you had about the pregnancy/baby this “past week...”) and, 3) prepare for the actual meeting with the baby (“What will it be like when the baby is born”, “What is my child going to be like”). The distinct feature of this work is that it is not just about talking. As in other forms of Theraplay, interactive multimodal activities are used to encourage the bodily perceptions of baby and experiencing and exploring different emotions related to pregnancy and motherhood. Thus, the therapist introduces tasks like singing to the baby, practicing different relaxation and breathing techniques, drawing, writing a baby diary etc. The feelings and perceptions arising during these activities are then discussed. Pregnancy Theraplay usually begins in the gestational weeks 28-30 and continues until birth.

A Modification of Theraplay for Depressed Pregnant Mothers: Nurture and Play Groups

Maternal Pre- and Postnatal Depression and Child Development

Maternal depression threatens two core parental functions: fostering healthy relationships and carrying out the practical functions of parenting. The negative effects of maternal depression on children’s health and development can start during pregnancy (Bonari et al., 2004). The prevalence of prenatal depression varies from roughly 7% to 12%, suggesting that rates of depression especially during second and third trimester are substantial (Bennet et al., 2004). A recent review of the effects of prenatal depression suggests that it is a strong predictor of postpartum depression and is more common than postpartum depression. It has been associated with excessive activity and growth delays in the fetus as well as prematurity, low birth weight, disorganized sleep and less responsiveness to stimulation in the neonate. Infants of depressed mothers have difficult temperament, and later may develop attention, emotional and behavioral problems during childhood and adolescence, as well as chronic illnesses in adulthood. Several variables have confounded the effects of prenatal depression including comorbid anxiety and anger as well as stressful life events. (Field, 2010). Clearly, preventive work with prenatally depressed mothers warrants clinical attention.

The deleterious effects of maternal depression may be mediated in several ways. The biomedical pathway includes potential mediating variables of low prenatal maternal dopamine and serotonin levels and elevated cortisol and norepinephrine. The associated intrauterine artery resistance may limit blood flow, oxygen and nutrients to the fetus. Recently, the negative effects of chronic maternal depression on child social outcomes have been related to genetic and peripheral biomarkers of the oxytocin system (Apter-Levy et al., 2013). Indeed it has been demonstrated that oxytocin (a neuropeptide synthesized in the hypothalamus) is involved in early parenting behaviors particularly social synchrony and affectionate touch (Apter-Levy et al., 2013), and that parental oxytocin influences the infant’s oxytocin system through the provision of synchronous parenting. (Feldman, Gordon, & Zagoory-Sharon, 2010).

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There are numerous studies demonstrating that depressed mothers are less sensitive, more intrusive, and use less affectionate touch in their interaction with their infants (Goodman & Gotlib, 2002; Field et al., 2010). Also, impairments and distortions of mentalizing are most likely to be encountered in depressed patients (Luyten, Fonagy, Lemma, & Target, 2012). From a phenomenological perspective the depressive state reflects a state of psychic equivalence where an inner negative and loveless worldview is equated with outer reality. There is little room for pretend or play, symbolization or willingness to explore one’s own inner mental state. Since the role of positive imagination and reverie becomes especially highlighted during pregnancy (Slade et al., 2007) focusing on reflective functioning among depressed pregnant mothers is of greater importance. Additionally, psychic equivalence leads to equating psychological pain with physical pain and emotional and physical exhaustion, which may explain the high co-morbidity between pain, fatigue and depression (Van Houdenhove & Luyten, 2008). A state of hyper-embodiment ensues in which subjective experiences are experienced as real. This may be especially painful during pregnancy where the normative bodily changes may be perceived as burdensome rather than signs of positive change with the reward of delivering a new baby. An additional feature in the failure of mentalization may be a disturbance in the experience of time. Past, present and future seem to hold painful and immovable states of loneliness and rejection (Luyten et al., 2012). During pregnancy this may lead to a failure to move forward in the psychological process of pregnancy (Broden, 2011), from visiting past attachment relationships to imagining the child and onwards into preparing for the labor and actual meeting of the child. Indeed, it has been shown that among high-risk mothers the inability to move from the idealized idea of the baby towards actual meeting of the child was related to early interactional difficulties (Flykt et al., 2012). Here, again, one possible pathway may be related to biochemical underpinnings of depression given that oxytocin is linked with empathy, theory-of-mind, and prosocial orientations (Bartz, Zaki, Bolger, & Ochsner, 2011), suggesting its role in the overall mentalization skills related to human interaction.

Given this, it is probable that the provision of affectionate touch may help in increasing maternal oxytocin production, leading to an expectation that touch-based interventions such as massage therapy will have positive outcomes (Field, Diego, and Hernandez-Reif, 2010). Based upon our understanding of the mental reflections of the depressive state as described above, the joint effect of increasing positive affectivity and focusing on the here-and-now through reflective relationship with the therapist were the foundation for planning our prevention project for prenatally depressed mothers.

Baby Magic Project
A project called Baby Magic was launched in Lahti in Southern Finland in 2011. The project is run by a non-profit organization and has been funded by a foundation for three years. The basic aim of the project was to develop a preventive group-based intervention for mothers with prenatal depressive symptoms screened for depression from the well-baby clinics of Lahti. The three project workers were social and mental health professionals trained in Theraplay as well as mentalization theory and practice. Before launching this project in 2011, there was a pilot feasibility study made in 2010-2011 where the Nurture and Play Group model was developed and practiced with a volunteer group of depressed mothers. During this pilot phase the manual was written and refined.

As the feedback and findings from this pilot were positive, the Baby Magic project was launched in 2011 to study the effectiveness of the intervention in a randomized control trial. The sample consisted of 42 prenatally depressed mothers (Edinburgh Postnatal Depression Scale, or EPDS scores between 9-20) screened for depression between 22 - 31 gestational weeks from a community sample from well-baby clinics. Various standardized measurements tapping attachment style (AAI; George, Kaplan, Main, 1985), reflective functioning (PI; Slade et al., 2007) and interaction (Prenatal MIM-assesment; Jernberg, 1982) with the fetus/baby were conducted pre- and post-intervention. The aim of these interviews and observations was both to gather data and interventive, i.e., to focus on the mothers’ current state of mind and thinking about motherhood. After randomization, 20 mothers participated in Nurture and Play prevention groups which are based on mentalization and Theraplay techniques. There were 4 prenatal and 7 postnatal group meetings plus individual home visit after birth. The purpose of the empirical study is to evaluate the efficacy of this preventive group intervention in 1) enhancing mother-infant emotional interaction and 2) maternal reflective functioning. The empirical results are being analyzed and will be published in an international peer reviewed journal.
Nurture and Play Groups

Nurture and Play Pregnancy and Baby Groups are based on Theraplay and mentalization theory principles. Each group session lasts 1.5 hours. Four mothers and two therapists participate in each group. The groups have a preplanned structure which is manualized (Nurture and Play – Mentalization-Based Play Intervention; Salo et al., 2012). In the sessions, we alternate interactional activities (e.g., singing to the fetus baby or baby) with reflective talk about pregnancy/infant mood, and motherhood. This structure aims to strengthen both the experiential (how the baby is felt, what can be perceived through bodily emotional and somatosensory cues) as well as imaginary (mentalized) relationship with the baby.

Thus, in practice all group sessions during pregnancy included play, talk and homework aiming to increase both the experienced level of positive affectation and the capability of reverie, thinking and imagining all the possibilities a new relationship holds. A special emphasis was placed on stimulating the maternal bonding system by using touch (e.g., massage), and here-and-now experiences/reflections (“What might the baby be feeling right now”). All mothers kept Baby Diary where impressions about the baby, pictures, feelings and thoughts were gathered between the group sessions.

After the babies were born the case workers did a home visit. During this visit the birth experience and initial settling in living with the baby were discussed. The weekly Nurture and Play – Baby Groups started when the babies were about 2 months old. Once again, both reflective talk and Theraplay activities were used in each session. Theraplay activities were selected according to the babies’ developmental stage, and reflective discussion themes varied in each session. Mothers also did ‘homework’, e.g., observation of the baby.

<table>
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<tr>
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<th>Nurture and Play Pregnancy Groups</th>
<th>Nurture and Play Baby Groups</th>
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<td>Mentalization</td>
<td>• Singing/playing musical instrument to the baby</td>
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<td>• Drawing a picture of the baby</td>
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<td>Baby Diary</td>
<td>1) Give space to imaginations (&quot;What kind of mother I want to be&quot;),</td>
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<td></td>
<td>2) deal with ambiguity related to pregnancy (&quot;What kind of positive/negative feelings/thoughts have you had about the pregnancy/baby this past week.&quot;)</td>
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Preliminary Clinical Results
The initial feedback from all mothers participating in both Pregnancy and Baby Groups has been positive. Therapists' experiences have also been positive, especially with regard to stimulating more positive feelings and thoughts about motherhood and more competence and enjoyment of being with the baby. These positive results occurred within the context of maternal depression and related issues such as marital difficulties. The Nurture and Play Group structure with varying emphasis on reflection and experiencing has also received positive feedback.

Conclusions and Future Suggestions
Working with mothers using Theraplay from pregnancy on has by our clinical experience proven to be growth-promoting and a positive way to help the mothers build new relationships with their future babies. Theraplay focuses at the core of any adult-child relationship: perceiving and affectively synchronously responding to others during interaction, guiding and giving appropriate structure, soothing and nurturing when needed, and active playfulness in nonstressful situations. These interactional dimensions are found to meaningfully predict the child's later development. Underlying these observable ways of being together is parental mentalization, the ability to understand meaning and intentions behind observable behaviors. During Theraplay, this parental understanding can be supported via experiencing the affective interchanges as well as reflecting these sequences. Furthermore, according to our clinical experiences, using Theraplay elements (attachment based play activities) early during pregnancy alongside discussing and making room for maternal reflective thinking and feeling may in meaningful and powerful ways support the relationship with the actual baby. With prenatally depressed mothers, whose affective tone is negative and whose thoughts are pessimistic and circular, this positive here-and-now experience and imagining the future baby and motherhood may alleviate the effects of the otherwise depressed mood. Empirical findings from this project are underway and in time might further strengthen the view of early preventive work with depressed mothers.

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The Pre-Natal and Infant MIM tasks are available in our MIM Manual and Card set for $60.

Order at: www.theraplay.org