Antenatal and Postpartum Psychological Intervention. Case Study.

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Abstract

Introduction: *The pregnancy period and the birth of a child are unique events, full of joy and hope. The future child represents the origin of a new family, changing the parents' lifestyle and perspective upon life. On another note, the prenatal period may be experienced in a less positive manner due to the stress that a pregnancy typically involves, the intense changes and the numerous difficulties that the woman may face. The woman becomes a mother, which means that this interior revolution implies a lot of physical significant changes.*

Objectives: *The objectives of the current study, focused mainly on psychological evaluation, are as follows: assessing the emotional state of the pregnant woman and assessing the emotional relationship between mother and fetus (at the prenatal stage), as well as that between mother and child (once the child is born, at postnatal stage). The objectives of the psychological assistance meetings were: connecting the pregnant woman with her own body, physical and mental stress relief and optimizing the mother-fetus relationship/ mother-child attachment.*

Methods: *The methods that we used in the evaluation were: clinical observation, clinical interview and questionnaires. The methods that we used in our intervention that subserve the mentioned objectives were: expressive-creative techniques, relaxation techniques, music on the background of relaxation exercises and yoga for pregnant women, the observation of mother-child relationship and techniques for optimizing this relationship.*

Results: *There have been minimal changes at psychological level, but there has been remarkable improvement in the mother-child relationship during the three months of intervention, when we noticed an activation of maternal resources and an increase in the mother's affective availability for the child.*

Conclusions: *It can be concluded that the psychological intervention process has achieved its objectives by building a harmonious mother-child relationship and by leading to consciously assuming the maternal role. Mother-fetus relationship techniques from the prenatal period have contributed to the development of an afterbirth relationship based on emotional and physical security, protection, affection and mutual interaction.*

Keywords: prenatal stress, depression, anxiety, emotional attachment, mother-child relationship

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I. Introduction

Pregnancy is a unique period in the life of any woman in that the particularities and changes of biological and psychological nature associated with it are unprecedented at any other time in life. This phenomenon can be experienced as an accumulation of moments of joyful and positive expectations, but, on the other hand, it can also be a challenging time with negative experiences, in view of the many stressors and difficulties that pregnant women are usually exposed to.

Some women go through episodes of depression and increased anxiety over pregnancy and childbirth, which can have negative consequences in terms of emotions, behaviors and possibly even in terms of how the stress system develops, not only for them, but also for their children. Many studies have concluded that depression and anxiety can have a negative impact on the developing fetus, being associated with premature birth and low birth weight (O'Donnell et al., 2014; Van den Bergh et al., 2005).

Over the past decade, psychiatry and psychology have been concerned with unravelling the causes and consequences of prenatal birth stress and symptoms of anxiety and depression during the few months after birth. Although most literature studies focus on the postnatal period, depression during pregnancy remains of considerable importance, with its implications for mother, child and family.

Depression and anxiety are the most common mental disorders in both pregnancy and after birth (Alipour et al., 2012), and the symptoms may range from mild to severe. In any case, it is still unknown why some women are at increased risk of having prenatal stress symptoms, while others are resilient to the difficulties. However, it is assumed that an important factor is genetic predisposition, but also early experiences in the mother's life, in the sense that negative life events may lead to an increased risk of developing emotional problems during life-long lifetimes (Rutter, 2009).

Over the past two decades, research into the effects of maternal stress during pregnancy has increased significantly. At present there are solid studies and conclusions that emphasize that the prenatal emotional state of the mother has long-term implications for the child's physical and mental health and comfort (Van den Bergh et al., 2005; Talge et al., 2007). Strong associations have been identified (usually by using questionnaires for depression and anxiety) between stressful manifestations in various stages of pregnancy and developmental milestones of the fetus, infant, child and adolescent, as well as mental health problems (O'Donnell et al., 2014).

Animal and human research on maternal stress during pregnancy (anxiety, depression) has provided important evidence of the negative consequences of maternal stress on pre- and postnatal development of children (Fowles et al., 2009). The fact that intrauterine experiences can significantly affect the fetus and may subsequently influence postnatal development has been theorized into an influential hypothesis called 'the prenatal programming of behavior' (Van den Bergh et al., 2005). This concept of fetal programming of adult pathology has recently been proposed by the British researcher David Barker; he postulates the idea that certain dysfunctions in areas of physical health such as cardiac pathology or certain metabolic diseases (e.g. type II diabetes) in adulthood may originate during the prenatal period, when certain risk factors, such as physical trauma or infections, can "program" the body to decompensate from a medical point of view. More recently, hypotheses were formulated that fetal programming could extend not only to physical health but also to mental health (Costello et al., 2007). There is evidence from different animal studies that prenatal stress has an effect on the health of the offspring, mainly regarding their growth and immune functions (Merlot et al., 2008). However, in human studies, the consequences of physical health are often limited to complications at birth, premature birth and low birth weight (Beydoun et al., 2008), or at least science is not yet developed enough to be able to investigate more complex biological consequences that possibly extend beyond the perinatal period (emotional or cognitive problems, risk of attentional deficit/hyperactivity, anxiety, and language delay).

Only a few studies have investigated the effects of anxiety and prenatal stress on the risk of developing certain diseases in offspring. Stott and his collaborators (1957) were the first to show that prenatal stress is positively correlated with health condition in children. More recent studies correlate anxiety and prenatal stress with the development of asthma in childhood (Cookson et al., 2009), with an increased risk of atopic dermatitis in the first two years of life (Sausenthaler et al., 2009) and respiratory problems (Beijers et al. al., 2010).

Stressful life events, lack of social support and the mother's lack of self-confidence during pregnancy have an influence on the child's subsequent psychological development. For example, recent studies (Biaggi et al., 2016; Alipour et al., 2012) have shown that prenatal stress is a significant risk factor for postnatal depression in participants from both developed and underdeveloped countries, together with the history of psychiatric disorders and diseases, dysfunctional

partner relationship, stressful life events, a negative attitude towards pregnancy, and lack of social support. All of this also have implications for the mother-child relationship during pregnancy and after birth, the mother's health status being determinant for the well-being of the child.

Both during prenatal and immediate postnatal periods, maternal depression has been understood as affecting the development of the child, due to the mother's limited affective availability to provide the child with a secure environment. The less optimal interactive behavior of depressive mothers ranges from non-involvement to rejection, insensitivity and lack of warmth, sometimes long depressive periods – which may have the most dramatic effects for children, similar to psychosocial deprivation (for example, in the case of institutionalized children, where the absence of a parent figure is associated with extreme psychopathological manifestations). Children of depressed mothers are likely face major difficulties in social and cognitive skills starting with even the first few months of life (Bogels et al., 2006).

Maternal prenatal stress can have many consequences on child development, including a negative impact on verbal development of the child. Children whose mothers were depressed during pregnancy are withdrawn, irritable and inconsolable, and may spend long periods of time in excessive crying (Năstase, 2007).

The clinical and public policy importance of addressing such a subject is indisputable. The healthcare costs of countries experiencing high rates of mental health problems and lack of antenatal prevention systems are very high, and these may also include the offspring of the antenatally stressed mothers, given the likely susceptibility to intergenerational transmission of psychopathology. This is why a rapid detection of symptoms of psychopathology in pregnancy is essential for setting up an effective prevention program and reducing the risk of recurrence of these manifestations in the future.

II. Objectives

In line with these interpretative assumptions, the objectives of the psychological assistance meetings consisted of:

• connecting the pregnant woman with her own body;

• physical and mental stress relief;

• activation of maternal resources;

• creating mental and emotional availability for the fetus;

• optimizing the mother-fetus relationship/ mother-baby attachment (after birth).

III. Methods

Because the present study is based on the case study methodology, we present in the following pages data from the psychological evaluation protocol, hypotheses, strategies and intervention methods, as well the procedure used to apply all these.

The psychological evaluation took place during two sessions, and the counseling intervention consisted of ten sessions: three prenatal sessions and seven postnatal sessions.

1. Psychological evaluation protocol

Client Information

Name: L.

Age: 29 years

Education level: university degree

Purpose of the evaluation

L., pregnant with her first child, requires psychological evaluation, accusing recurrent bouts of sadness, restlessness, anxiety, and fear of confronting the moment of birth, amid the risk declared by one of the doctors assisting her pregnancy, that the baby might have Down Syndrome. The goal of the sessions, according to the client, is that she wants to gain better control over her negative emotional states.

Objectives of the evaluation

The two prenatal evaluation sessions aimed at a better understanding of the emotional states of the pregnant woman (depression, anxiety as a state condition, pregnancy-focused anxiety and sleep quality) and quantifying them.

Also, in the second evaluation session, besides the aforementioned psychological aspects, the evaluation of the maternal-fetal attachment relationship, as well as the recognition by the pregnant woman of infant distress via a video watching procedure that involved six short videoclips was followed to assess the degree to which she may be in touch with her baby's needs after birth.

Clinical evaluation instruments

For the clinical evaluation, the following psychological assessment tools were used:

1. clinical observation;

2. clinical interview with the pregnant woman;

3. depression scale: Edinburgh Postnatal Depression Scale (EPDS);

4. anxiety-state scale: State-Trait Anxiety Inventory (STAI);

5. Pregnancy-Related Anxiety Scale (PRAS);

6. sleep quality questionnaire: Pittsburgh Sleep Quality Index (PSQI, Buysse et al., 1989);

7. prenatal attachment scale: Maternal Antenatal Attachment Scale (MAAS, Condon, 1993);

8. the videos developed by Esther Leerkes's group, used to recognize infant discomfort and to capture maternal sensitivity (Leerkes & Crockenberg, 2003).

Evaluation results

The results of the psychological evaluation reveal scores that are situated above the clinical threshold, indicating very high levels of the investigated psychological aspects that fall within the clinical range:

1. the Edinburgh Postnatal Depression Scale (EPDS) revealed a raw score of 20 (exceeding clinical threshold of 13);

2. the State-Trait Anxiety Inventory (STAI) was found to exceed the clinical threshold (gross score 41), L. obtaining a raw score of 70;

3. on the Pregnancy-Related Anxiety Scale (PRAS) she obtained a clinical score of 36;

4. the sleep quality questionnaire resulted in a gross score of 4, a score that falls within the clinical range;

5. on the Maternal Antenatal Attachment Scale (MAAS) scale, the client achieved a raw score of 65 (the mean being 57), but there are ambivalent feelings about the baby (L. says she has mixed positive and negative feelings, of happiness and sadness, with respect to the fetus), and the score on the intensity of the preoccupation with the fetus scale is lower compared to the quality of attachment score;

6. at the baby's discomfort test, she correctly identified the fear emotions (associated with anxiety, disquiet) of the babies in the videos, but only partially identified the emotions of anger/ annoyance, declaring that they were emotions of sadness, boredom, and anxiety.

Additional information

Based on the information collected during the clinical interview, it appears that depression, for L., means helplessness, that nothing works, a lousy state accompanied by sadness, lack of appetite and sleep, or the state of resting all the time.

Also, what makes her feel unhappy, upset and in a negative way are the thoughts about baby's health status, birth-related anxious thoughts, the ability to perform physical tasks and discomfort during pregnancy (palpitations, incontinence), childbirth related problems, visits to the gynecologist and medical arrangements.

Summary and conclusions

The psychological states of the pregnant woman, illustrated by psychological assessment tools, can be assigned to the clinical setting, living the pregnancy with a strong tension, anxiety, and sadness. The predominant emotional states of the client are dysphoric: fear (fear about baby's normality, fear of childbirth), sadness and shame.

The mother-child relationship is ambivalent (she has mixed positive and negative feelings about the fetus, of happiness and sadness), which highlights the fact that L. has not developed a secure affective relationship with her baby. It is noticeable that the fetus is unavailable, which may impair the optimal development of the prenatal and postnatal mother-to-child relationship.

Also, from the observations and the clinical interview resulted that L. has some insecurity, low self-esteem and confidence, with difficulty in coping with the challenges and difficult situations she faces. The support that she receives from her partner, family and friends is likely to be low.

Recommendations

Following the evaluation, it is recommended to start a psychotherapeutic approach with the following objectives:

• increasing self-confidence;

• understanding and overcoming fears;

• raising awareness of dysphoric emotions and about how they can have implications for the fetus;

• developing a mother-fetus / mother-child relationship (after birth).

Following the data obtained during the psychological evaluation and highlighted by the psychological evaluation protocol, the following **hypotheses** are elaborated:

• there will be evidence of high levels of prenatal maternal stress, consistent with a pre-existing psychological background (diagnosis with depression in 2011);

• depression and anxiety may be related to recent events in the pregnant woman's life (medical information that there is a risk for the baby to be diagnosed with Down Syndrome – 16 weeks of pregnancy; misunderstandings at work – 20 weeks of pregnancy; partner leaving abroad – 25 weeks of pregnancy);

• prenatal maternal stress has negative implications to the mother-child relationship.

2. Strategies and methods of intervention

Individual prenatal sessions will be aimed at reducing perceived maternal stress (diminishing anxiety, rising awareness of negative thoughts and how they impose mental health footprint) and addressing the biases that perpetuate discomfort and anxiety.

Through experiential expressive techniques (drawing, music), the external conflict will be traced. Drawing is a good way to assess emotional issues, anxiety level, by spontaneously expressing the personal view of the environment. Through projection, the client is likely to bring at surface unresolved unconscious conflicts, hidden, repressed or negated issues, attitudes and feelings, frustrations and anxieties, suppressed jams and sufferings.

Intervention music can be used in many ways. It can be used as a means of expressing emotions, and subsequently it facilitates the client's coming in closer contact with their feelings, so that he/she can then express them in an optimal manner in the outer environment. In other words, music can be used against a background of therapeutic meditation to create a relaxing atmosphere. In this way, the client will experience a state of inner peace, a state that will allow them to become increasingly attentive to their emotional experiences. The relaxation state with a musical background can lead to a global awareness of the present emotional and physical experiences, as well as those from the outside and the cognitive process.

Given the importance of the affective mother-fetus/ mother-child bonding, we will work different ways to foster L. get emotionally closer to her child, with an emphasis on the interaction already created in the prenatal period. Mother and child should be considered a complex system in which each member of this duplex interacts and influences each other, each parent-child couple having a particular way of harmonizing their interactions, the child directing and modelling the behavior of the mother, and the mother adapting successively to the infant's developmental degree, depending on his age and his temperament.

3. Procedure

Sessions of prenatal intervention

In the prenatal period, the three psychological counseling sessions were followed by experiential expressive techniques (drawing, music), in order to externalize the inner conflict (the feeling of fear about the baby's health, the inability to care for a child with Down Syndrome and the guilt related to her giving birth versus her need for him to be healthy, to give love to her child).

In her discourse, the predominance of fear came up as one of the main themes, so I invited the client to express it through creative-expressive means. In the lines below are some representative excerpts from the therapeutic dialogue:

Therapist: "How does this fear look like? You can express it as you feel, using musical instruments, sounds/music, with colored pencils..."

Client: "Colorful pencils inspire me something beautiful, joy. The music the same... I would rather draw a sad face with a dark color. Fear is sad for me at this moment."

Through the graphic representation of fear, the client externalizes, faces fear and learns to control it. The purpose of the exercise was to gain a better emotional control.

Also, we discussed about the mother-fetus relationship:

T: "Tell me about the relationship you have with your baby, growing and developing inside your womb."

L.: "It's a very beautiful relationship, we talk, we discuss."

T: "You talk..."

L.: "Oh, yes. I feel his feet when he moves. I tell him that I'm hungry, I tell him that we're going to eat. When I eat, likewise, he starts to move. We talk about dad, that he's going to come home..."

T: "I understand you have a good relationship. What does it express to you?"

L.: "It gives me great joy and I can barely wait for it."

T: "Do you also communicate in a different way?"

L.: "Well, for example, when he moves, I think I might sit in a position he does not like, he might stay with folded hands and feet, and then I change my position."

T: "So I understand that you think he might be inconvenienced by the way you sit and then you're doing all you can do so that he feels good."

L.: "Exactly."

To strengthen the mother-child relationship, L. was invited to talk to the fetus, to integrate her polarities (fear, helplessness, love, acceptance), and to become more aware of her own positive feelings, thoughts, and beliefs.

T: "I invite you to sit on a chair and to be the baby you have in your womb. Now you are the baby in the womb. Do you have anything to say to your mother?"

L. (laugh, short pause): "To let her know she can rest assured, I'm healthy."

T: "Tell her right now."

L. (in the role of the fetus): "Mom, I'm healthy. No more trouble." (starts crying)

T: "Please get up and sit on the couch. L., your baby tells you he's healthy and does not want you to worry. Would you also like to say anything to him?"

L.: "No... (she continues to cry). I'm very afraid of giving birth from this point of view. And, on the other hand, I cannot wait for him to come out, to get through this stage. These thoughts and states do not do me well, nor to the baby... he feels all my moods. [...] It is very tough because my husband is not next to me." (her husband went to work in another country)

T: "I understand it is difficult and it is normal for you and your husband to think about your baby in negative terms. What helps you overcome your fears, in addition to your husband's affectionate support?"

L.: "I'm trying to think that everything will be fine, I imagine myself holding him in my arms, near my husband. I take my time so I do not overthink anymore. [...] I try to get rid of negative thoughts and fears."

In this dialogue, L. became more and more aware of her own anxiety about the pregnancy, but also about her relationship with her partner. She also found resources to fight these fears: positive thoughts, reshaping the future, various activities that pleased her (floral decorations, listening to relaxation songs). Also for the benefit of the mother-child relationship, in another session, L. was invited to talk about her thoughts, feelings, expectations about the baby, and how she thinks her relationship with the baby will be after birth.

T: "What could you tell me about your thoughts, feelings, expectations about the child, and how do you think your relationship with him will be after birth?"

L.: "First of all, I want him to be born healthy, the first question I will ask after giving birth will be if he is healthy. I hope there will be no problems, neither during labor, nor regarding the baby. I hope to be able to breastfeed him, which will give me a special mother-child bond. I know it will be hard. I want this to be a very close relationship, being my first child. There will be unconditional love for the child. I cannot wait to see him, I want him to be bold, with a strong character just like his father, from an emotionally point of view. I want him to be close to me as a mother. I want to talk with him openly about any subject. I would not want him to ever be afraid of me, which is why I'm not going to ever argue with him. I will try to keep up with him all the time, to find ways to make him develop his own personality, to play as much as possible, which will let us get quite close. In principle, I want to be happy and feel that we, the parents, will always be close and helping with everything we can."

From this therapeutic sequence it is understood that L.'s major concern is the health of her child. However, she could disconnect from the current issue, being able to imagine a positive future. It can be noticed that L. has the resources to create an affective environment, favorable to the child's well-being: she shows availability to play, willingness to spend much time together, to talk when the child grows, and to offer the help he may need.

In a different prenatal session, in order to make it easier for the client to have access to relaxation, to release tensions accumulated in the body, considering the fear that the baby could be diagnosed with Down Syndrome, fear that is not easy to accept and release, I proposed her a type of exercise based on muscular relaxation, accompanied by therapeutic music in the background.

The relaxation exercise allowed L. to become aware of the present moment, to focus on internal emotional and body experiences, stating that after this stress-relief exercise she felt very relaxed and could feel the child, sensing in touch with him. From observations, she was in touch with her own emotions, with her baby, caressing her belly permanently, and seemed relieved and relaxed.

Both music, amid relaxation exercises, and drawing have been used as means by which the client came into contact with her own experiences, becoming aware of them and exploring them.

In another session, we used the yoga method for pregnant women (Martine Texier, 2009), which she can try at home whenever she feels tension in her body: "At the smallest sign of fatigue (lances, stretches, painful points, tensions), take time to stretch and relax. Put your hands on your belly, feel the warmth, how relaxed it is or on the contrary, crisp. Pay attention to the go-go motion of the belly. Do not induce anything, just let normal breathing be placed under your hands: abdominal or low breathing. The belly rises when you breathe and lowers back when you exhale. In this way you will find a natural breath, which deals with the sympathetic nervous system. It is the one who deals with the rapid regulation of this respiratory function, considering the physiological needs of the present moment."

By practicing this breathing technique, muscle tension will be reduced and the ligament pain of the womb will be less intense.

Sessions of postnatal intervention

It should be mentioned that L. gave birth to a healthy baby, without Down Syndrome, through caesarian surgery. The child is quiet, usually crying only when he is hungry. The mother says she was very happy when she saw him.

In the postnatal period, the sessions focused on optimizing the mother-child attachment relationship, increasing awareness of maternal resources, facilitating feelings of acceptance, self-confidence, and availability for the child, while adapting to the new context of life. The sessions were also sought to raise awareness of available resources and their transfer to resolving new difficulties in the life context.

With the help of some of the questions raised by Charles Zeanah's interview, "The Child's Internal Model of Work" (Zeanah et al., 1995), were encountered important issues related to emotions felt at birth, when she came into contact with the newborn, the reactions of others, psychological involvement in the relationship with the child, child acceptance, fear for child safety and child representation.

Here are some representative excerpts from the therapeutic dialogue:

T: "How did you feel after birth?"

L.: "Until my husband returned (he was abroad), I was crying constantly. When he came home it was much better, because he helped me, I could do more things too. It was of help. But I was still crying sometimes."

T: "You were crying..."

L.: "Yes, I felt the need to release some tensions and stress."

T: "How did your husband react when he saw you crying?"

L.: "At first he argued with me, then I told him I needed understanding and I need him to help me get up."

T: "Get up..."

L.: "Yes, to get back on my feet. And he understood, did not say anything, just held me in his arms."

T: "I understand that there is support from him, that you are important to him, he values you, and this has made you feel understood, feel good."

L.: "I was feeling very well when he was next to me. Now that he's gone again, I'm having a hard time, it's really hard to raise a baby alone."

T: "I agree. It's a difficult time for you. Are there any benefits from this situation?"

L.: "Yes, I can make a difference between the times when I have had help and the times when I am alone, and I appreciate it more when he is next to me."

T: "That's the way it is and, on the other hand, you appreciate yourself more..."

L.: "I can do all these things alone."

This therapeutic sequence, as well as observations point out L. is going through a difficult period of accommodation with the new mother state. She has gone through the baby blues period, a period that disrupts the performance of certain maternal functions, which gives her a limited availability for the baby. It is all more difficult for her as she does not have her husband to support her, as he is not physically beside her. I have also found out that other family members are involved in a certain extent in child raising, but they are service-dependent and in this case L. can only rely on her own powers, figuring out how strong she is because she can cope with the difficulties of the new status.

Through security and emotional validation, L. understood that separation is a source of suffering because it involves recognizing the distance, the absence of the other, but physical distance is easier to endure as long as she keeps affective contact, accepting and maintaining the relationship with the partner.

T: "What was your first reaction when you saw the baby?"

L.: "I was very happy, but in addition to happiness, the first time I saw him, he seemed very ugly. He was swollen, he really was ugly. But he changed, the next day they brought him to me, he was washed, arranged, he was more beautiful."

It is highlighted that the attachment did not instantly occur, as the baby did not look like in his mother's dreams. At birth, the baby did not look extraordinary (red skin, flattened nose), and this caused her anxiety, fear, even a form of rejection. These aspects lead to the hypothesis that a tolerance period in which the attachment will develop more slowly is set.

T: "What do you think is unique or different in your child compared to other children?"

L.: "I think he is the most beautiful, and when I see him mumble and when we talk, he is the most special, the cutest, the best."

T: "Can you tell him these things right now, while you keep him in your arms?"

L. (laughs): "You are the nicest, the most beautiful, the most special and the most delicate."

Positive, emotionally joyful responses describing the positive attributes of child's behavior can be noticed. In order to optimize the mother-child relationship, I recommended L. to tell the child what she feels about him when she holds him in her arms. I have noticed feelings of fulfillment on her face in that

moment, which means she enjoys being emotionally close to her baby, and this can secure and strengthen their relationship.

T: "Which of the child's behaviors do you find most disturbing to you?"

L.: "In the morning, it is the moment when he wakes up. I cannot understand what is wrong, he is agitated, but besides this I do not mind anything."

T: "How would you describe the relationship you have with your child now?"

L.: "It seems to me to be an open relationship, I tried to understand it, to see what his needs are: if he is crying, he is usually hungry, but if he continues to cry, I give him tea, maybe he's thirsty, if he does not want any tea, I'll take the blouse off, if not, I have a look at the diaper. I try to understand him and not leave him crying."

It is noticed that L. is aware of her own limitations, that she does not always understand the reason the baby is crying, but she tries to identify and satisfy his primary needs, proving she is concerned about the child's well-being. L. perceives certain aspects of her child's behavior as problematic, but this does not indicate that the baby is seen as a burden. Generally, the child's difficult behavior is perceived to be within a predictable average.

Another method used to investigate the parent-child relationship is parent-child interaction for 5 minutes. Verbal and physical dialogue and interaction are among the most important aspects that define the affective mother-child relationship. The baby has sensory and perceptual capabilities, so he is able to respond to the mother's intentions of communication. From the psychological analysis of the 5 minutes of interaction, one can conclude that the maternal emotional tone is neutral, but there are also positive aspects: warmth in the mother's voice, availability to talk and interact with the child, ability to interpret the child's facial expressions. One aspect that will need to be improved in their relationship is that the mother responds appropriately and promptly to the child's clear and precise signals (the need to get in her arms, to be more physically in contact with his mother).

An exercise to strengthen the parent-child relationship that L. experienced with the help of the therapist is: to observe the child, to spend time playing with him, holding him in her arms and talking to him, caressing him, being attentive to how she feels in those moments. Thus, L., being emotionally connected to her baby, is encouraged to directly communicate with the child. An example of interaction between them is: "I notice you are smiling and that tells me that you are happy. You pay attention to me, and that makes me feel fulfilled." Eye contact is the best proof that communication has been established between the two. In the prelinguistic period, eye-to-eye looks like a conversation. Non-verbal communication is established not only based on eye contact, but also with the aid of gestures.

At the end of this exercise, L. concluded that it is important for the mother to create a good communication link with the child, it is important to be attentive to what happens with her child, in order to figure out what needs he has and how she can satisfy them.

The last two sessions within the therapeutic approach were aimed at psychological reevaluation and a balance sheet on differences perceived before and after the therapeutic process was completed.

For the re-evaluation, some of the originally applied tools were used, such as the Edinburgh Postnatal Depression Scale, the State-Trait Anxiety Inventory, the Pittsburgh Sleep Quality Index, and the Maternal Postnatal Attachment Scale.

Following re-evaluation, the gross scores obtained were:

1. scale of depression, Edinburgh Postnatal Depression Scale (EPDS): gross score = 14 (which exceeds the clinical threshold, 13);

2. anxiety-state scale, State-Trait Anxiety Inventory (STAI): gross score = 38 (does not exceed clinical threshold, 41);

3. sleep quality questionnaire, Pittsburgh Sleep Quality Index: score = 4 (that falls within the clinical limit);

4. postnatal attachment scale, Maternal Postnatal Attachment Scale (Condon, 2015): total gross score = 80 (maximum gross score being 95).

At the "Attachment Quality" subset, the theoretical values are between 9 and 45. The gross score of the client in this subscale is 36.

The "Absence of hostility" subscale can have scores ranging from 5 to 25, L. obtaining a gross score of 18.

The last subscale, "Enjoy Interaction", has scores ranging from 5 to 25, L. ticking the maximum gross score.

The degree of attachment and relationship with the child can also be assessed from direct observations of the behavior and mother's attitudes about the child, but also from the dialogues in which this relationship is spoken. Thus, from discussions focused on the mother-child relationship, L. reports that she spends a lot of time

with the child while playing, comforting and giving him love (maternal touch being a component of the attachment). L. also believes that how she behaves has a strong influence on the child's cognitive, social and emotional development. She tries, as much as possible, to talk with her baby, to play with him, to make him laugh, to reassure him when he is upset or crying, to satisfy his primary needs (to nourish, to change, to wash) and give him affection (to comfort him, to kiss him, to keep him in her arms, to rock him).

At the last counseling session, I was considering an assessment of the before counselling as compared to the present moment perceived differences, in order to raise her awareness.

The client noted that, at this moment, she feels more confident in herself and in her maternal abilities and she wants to become more and more able to be the master of problematic situations in her life, in order to successfully deal with the stressful life events which may appear in the future.

IV. Results

As far as the results of the counseling process are concerned, it can be said that there have been minimal changes in psychological terms, but there has been remarkable improvement in the mother-child relationship. The degree of attachment and relationship with the child can also be deduced from direct observations of the mother's behaviors and attitudes regarding the child, but also from the dialogues in which she speaks about this relationship. Also, the therapeutic approach has helped increasing self-confidence, maternal affective availability and awareness of maternal resources and competencies.

It can be argued that an important aspect of the therapeutic approach is the activation and development to an optimal capacity of maternal abilities, fact confirmed by psychological reassessment through the postnatal attachment scale. The quality of the child's attachment reflects the quality of the mother-child relationship.

The client's feedback one and three months after the intervention confirms the relationship with her baby continued to develop in a positive way.

V. Discussions and conclusions

The main benefits expressed by the client refer to the development of an affective relationship with the child, from the prenatal period, through verbal and nonverbal communication, by reducing physical and mental stress, so that she is emotionally available to the child. At the same time, mother-child relationship techniques from the prenatal period contributed to the development of a relationship based on safety, protection, affection and mutual interaction. Besides these aspects, the client appreciates that social relationships have improved, being more open to share with others different feelings and thoughts.

Therefore, we may conclude that the psychological intervention process has achieved its objectives by building a harmonious mother-child relationship and by her consciously assuming the maternal role.

The field of studying the prenatal period is of significant importance in recent years, with the rise of psychopathological manifestations in terms of maternal stress. The use of longitudinal study designs to investigate the relationship between prenatal stress and risk factors and how they influence the mother-child relationship constitutes possible future research directions.

At the same time, developing a screening program and implementing an individual or group therapeutic intervention program could help mothers better cope with changes associated to pregnancy, birth and postnatal challenges, and the emotional issues they face in this unprecedented period of their lives. An understanding of the factors influencing the parent-child relationship can help in the development of appropriate assessments, interventions and psychosocial services to support primary mothers and their children. Another significant way to strengthen the parent-child relationship is to optimize parenting skills. To foster these 'increases' in maternal skills, courses or workshops can be launched, in which mothers are emotionally supported and guided through various therapeutic techniques (maternal touch, baby's emotions recognition, baby communication) in developing relationships with their babies.

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