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Mental health care for adolescent mothers in Cameroon: Psychoanalytically inspired tools, complementing the WHO's IG-mhGAP protocol

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Summary

In Cameroon, a quarter of teenage girls aged 15 to 19 are mothers, i.e., pregnant or breastfeeding. The prevalence rate of mental illness among teenage mothers is 66.4%. In this context, a mental health care program for these mothers was launched for the first time as part of a pilot project. This program was based on a guide from the World Health Organization. Psychoanalytically inspired tools not included in this guide were introduced.
After obtaining ethical approval, participants were selected through non-probabilistic sampling. Assessment and treatment tools based on the Mental Health Global Action Plan approach were used, including psychoanalytically inspired tools. Mixed methods were used for data analysis.
227 health workers were trained. 1,633 teenage mothers participated in the study. 1,069 were diagnosed and 715 were supported until term. The treatment tools used were: psychoeducation, problem-solving counseling, cognitive restructuring or thinking healthy, and relaxation. The psychoanalytically inspired tools introduced and found to be useful were: free association, analytical listening, identification of transference and countertransference, addressing or, if possible, elaborating on aspects of parenthood and perinatality, interpretation of family dynamics, and working on transgenerational transmission.
The results of this study reveal that psychoanalytically inspired tools can be integrated into a WHO program for mental health care for adolescent mothers in Cameroon.

Keywords: adolescent mothers, perinatal mental health, IG-mhGAP, psychoanalytically inspired tools, Cameroon.

Resumen. *Atención de salud mental para madres adolescentes en Camerún: herramientas inspiradas en el psicoanálisis, que complementan el protocolo IG-mhGAP de la OM*

En Camerún, una cuarta parte de las adolescentes de entre 15 y 19 años son madres, es decir, están embarazadas o en periodo de lactancia. La tasa de prevalencia de enfermedades mentales entre las madres adolescentes es del 66,4 %. En este contexto, se puso en marcha por primera vez un programa de atención de la salud mental para estas madres como parte de un proyecto piloto. Este programa se basó en una guía de la Organización Mundial de la Salud. Se introdujeron herramientas de inspiración psicoanalítica que no figuraban en dicha guía.
Tras obtener la aprobación ética, se seleccionó a las participantes mediante un muestreo no probabilístico. Se utilizaron herramientas de evaluación y tratamiento basadas en el enfoque del Plan de Acción Mundial para la Salud Mental, incluidas herramientas de inspiración psicoanalítica. Se utilizaron método mixto para el análisis de los datos.
Se formó a 227 trabajadores sanitarios. Participaron en el estudio 1633 madres adolescentes. Se diagnosticó a 1069 y se prestó apoyo a 715 hasta el final del embarazo. Las herramientas de tratamiento utilizadas fueron: psicoeducación, asesoramiento para la resolución de problemas, reestructuración cognitiva o pensamiento saludable y relajación. Las herramientas de inspiración psicoanalítica introducidas y que resultaron útiles fueron: asociación libre, escucha analítica, identificación de la transferencia y la contratransferencia,

abordar o, si es posible, profundizar en aspectos de la paternidad y la perinatalidad, interpretación de la dinámica familiar y trabajar en la transmisión transgeneracional.
Los resultados de este estudio revelan que las herramientas de inspiración psicoanalítica pueden integrarse en un programa de la OMS para la atención de la salud mental de las madres adolescentes en Camerún.

Palabras clave: Madres adolescentes, salud mental perinatal, IG-mhGAP, herramientas inspiradas en el psicoanálisis, Camerún.

Résumé. *Soins de santé mentale pour les mères adolescentes au Cameroun: outils inspirés de la psychanalyse, complétant le protocole IG-mhGAP de l'OMS*

Au Cameroun, un quart des adolescentes âgées de 15 à 19 ans sont mères, c'est-à-dire enceintes ou allaitantes. Le taux de prévalence des maladies mentales chez les mères adolescentes est de 66,4 %. Dans ce contexte, un programme de soins de santé mentale destiné à ces mères a été lancé pour la première fois dans le cadre d'un projet pilote. Ce programme s'est appuyé sur un guide de l'Organisation mondiale de la santé. Des outils d'inspiration psychanalytique non inclus dans ce guide ont été introduits.
Après avoir obtenu l'approbation éthique, les participantes ont été sélectionnées par échantillonnage non probabiliste. Des outils d'évaluation et de traitement basés sur l'approche du Plan d'action mondial pour la santé mentale ont été utilisés, y compris des outils d'inspiration psychanalytique. Une méthode mixte a été utilisée pour l'analyse des données.
227 soignants ont été formés. 1 633 mères adolescentes ont participé à l'étude. 1 069 ont été diagnostiquées et 715 ont été accompagnées jusqu'à terme. Les outils de traitement utilisés étaient les suivants: psychoéducation, counseling en résolution de problèmes, restructuration cognitive ou pensée saine, et relaxation. Les outils d'inspiration psychanalytique introduits et jugés utiles étaient les suivants: association libre, écoute analytique, identification du transfert et du contre-transfert, abordage ou, si possible, élaboration des aspects de la parentalité et de la périnatalité, interprétation de la dynamique familiale et travail sur la transmission transgénérationnelle.
Les résultats de cette étude révèlent que les outils d'inspiration psychanalytique peuvent être intégrés dans un programme de l'OMS pour les soins de santé mentale destinés aux mères adolescentes au Cameroun.

Mots-clés: mères adolescentes, santé mentale périnatale, IG-mhGAP, outils inspirés de la psychanalyse, Cameroun.

Introduction

The perinatal period, from the first day of pregnancy to the end of the baby's first year of life, is not only a period of crisis but also one of opportunity (Nanzer, 2009). Parenting is supposed to be a phase that all human beings go through, regardless

of their circumstances. Sometimes this perinatal period coincides with adolescence, and the combination of the two increases the risk of psychological distress for both the teenage mother and the family (*ibid.*). In Cameroon, a quarter of adolescent girls aged 15 to 19 are mothers. This means that they are either pregnant or have a baby (Cameroon DHS, 2018). Research conducted on the mental health of these teenage mothers indicates a prevalence rate of mental illness of 66.4% (Miafo and al., 2024). However, it has been noted that there is virtually no specific care provision for this section of the population within the Cameroonian health system (Nicolet and al., 2021). This situation of mental distress among teenage mothers led to the establishment of a care system between 2014 and 2018. This clinical system was deployed as part of a project involving several national and international partners. It was based on a care protocol recommended by a World Health Organisation (WHO) programme called the Intervention Guide for mental health Global Action (IG-mhGAP) for mental, neurological and substance use disorders in non-specialised care settings (WHO, 2011). Another aspect of this WHO protocol is to conduct family interviews where appropriate. Here, intervention techniques use interpersonal skills and cognitive, behavioural and problem-solving strategies to support individuals and their families facing mental disorders or dysfunctions. However, given the complexity of the situations, these techniques are sometimes insufficient and need to be supplemented by others. One complementary perspective would be the introduction of a psychoanalytic approach, which is not included in this WHO programme. The aim of our work is to describe the WHO intervention framework applied to teenage mothers and their families in Cameroon, and to observe how psychoanalytic input is introduced into a non-specialised care setting. We will therefore present the context of the project and the methodology of the intervention. The overall results will be highlighted, as well as the psychoanalytically inspired tools that have been introduced. A clinical illustration will present an application.

Methods

Study framework

This research is part of a two-part project, the first part being clinical and the second part being research. In Cameroon, the partners involved in the project were: the Ministry of Public Health (MINSANTE), the Ministry for the Promotion of Women and the Family (MINPROFF), the National Network of Tantines Associations (RENATA), Uni-Psy et Bien-Être (UNIPSY), an organisation of mental health professionals. In Geneva, the University of Geneva, Action en Santé Publique (ASP), a non-governmental organisation, the Child and Adolescent

Psychiatry Service (SPEA) of the Geneva University Hospitals and the World Health Organisation (WHO).

Ethical considerations

The study procedures were conducted in accordance with the ethical principles and obligations to which researchers are bound by the Declaration of Helsinki (WMA, 2013). All participants were informed and gave their consent. They were told that they could withdraw from the study at any time. Ethical approval was granted by the National Ethics Committee for Human Health Research (CNERHH) in Yaoundé, after evaluation of our research protocol. The approval number is: 2014/03/436/L/CNERSH/SP.

Study population and site

To be included in this study, participants had to be adolescent girls aged between 11 and 20 years old who were in the perinatal period, i.e. pregnant or with a baby aged 12 months or younger. Family members of adolescent mothers could participate, if applicable. Participants also had to give their free and informed consent. A non-probability sampling technique was used to select the participating adolescent mothers. Three types of sampling based on this technique were carried out. Typical sampling was used for participants recruited at the hospital and through the personal network of carers, and accidental sampling was used for those recruited door-to-door (Angers, 1992). Purposive sampling was used to select cases with characteristics relevant to demonstrating the usefulness of psychoanalytically inspired tools (Yin, 2018). The study site was the city of Yaoundé and its surroundings. Recruitment ran from April 2014 to September 2018.

Description of the clinical setting

The care approach is based on the WHO's mhGAP. It is in line with the WHO's 2013-2030 mental health policy for low- and middle-income countries (WHO, 2013). It is also aligned with the mental health and psychosocial support guidelines of the Inter-Agency Standing Committee (IASC, 2007). This approach posits that in low- and middle-income countries such as Cameroon, and in emergency settings, there are significant gaps in mental health care. The needs are enormous and resources are very limited. To address these gaps, it is important to develop low-intensity protocols for the management of mental disorders. This care can be provided by healthcare providers who are not mental health specialists and can achieve positive results (WHO, 2011). Providers must first be trained in the use of

the guide and then be supervised on a regular basis. With this in mind, a team of professionals was selected and trained in perinatal mental health in Cameroon. The team was divided into three groups. The first line consisted of healthcare providers working on the project, most of whom were not specialised in mental health. They were in direct contact with the teenage mothers. They included community workers, social workers, nurses, general practitioners, trainee psychologists and inexperienced psychologists. The second line consisted of experienced Cameroonian clinical psychologists and psychiatrists with expertise in perinatal mental health. Their role was to supervise the front-line health workers and to deal with complex cases and families. The third line consisted of Swiss child psychiatrists, psychiatrists and ethnopsychoanalyst, whose role was to supervise the Cameroonian supervisors.

Technical interventions

Although in line with the WHO's mhGAP approach, our intention in the interventions was to be more targeted, more precise and more effective. The main target was the adolescent mother, but depending on the situation, actions or measures could be taken towards the family and even the caregiver. The important thing was that it directly benefited the well-being of the adolescent mother. The treatment process began with a psychological and social diagnostic assessment. This assessment was fourfold, as it was symptomatic, dimensional, developmental, and environmental. It was systematically based on all of the following elements: the mhGAP intervention guide, other manuals and diagnostic tools such as: the *Diagnostic and Statistical Manual of Mental Disorders* or *DSM V* (American Psychiatric Association, 2013), the *Psychodynamic Diagnostic Manual* or *PDM-2* (Lingiardi & *al*., 2017), the *Mini International Neuropsychiatric Interview* or *MINI* (Sheehan et al., 1988). An inventory of risk factors for perinatal mental disorders and the Edinburgh Postnatal Depression Scale (EPDS) for screening perinatal depression (Djatche & *al.*, 2024) was administered. In addition, an interview guide was administered, covering the following topics: perinatal history, parenting, identity, family relationships and social situation. This assessment phase lasted 1 to 2 sessions, each lasting one hour.

Table 1: Psychological and social assessment tools for teenage mothers

Assessment tools	Contents and objectives
Structured interview based on DSM V and IG-mhGAP	Diagnostic criteria for mental disorders, imminent risk of suicide
Structured interview based on PDM-2	Diagnostic criteria for mother-baby relationship disorders, postpartum mental disorders, complex psychological trauma
MINI (Mini International Neuropsychiatric Interview)	Suicide risk assessment grid
Edinburg Post-Partum, Depression Scale (EPDS)	Screening for perinatal depression
Inventory of risk factors for perinatal mental disorders	5 categories: circumstances of pregnancy and motherhood, health issues, social risk factors, negative experiences of childbearing, marital and family relationships.
Topics related to parental and perinatal experience	State of the relationship with the partner, state of the relationship and social interactions with others during the perinatal period, pre-, perinatal and postnatal experience, changes and evolution in the health status of the mother and child, transformations related to parenthood and quality of the mother-child relationship, etc.
Social assessment	Identification of social needs

For mothers suffering from perinatal mental health disorders, the therapeutic approach was brief. The tools used were diverse and varied. A supervised carer could use and/or combine one or more of them, depending on the request, the particularities of the adolescent mother and the clinical situation. This included psychoeducation, which consists of providing information about the illness and its consequences, as well as appropriate advice aimed at promoting well-being. Problem-solving counselling, the aim of which is to resolve problems in a relevant manner by following a specific approach (WHO, 2011). Relaxation techniques were also used, sometimes in combination with cognitive restructuring or 'healthy thinking' (WHO, 2015), both of which aim to treat anxiety and depression. The 'book-sharing' technique (Murray et al, 2016), or sharing a book between mother and child, is a mediation technique used to improve the mother-baby relationship. In serious situations, such as postpartum psychosis, pharmacotherapy was used. Family

interviews (psychoeducation, mediation, work on one or more specific objectives) complemented individual interviews and were introduced as much as possible. Social solutions (referral support, vocational training, income-generating activities) were initiated. These interventions, sometimes carried out remotely, relied on a variety of technologies (Skype, WhatsApp, SMS, green line). All of this was done in confidence and with respect for the dignity of the teenage mother. As the focus of the intervention was on her well-being, we felt it was legitimate to draw on as many scientifically and clinically proven resources as possible. This led to the introduction of psychoanalytically inspired technical tools in individual and family sessions.

Psychoanalytically inspired technical tools focused on parenting and family

Some tools from the psychoanalytically inspired therapeutic approach focused on parenting were used by trained health workers. These parenthood-focused tools are derived from mother-baby therapies. The impact of these therapies on the mother-baby relationship, on the child's symptoms, and on improving the mothers' mood has been demonstrated (Nanzer, 2012). The aim is to change the pathological and restrictive representations of the internal world of adults with regard to aspects of parenting. Here, representations refer to how the teenage mother sees herself as a parent and how she sees her baby. However, this psychoanalytic perspective was not limited solely to the individual cases of teenage mothers; it also influenced the caregiver's view and understanding of certain dysfunctional family situations. From this perspective, the supervisor used a few psychoanalytically inspired tools in family interviews, without this constituting psychoanalytic family therapy per se. Thus, in light of psychoanalytic theories, the tools used included free association in individual and family settings, which allowed teenage mothers and family members to express themselves freely (Ruffiot & *al.*, 1981). What is expressed must be accepted and listened to with a benevolent and neutral attitude. The tool used for this purpose was analytical listening. This particular form of listening consists of observing the patient, verbal and non-verbal associations, and interactions from a psychoanalytical perspective. It was also a question of considering the manifest and latent content of discourse, resistance, and dreams (Nanzer, 2012). These contents stem from another tool, which is the elaboration around aspects of parenting such as identity, psychological ambivalence, and the representation of the baby. All carers were taught to analyse, or more precisely, to identify transference and countertransference. Transference refers to the unconscious projection of the patient's feelings, attitudes or fantasies onto the therapist, based on past relational experiences (Freud, 1912). It can be negative or positive, maternal (Wrye & Welles, 1989) or paternal (Diamond, 1993). Countertransference refers to the therapist's emotional, cognitive and unconscious reactions to the patient, influenced by their own experiences and internal conflicts. It can be positive or negative (Freud, 1912),

subjective, objective, concordant or complementary (Bitencourt Machado and al., 2014). The aim here was not to interpret or verbalise them, but to use them to better understand the teenage mother or family member, and to distance oneself or detach oneself from intrusive experiences.

The interpretation of family dynamics was also sometimes carried out, with the aim of promoting awareness of family dysfunctions (Jaïtin, 2006). Working on transgenerational transmission was another technique used. The aim was to free family members from pathological projective identifications and restore a healthy flow of fantasies (Eiguer and al, 2006). None of the above can be achieved without taking into account the framework, which is a set of fixed elements within which psychotherapeutic processes unfold (Nanzer, 2012).

The introduction of psychoanalytically inspired technical tools in the implementation of the WHO mhGAP intervention protocol would be a novelty, as prior to this project for adolescent mothers in Cameroon, we do not believe this has been done elsewhere.

Table 2: Clinical treatment tools

Therapeutic tools	**Objectives and contents**
Psychoeducation	Information about the condition and its derivatives, and advice on how to behave
Problem-solving counselling	Implementation of problem-solving strategies one by one, according to urgency and importance
Cognitive restructuring (healthy thinking) and relaxation techniques	Replacing negative thoughts with positive ones and learning to manage intense emotions
Book sharing technique	earning to share books, or exchange ideas through content, with the aim of promoting satisfying exchanges between mother and baby (from 6 months)
Pharmacotherapy	Prescription of pharmacological drugs
Family interviews	Objectives: to inform and educate the family, to mediate, to work on an identified problem, to encourage discussion and to listen analytically
Psychoanalytically inspired tools	Free association, analytical listening, identifying transference and countertransference, addressing or, if possible, elaborating on aspects of parenting and perinatality, interpreting family dynamics, working on transgenerational transmission

Data analysis

The data were collated using Epidata 3.1 and processed using SPSS 25. To obtain the overall results, we used descriptive statistics, i.e. we highlighted the different frequencies of the variables. With regard to the contribution of psychoanalytically inspired tools, we used thematic analysis (Braun & Clarke, 2006), case analysis and case studies (Yin, 2018).

In the rest of our work, we will present the overall results and the contribution of psychoanalytical tools, illustrated by an individual and family clinical situation.

Results

Overall results

One of the objectives of this work is to provide an overview of the intervention and highlight its results. The WHO's mhGAP approach involves setting up a clinical system that relies on various categories of local stakeholders, mainly healthcare providers who are not mental health specialists. The first step is to train these health workers (doctors, nurses, midwives, social workers, nursing assistants and peer educators), including psychologists, as part of the project in Cameroon. In the field of perinatal mental health, the training takes place over five full days. At the end of the study period, 227 health workers had been trained in the use of the assessment and treatment tools outlined in the mhGAP intervention guide, with the exception of psychoanalytically-inspired techniques. These techniques, which require more extensive training, were used by psychologists who had already been trained in these tools over several years. In addition, capacity building for health workers was also provided on an ongoing basis, every week through reading seminars on theoretical and clinical topics and supervision, in line with the realities of clinical contexts. Although 227 health workers were trained, only 68 actually worked on the project.

1,633 teenage mothers were assessed psychologically and socially between April 2014 and September 2018. 1,069 were diagnosed with at least one mental health condition, with a prevalence of perinatal depression of 60.9%, perinatal anxiety of 10.7% and mother-baby relationship disorder of 6.1% (Miafo & *al.*, 2024). 715 out of 1,069 received support until the end of their pregnancy, representing a significant compliance rate of 66%. Therapeutic interventions took place over a dozen sessions on average, with each session lasting an hour on average. The techniques used almost systematically were those contained in the mhGAP intervention guide, including psychoeducation, problem-solving counselling, cognitive restructuring or healthy thinking, and relaxation. A few psychoanalytical tools were used gradually, due to the fact that few health workers were familiar with them at the outset. They

became acquainted with them through reading seminars and supervision sessions. The tools used in this approach, which were employed almost systematically, were: the transfer and counter-transfer approach, the psychic ambivalence approach, and the identity development approach. The duration of a therapeutic intervention varied between three and seven months. These interventions took place either in a hospital setting or in the teenage mother's home environment. In 86% of cases (out of 66) that reached completion, there was an almost total regression of symptoms. Improvements were observed in the health of the teenage mothers and their subjective self-image. The mother-baby relationship improved, thanks in part to book-sharing and the information acquired during psychoeducation sessions on perinatal mental health. On a practical level, the teenage mothers learned problem-solving techniques, healthy thinking and relaxation skills. They also learned or relearned how to mobilise internal and external resources.

This study also found that 25.2% of teenage mothers lived in dysfunctional families (Miafo & *al.*, 2024). By dysfunctional (Eiguer, 2001; Minuchin, 1974), we mean: chronic conflict, rejection, disrupted or absent communication, constant violence, lack of emotional support, unhealthy alliances, inappropriate roles, addictive or destructive behaviour, and blurred or rigid boundaries. A statistically significant link between perinatal mental disorders and dysfunction within the family has been established (p=0.000). Furthermore, teenage mothers who are in families with difficulties are 2.5 times more likely to have a mental disorder. On this basis, caring for a suffering teenage mother would, as far as possible, also involve addressing what is happening within the family. 293 family interventions were carried out, and in some cases, psychoanalytically inspired tools were used.

Table 3 : Summary of overall results

Variables	**Frequency**	**Percentage**
Health workers trained in the use of IG-mhGAP and other tools	227	100%
Adolescent mothers assessed psychologically and socially	1,633	100%
Adolescent mothers diagnosed with at least one mental disorder	1,069	65.46 %
Adolescent mothers who received support until the end of their pregnancy	715	66.8%
Adolescent mothers whose symptoms had almost completely disappeared after completing psychological follow-up	615	37.6%
Teenage mothers living in dysfunctional families	411	25.2%
Teenage mothers for whom family intervention was carried out	293	18%

The contribution of psychoanalytically inspired tools

Solid training and experience are necessary to use these tools properly. However, for certain tools, we find that a certain level of use is possible by and with health workers who do not have extensive training and are not mental health specialists. These include:

Elaboration around aspects of identity. Elaboration means exploring thoughts and emotions, analysing them, looking for connections, deeply understanding one's experiences, and identifying important aspects of the theme around which the elaboration takes place. Psychoanalytic theories postulate that the arrival of a baby consciously or unconsciously triggers a questioning of one's origins, status, functions and roles, past, present and future. It is a question of working through developmental grief, which leads to sensitivity and psychological fragility in the parent. This can be all the more upsetting for a teenager who becomes a mother. It is with these psychological realities in mind that we introduce the concept of identity. For a non-specialist health worker, it is not a question of helping the teenage mother explore unconscious aspects, but rather of putting into words her experiences of self-perception and changes in her view of herself, for example. This can be achieved by asking the teenage mother the following questions: how would you define yourself today? What is your current status? Are there things you feel you have lost? Can you give five words or phrases to describe yourself? Secondly, unconscious aspects of identity such as conflicts, fantasies and reworkings can be explored during sessions with the supervisor. The latter uses *analytical listening* to understand the teenage mother's story as reported by the health worker. The carer will return to her with a much broader and deeper understanding, and will use this to possibly prompt her to elaborate further. On this subject, Julie, aged 18, says: "*I remember when you first came here, you asked me a question that completely baffled me: how do you see yourself today? I was lost, I didn't answer, I had nothing to say and it hurt me so much that I even started crying. But the question helped me, because afterwards I started to think, to look back on my past, and the more we talked about it during the sessions, the more I began to find myself again, little by little... Today, I'm not quite there yet, but things are much better. I'm starting to accept my complicated situation, which used to be that of a child who had a child, to that of a young mother today, and I even have some small plans for the future...*"

Psychological ambivalence. In the urban context of Cameroon, being a teenage mother is not desirable. In our study, 69.3% of them did not want to be pregnant. The outcome also leads to stigmatisation and rejection by those around them. In addition to the environment, the teenage mother's personal history and relationship with her parents can be a source of ambivalence. She may therefore experience

conflicting feelings about her situation, which can intensify and crystallise into perinatal depression. Addressing psychological ambivalence can be done by all healthcare professionals who are not mental health specialists. The aim here is to encourage her to talk about her ambivalent feelings and normalise them. Experience shows that doing so improves the teenage mother's subjective self-image and tolerance of negative feelings and reduces guilt. From there, it becomes easier for her to apply cognitive restructuring or healthy thinking. She can now allow herself to "think positively". Indeed, 17-year-old Jeanne states: "*Since you told me that it's normal to have bad thoughts about your baby and that it happens to almost all mothers around the world, I feel much better... It's becoming easier to talk about these negative thoughts and to tell myself that I'm normal and not just a bad, mean person with no heart...*"

Transfer. Teenage mothers project various feelings onto health workers, depending on their psychological realities. These feelings can be positive, negative, erotic, or related to a maternal or paternal figure. We may therefore be dealing with positive transference, negative transference, erotic transference, maternal transference, and paternal transference. Becoming aware of this and acting accordingly is not taught in the technical tools offered by IG-mhGAP. As part of our project, frontline health workers were gradually introduced to identifying this phenomenon during seminars and supervision sessions. The aim was simply to identify it, as far as possible, and not to interpret it. Health workers were then able to gradually observe or experience hostility, admiration, or intense affection in their relationships with teenage mothers. They also noticed that teenage mothers behaved like children in front of their fathers or mothers. This enabled them to avoid taking things personally and to better manage their relationship with the teenage mothers. It also greatly contributed to the continuity of the support, which could have been interrupted if the transference had not been identified. Health worker B: "*During the last two sessions, we talked about her ex-boyfriend and father of her child, from whom she is currently separated. For this session, which didn't take place because I arrived five minutes late, she left, I called her and she scolded me on the phone, just like the scenes she told me about between her and her ex... I was really annoyed because I had driven an hour to get to her house... well, during this supervision session, I understand that it was a rehearsal, so that calms me down...".* Another health worker reports*: "Brenda told us that she didn't expect it to be so short and that it was over, because she doesn't know how she'll manage without us, that we were like a second mother to he".* Health worker R recounts: *"The fact that the teenage mother doesn't talk to us makes us understand that she's been like this since she was a little girl with her father".* Another health worker found himself very concerned and distressed after each meeting with the teenage mother, who also found it difficult to part with him "*her face would grow sad every time I was about to leave, and when I was gone, I would*

have a hard time...”. This teenage mother lived with her aunt, who was sometimes abusive, because her mother had died four years earlier. She had experienced this as abandonment, a feeling that was reactivated every time the caregiver separated from her. Working through the grief of the teenage mother’s mother improved the situation by reducing separation anxiety and encouraging the implementation of psychoeducation advice.

Countertransference. Countertransference refers to the set of feelings, cognitions and unconscious reactions that health workers have towards teenage mothers. This is discussed at each supervision session. The types of countertransference observed in health workers are: concordant, subjective, objective, negative and positive. Concordant countertransference means that the caregiver identifies with aspects of the adolescent mother’s psyche without exaggeration. This was the case for the majority of health workers who felt deep empathy for teenage mothers, for example, feeling the sadness of mothers suffering from depression “*I feel really sad... for her”*. Subjective countertransference refers to the fact that health workers’ reactions are independent of teenage mothers and stem from their own issues. After meeting with six teenage mothers, one health worker reported during each supervision session that these mothers “*do not want to express themselves, they are closed off”*. She was asked if she had ever found herself in this type of situation outside of work. She replied in the affirmative, recalling that one of her former colleagues had asked her: “*Why do you always have your mouth tied like that?”*. She realised that this was linked to the defensive stance she had always adopted towards her siblings, with whom she usually had a conflictual relationship. In addition, several health workers initially developed a kind of positive countertransference. This manifested itself in excessively positive feelings towards the teenage mother, to the point of caring for her beyond what was required. For example, they gave her money and helped her solve problems, to the point of blurring the boundaries of the relationship. Working on this in supervision enabled them to become less involved and less burdened by the relationship, which was a major cause of psychological fatigue. A health worker speaks out: “*If it weren’t for the fact that we didn’t discuss my experiences in supervision, I would have already given up this job...”*. After a few months, a health worker shares her experience in a discussion with others: “*How does knowledge of transference elements help in assessment and treatment, both theoretically and practically? Answer: By helping us to understand ourselves better. By helping us to avoid influencing patients. By helping us to separate transference and morbid discourse from the therapist’s own experiences. By helping us to make an objective, clear diagnosis*”.

Below, we present a clinical case to illustrate how treatment is managed.

Clinical illustration

Context of the meeting and identification: M. is a 17-year-old teenager. She comes into contact with health worker S. through a friend (of the carer). The teenage mother lives with her mother and her 11-month-old child. She is the eldest of two children, the youngest of whom (her little sister) lives with her grandmother. Her father died when she was five years old. She was raised by her mother. She always considered her uncle, her father's twin, to be her real father, even though he was not sufficiently present in her life. Five months into her pregnancy, she was informed that he was her uncle and not the biological father. Regarding her pregnancy, those around her wanted her to terminate it, but she refused. She discovered she was pregnant shortly after separating from the perpetrator. The latter denied paternity. They (she, her mother and her baby) are staying with one of her aunts, as they do not have the financial means to find accommodation.

Psychological issues: At the end of the assessment, it appears that patient M. is experiencing profound sadness accompanied by crying, suicidal thoughts and scenarios (leaving her child at the orphanage and taking a lethal dose of medication), difficulty sleeping and eating, somatic symptoms (back pain, headaches, neck pain), rumination, isolation, irritability, and disinterest. This condition has lasted for three months. There is a chronic presence of massive conflicts with her mother and family (relating to the secret about her father); a reproduction of the same aggressive behaviours as her mother. There is also a history of suspected conversion hysteria. For this, she received psychiatric treatment (medication) which was unsuccessful. She and her mother went to see a pastor who began praying, and the seizures stopped. For the pastor, it was madness, and for him, the fact that she had given birth meant that her life was over. Moreover, he claimed to have 'seen' the emptiness within her. Ultimately, she was diagnosed with depression with suicidal thoughts, with an EPDS score of 24/30 and nine risk factors identified. In terms of her interactions with her baby, she alternated between excessive care and attention, partial care or no care and attention. The baby, meanwhile, cried constantly and regularly.

Proposals for treatment, illustrating the combination of several tools and effects of treatment:
The treatment took place over 14 sessions, in the patient's home environment. As she could not be hospitalised due to a high risk of suicide, it was decided to maintain constant contact with her via text message. The patient could send a text message whenever she had suicidal thoughts, to which the health worker would respond briefly while waiting for the next session. Initially, two sessions per week were scheduled.

The health worker began with psychoeducation (a tool proposed by IG-mhGAP) on depression and suicidal behaviour. This involved talking about the illness, its symptoms, its prevalence around the world, its consequences, and how it is treated. Learning that nearly one million people worldwide commit suicide each year reduced the tension surrounding these thoughts, as the patient blamed herself for having them. She also welcomed the fact that she was suffering from an illness and, above all, that she could be cured, rather than being 'crazy' as the pastor had suggested. At the end of this psychoeducation session, she was advised to resume activities that she previously enjoyed, such as drawing, writing, playing sports and going to school; to choose and stick to a bedtime and wake-up time; not to stay alone; and to increase her social interactions. Five sessions and weeks later, none of these recommendations had really been put into practice.

Secondly, the problem-solving strategy outlined by IG-mhGAP was initiated. She was asked to list her problems, select the most urgent and pressing ones, brainstorm at least three solutions with her health worker, and implement the most viable solution. The patient mentioned two problems: lack of financial independence and ongoing conflicts with her mother. The lack of financial resources was selected as the most urgent and priority issue, and the solutions: "*look for a job, do a paid internship, or take an entrance exam"*. From that point on, a prerequisite arose: weaning her baby. She had been thinking about doing so and wanted to, but was unable to. The solutions proposed were: weaning gradually (the child was already eating solid foods), seeking advice from an experienced mother and following it, and taking traditional medicines. The choice was made to wean gradually, but this could not be achieved at first. It was the effect of family counselling that ultimately led to weaning and the resumption of efforts to find solutions to the problem of financial independence (searching for an internship and/or funding for income-generating activities).

The distress experienced by the patient led to persistent negative thoughts, associated with negative emotions such as sadness and anger. The recurring negative thoughts identified were: "*1- I am a burden to my mother, 2- I cause problems, 3- I am incapable of acting"*. After questioning the validity of these thoughts, the aim was to work with her to find alternative thoughts that would reduce her sadness and anger: *"1- I am capable of taking control of my life again. 2- I will look for jobs, and in the meantime, I will make crisps to earn some income. 3- Whenever I have negative thoughts, I will systematically call the helpline or send a text message to my health worker"*. So the task at hand was to replace negative thoughts with alternative ideas and note down elements of reality that could reinforce them. From the third to the seventh session, the patient was unable to do this. She only began to do so after several sessions of free and spontaneous verbalisation around the topics discussed. It seemed that the fact that she had sufficiently unburdened herself gave her more space for restructuring.

The patient initially struggled to implement the first three strategies (psychoeducation recommendations, problem solving and positive thinking) and therefore improve her condition. The option of putting her thoughts into words through free association was adopted. After two sessions of free and spontaneous expression, the patient began to put into practice a psychoeducation recommendation: walking to get some physical exercise. Still with this in mind, the theme of psychological ambivalence was addressed. The patient expressed that she appreciated the fact that she had become pregnant. Being would allow "*to have another person with whom I could have a good relationship, because with my mother, things are often tense"*. However, this is difficult after giving birth, as caring for a baby is often challenging; it is a "*very heavy load, it's enormous"*, and she adds: "*I even think that's why I often neglect him, because he annoys me. It bothers me because it's as if I'm becoming like my mother"*. The fact that the health worker told her that ambivalence was normal given the difficult circumstances she was experiencing (family discord, a difficult relationship with her mother, financial insecurity, difficulty balancing school and motherhood) relieved her and lessened her feeling that she was as bad as her own mother. The question of identity was also a source of suffering for the patient. The father she had had was not her father, but rather her uncle. During arguments with her mother, she was often called "*Chadian, the Chadians are causing trouble..."*. In the end, she did not know whether she was Cameroonian or Chadian.

As the situation between the teenage mother and her mother was very tense, family interviews were introduced. These interviews were conducted by the supervisor, with the patient, her mother, the baby and the health worker present. Initially, the carer was asked to prepare for the family meeting with the patient. The patient wanted to discuss the following topics, or have the caregiver discuss them on her behalf: *"abortion, difficulties at school, my mother's aggressive welcome when I come from school, my mother's hurtful comments, my mother's hatred for me and her son"*. These issues were discussed, and the patient's mother decided to be more conciliatory towards her daughter. A striking scene took place during the second consultation: the baby refused to feed. It was the first time this had happened, as she had been trying to wean him for two months without success. In fact, whenever the baby cried, she would systematically calm it down by breastfeeding it, or the baby would go to her to ask for milk. After this session, things changed; it was as if the baby had regained some autonomy and emotional control. He never breastfed again after that. At the end of the third family consultation, they were invited to reflect on what might happen in both the mother's and daughter's lives, a bit like a rehearsal. At the fifth interview, they reported that "*they both gave birth at 16, we didn't grow up with a father figure, we were abandoned by the child's father, we don't really get along with our mothers, and it's the same for our grandmothers and great-grandmothers. We really miss the support and affection of our family members*".

After this conversation, there was a change; the patient's mother became more supportive.

Transference and countertransference movements: The health worker often felt tired and irritated by the patient, without really understanding why. This feeling made interaction difficult. During supervision, she realised that the patient herself was very irritated by her mother and that the relationship was difficult and even violent at times. In addition, the carer felt sadness, which contributed to making the interviews difficult. Talking about it during supervision helped the health worker to distance herself from it and lighten the burden she experienced during the interviews.

End of care. Fourteen individual interviews and seven family interviews were conducted. The patient's situation improved considerably, although not completely. Her interactions with her child were now good, as she allowed him to explore, become more independent (playing with the neighbour's children, which she had not allowed before) and regulate himself. Relationships with her mother improved and her initial symptoms had almost completely disappeared.

Conclusion

1,633 teenage mothers were recruited, and 227 health workers were trained. The clinical program, consisting of several tools that can be used depending on the clinical situation, proved effective for 615 teenage mothers. Psychoanalytically inspired tools made a significant contribution. The 66.4% prevalence of mental illness among teenage mothers means that preventive and treatment measures must be made permanent as a matter of urgency. This model of care, involving both specialized and non-specialized mental health workers, should be replicated more widely.

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