Severe and Mild Depression

POSTPARTUM DEPRESSION

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Silvano Arieti

Introductory Remarks

We have seen in chapter 3 that most types of psychiatric disorders can occur after childbirth. Many authors have stressed that there is nothing specific about these conditions: childbirth is only a precipitating factor which acts by weakening the resistance of the puerperal patient.

The birth of one's child, however, is a very significant event and cannot be considered just as an ordinary precipitating factor. It may well be an event that, because of its intrinsic characteristics, finds in the patient the most suitable ground in which to evoke a psychiatric condition. It is quite possible that no other event could have caused a similar condition in that particular period of time in the life of the patient, or in any antecedent or subsequent time.

My studies of postpartum schizophrenic psychoses have convinced me of the psychogenic importance of the birth of one's child (Arieti, 1974). The study of postpartum depressions leads me to similar conclusions.

Zilboorg (1928, 1929) was one of the first authors to consider

postpartum conditions from a psychodynamic point of view. He gave, however, the most orthodox Freudian interpretations. According to him, the mother has a castration complex and sees in the child "more the value of a lost male organ than anything else." She also experiences an inadequate motherly relation to the child and for this reason turns to masculinity. In contrast with Zilboorg's observation, only rarely have I found a rekindling of dormant homosexual tendencies in women who underwent psychiatric complications after childbirth.

Zilboorg (1931) was also one of the first authors to report depressive conditions in both father and mother following the birth of a child. He mainly interpreted them as reactivations of incestuous Oedipal attachment for the parent of the opposite sex. In 1959 I reported that depression may be precipitated in either parent by the birth of a child that was ostensibly wanted. I wrote, "In some young fathers the birth of a son reactivates the trauma of replacement by a new sibling. In these cases one finds unconscious fantasies about the lost breast (for now the baby will have the breast of the mother-wife). It is interesting that, whereas the birth of the child precipitates a schizophrenic psychosis only in the mother, it precipitates an attack of depression as frequently in fathers as in mothers" (Arieti, 1959). I wish to add now that in my opinion, depressive conditions occurring in fathers following childbirth are reported less frequently than those occurring in mothers for two reasons: first, because it does not occur to many authors to make the

connection between the father's depression and the birth of a child; and second, because these depressions are generally much less serious than those occurring in mothers. I can also add now that although depressions in fathers occur much more frequently after the birth of a son, they also may occur after the birth of a daughter.

In 1966 Wainwright reported ten cases of fathers with psychiatric illness after the birth of a child, in seven of those cases after the birth of a son. In 1977 Bieber and Bieber reported postpartum psychiatric conditions of various kinds in mothers and fathers. A mechanism they encountered frequently in women was that the patient was afraid of evoking competitive hostility in her mother and consequently was afraid to have as many children as her mother had. When the pregnant woman was about to reach a number of children equal to that of her mother, her anxiety increased to the point of eliciting a serious psychiatric condition.

Psychodynamic Developments

I repeat here what I wrote in a chapter devoted to postpartum schizophrenic psychoses:

> The more we study each case psychodynamically, the more we realize that the experience of giving birth to a child was an episode of such magnitude as to require a complete psychological readjustment on the part of the patient. Chertok (1969) writes that maternity appears to be an integrative crisis in women's psychosexual development. The assuming of the

> maternal role involves the revival of the structuring conflicts that have marked the mother's personal history and molded her identifications. Chertok adds that "childbirth is the 'end'—at least a temporary one—of this crisis, and also frequently its culminating point. The way in which it is experienced depends upon the woman's whole past history; at the same time, it is exposed to the hazards of a crucial moment in time and may have a directive effect on the future." These words seem to be even more pertinent in relation to women who develop psychiatric conditions after childbirth. I believe that the revival of the structuring conflicts at times necessitates psychopathological developments. The psychopathology is the result of the interplay of the conflicts of the patient and of the psychological defenses that she can build up. Childbirth was thus an essential factor in the engendering of the disorder (Arieti, 1974).

What Chertok calls the crisis is the emergence, at a clinical and conscious level, of the instability of a certain equilibrium which had been reached previously through the adoption of certain patterns of living.

The baby—the little intruder—becomes for the vulnerable and very sensitive psyche of the mother and, as we have seen, also for the father, a big intruder who is capable of smashing the previous tenuous and precarious balance. The baby is now there, in his physical reality; he has finally arrived and cannot be sent back. Before his arrival he was experienced as something as vague as a dream, a forthcoming desirable addition to the family, or an object of love to be cherished and tended; however, now he is seen as a threat or as a smasher of an illusion, and more frequently as both.

Why does he appear that way? Let us examine the depressions occurring in fathers, which are much easier to understand. We have already

mentioned that as a rule they are less serious. The father generally reexperiences the trauma that he underwent when he was a child and the birth of a sibling caused what he interpreted then to be a partial or total loss of maternal love. In the majority of cases, the patient's mother (the grandmother of the present baby) did not decrease her love for the patient (the baby's father), but the patient interpreted the arrival of the sibling in this way for reasons which have to be elucidated in the course of psychotherapy. As we have already mentioned, many of these fathers are able to reevoke scenes of the mother in the act of nursing the sibling. In conjunction with these memories, they are able to reevoke fantasies in which they visualized the sibling not just as an intruder, but as a thief who had stolen the love and the breast of the mother. These fantasies were often accompanied by anger, vindictiveness, and guilt feelings.

Now the patient is threatened in a similar way. Against the dictates of his reason, he interprets the arrival of the baby as that of a usurper who will steal his wife's love from him. But more than that, the baby will demonstrate that he, the father, is not worthy of love—something that he had always suspected. Thus the father experiences the loss of an acceptable self-image and undergoes a catastrophically negative reevaluation of himself which is totally or predominantly unconscious and quite irrational. Generally the depression is not very severe; the patient is able to verbalize freely, and with the help of the therapist he can bring back to consciousness what was

repressed. He can also regain reassurance about his wife's love. There are, of course, important variables in these cases. In some patients the original trauma, sustained at the birth of the sibling, is the major antecedent factor; in some others it is the uncertain relation with the wife.

Depressions occurring in mothers after childbirth are more complicated. Unexpectedly an intense drama unfolds. Generally there are four characters in this drama: the mother, the baby, the husband, and the patient's mother (the baby's grandmother). On rare occasions the patient's father (the baby's grandfather) plays a role. The young therapist is inclined to suspect that the baby and the husband of the patient play a great role, and indeed they do, but in the majority of cases not so great as that of the patient's mother. In most cases which have come to my attention, the dominant other was not the husband or the baby, but the the patient's mother. I have already mentioned that Bieber and Bieber (1977) found as a frequent dynamic factor the patient's fear of competition with her mother over the number of children to have. I believe that what the Biebers have described could be called the Niobe complex, from Greek mythology. Niobe, queen of Thebes and daughter of Tantalus, boasted of her fertility, saying that the goddess Leto had only two children. Apollo and Artemis, who were Leto's two children, were angry at the insult and killed all the children of Niobe. Zeus also joined in the revenge and turned Niobe into a stone image which wept perpetually— an image of depressed stupor. The patient described by the Biebers feels that she is about

to show her superiority over her mother and, I would like to add, she also feels that she is already being punished in a way similar to Niobe.

In my experience, however, patients as described by Bieber and Bieber are only a small percentage of postpartum depressions. And even in their cases, the intense relation with the mother concerns many aspects of life and not just giving birth to a certain number of children.

In the majority of cases of postpartum depressions in young mothers which have come to my attention, the patient's mother—in addition to being a dominant other whom the patient had to placate and from whom she had to obtain constant approval—was a person with whom the patient identified, although reluctantly. In other words, the patient modeled herself after her mother, not because she admired her, but in order to obtain her approval and love. When the baby arrives the identification seems complete and irreversible. Now the patient is going to be a mother as her mother is, and probably the same type of mother her mother always has been. But the patient cannot accept this. Thus she must reject her mother and consequently a great deal of herself, modeled after mother, and a great deal of her connections with other people, imitated from mother's ways, and of course her relation with the baby, which confirms her as a mother. At the same time she experiences guilt feelings because she cannot accept the idea that she does not accept her maternal role.

In some instances, other constellations of thought become mixed with the one described and may even acquire prominence. The patient does not want to give up the woman she wanted to be—let us say, a scientist or a lawyer. Now she is going to be a mother and the career which was her dominant goal will not be actualized. She will be a mother in a role whose significance she now minimizes: even female animals can be mothers. Thus her whole sense of self and of life in general drastic changes.

Contrary to what one would expect, fear of losing the husband's love, which from now on may be directed only to the baby, has not played an important role in the cases of postpartum depressions that have come to my attention. This finding contrasts with what I have observed in postpartum depressions occurring in fathers. However, I must reiterate that patients treated by a single therapist cannot constitute a large number. Thus any impression about the possible incidence of a certain cluster of psychodynamic factors is likely to be corrected if a large number of cases could be assembled and correlated. In many cases of postpartum depressions, after following the initial modalities described in chapter 9, I try to determine as soon as possible whether the patient rejects the child and feels guilty about it. If she does reject the child and is willing to admit it, I rush to say, "Remember three important things: (1) You must accept the fact that you do not accept the child now but the day will come when you will accept him and love him (her). (2) Try not to feel guilty for what you cannot prevent. (3) Your child is not going

to suffer. Somebody will take care of him (her) until you are in a position to do so." I have found that these words are temporarily reassuring and helpful until deeper understanding of this situation is obtained.

The rest of the chapter is devoted to a case report which illustrates the psychodynamics of postpartum depression, as well as some therapeutic modalities. This report deals with one of the most severe cases of depression that I have ever seen. Although I believe that I have brought to solution the main aspects of this case, by no means do I claim that I have understood it in entirety. The reader will certainly discover several untapped possibilities and issues which would benefit from further clarification.

Case Report

Lisette was twenty-four years old when I first saw her. She was from Australia and was in this country with her husband, who had won a scholarship to do postgraduate research in New York City. Here is a brief account of the events that brought her to me. Several months previously she had given birth to a girl. Immediately after the birth she became depressed; however, she and her family did not give too much importance to her condition, and she received no treatment. Her condition became much worse and eventually she had to be hospitalized for a few months. She was treated with drug therapy, she improved, and was discharged. A few weeks later,

however, she started to be seriously depressed again. She started treatment with a psychoanalyst of classic orientation, but there was no improvement. On the contrary, the situation was deteriorating rapidly. The patient became unable to take care of the baby and was completely incapacitated. The mother-in-law, who lived in Australia, had to be summoned to New York to help the patient. When she arrived the patient resented her very much, so she returned to Australia. Then the patient's mother came and remained with her for several months. Suicidal ideas were freely expressed by the patient and suicide was an impending threat. She could not be left alone.

When I first saw her entering the waiting room of my office, she was accompanied by her mother and husband who were sustaining her on each side, almost to prevent her from falling. When I looked at her face, I saw a picture of intense sadness and abandonment, so picturesque as to give me a fleeting impression that perhaps it was not genuine, but histrionic and theatrical. I had never seen such scenes before except in Italian movies. But when Lisette was alone with me in my office, her real suffering revealed itself: it was a genuine, uncontrollable, overpowering, all-evolving, all-absorbing, all-devastating depression. The feeling of hopelessness and despair, as well as the motor retardation, prevented her from talking freely. Nevertheless she managed to tell me briefly that her therapist was not doing her any good, and she was sick and wanted to die. When I spoke to the mother and husband later, while she was closely watched in the waiting room by another person,

they told me that I was supposed to be only a consultant. They wanted to know whether the patient should receive electric shock treatment; it was no longer possible to manage her at home. They were consulting me to find out whether I was firmly opposed to electric shock treatment in this case. In view of the failure of drug therapy, psychoanalytic treatment, and the seriousness and urgency of the situation, I told the husband that shock treatment should be tried, and that they should consult me again afterward.

The patient received fifteen shocks. This is a large number for depressed patients, who receive an average of five. As a matter of fact, the treatment was eventually stopped because there was no improvement. I remembered from my early experiences in Pilgrim State Hospital that depressed patients who do not improve even after such a large number of treatments have a poor prognosis. When Lisette returned to see me, she was still very depressed, suicidal, and hopeless. In spite of fifteen grand mals there was practically no memory impairment. She told me that she strongly resented going back to her analyst or for more electric shock treatment and begged me to accept her in therapy.

I wish to describe my feelings when she made such a request. This wish of mine is undoubtedly partially motivated by narcissism, but also by my belief that it is important to evaluate the feelings of the analyst at the beginning of the treatment of every seriously ill patient. I was very touched by

that profound, seemingly infinite pain. I was also perplexed: I had already understood that all this had to do with the birth of the child, but how a birth could produce such devastating depression was a mystery to me. What basic construct or relation was undergoing a disintegration capable of producing such a violent and seemingly unhealing process in that young, promising, intelligent, and sensitive young woman?

Needless, to say, when I discussed the matter with the previous therapist, he did not object to terminating his treatment. So Lisette came to me. I am now going to give a brief history of the patient as it was collected during the first few months of treatment.

The patient was born in a small town which was contiguous to a big city in Australia. The parents belonged to the upper-middle class. The father was a successful divorce lawyer, blessed with a cheerful character that made him see the world with rose-colored glasses and helped him to make a brilliant career. His refined form of shallowness, with such effervescent optimism, made him navigate surely and fast but without leaving a wake. The patient felt much closer to her mother, who actually was a very demanding person. Mother had a humanistic education; would speak about art, literature, and poetry in particular; and seemed to have much more in common with the patient. She helped her with her homework while the patient was in high school and college. Mother also made many demands; and, according to

Lisette, there was an almost constant expression of disapproval in her face.

Mother had been engaged to a man who died during the engagement. She often referred to this man with enthusiastic terms never used in relation to father. Although father adored mother, mother had for father only a lukewarm, amicable attitude. Lisette defined the marriage of her parents as fairly good, but not marvelous. The patient knew that sexual life between the parents was not a thrilling one; mother had told her that she obliged.

Earlier in life mother had suffered from epilepsy and also from depression. It seemed that both her epilepsy and depression had started with the birth of the patient’s brother. Mother became depressed to such a point that four-year-old Lisette had to be sent to live with her grandmother for a while. Incidentally, this grandmother, the mother’s mother, was the only person throughout Lisette’s childhood who shone as a giver of affection, love, warmth, and care. Lisette always loved her dearly. In spite of grandmother’s affection, separation from her mother was experienced as a trauma by Lisette. Mother recovered quickly from her depression but, as already mentioned, she had also developed epilepsy. There was an atmosphere of secrecy in the family about mother’s epilepsy. In fact, Lisette had never seen her mother having an attack until she was twenty. On that occasion Lisette called on God to help mother, but in mother’s face during the attack was God’s denial of her request. The truth could no longer be concealed, and she experienced a sense

of horror—moral horror—because of the denial.

The patient was always very good in school. During adolescence she felt inferior and unattractive. She had a negative attitude toward life. Everything that appeared good or likable also appeared superficial, like father. Everything that was deep and worthwhile appeared inaccessible, like mother's approval. There was no doubt in her mind that mother had always preferred her brother, for whom she had strong rivalry and jealousy. She went through a period of rebellion during which she felt people were empty, superficial, and made of plastic. She did not care how she looked and was neglectful of her appearance. Because she was not well dressed and because of her bohemian ways, she felt disapproval not only from her mother but also from the upper-middle class of the small town where she lived. And yet as much as Lisette was critical of these people, she seemed to need their approval and acceptance.

When Jack, a young man of the lower-middle class, started to pay attention to her she was grateful that somebody had noticed her presence. Soon she felt very much in love with him, admired his idealism, intelligence, and interest in research; and when Jack graduated from school, they got married. The patient stated that her marriage was a happy one from the very beginning. The only thing she resented in her marriage was her husband's family, and especially her husband's mother. Jack's mother was so different

from her son, so cheap, vulgar, and materialistic. She was coarse; she ate with her fingers and sniffed tobacco. She was also narrowminded. To the degree that Jack was desirable, his mother was undesirable. Jack won a research fellowship in the United States, and everybody was very happy. In the meantime, however, Lisette had become pregnant. The pregnancy was accidental and came at a very inopportune time. The patient was angry about it and also experienced nausea. Although the pregnancy was a complication, Lisette and her husband came to the United States in May, during her fifth month of pregnancy. (The baby was expected in September.)

Lisette told me that during her pregnancy she had a peculiar idea. I must make it clear that when I first heard about it, the idea indeed seemed so peculiar as to make me think of a schizophrenic disorder. Lisette told me that during her pregnancy she had the feeling that her mother-in-law had entered her. "What do you mean?" I asked, unwittingly approaching her with an obvious feeling of perplexity or even consternation. Lisette told me with a reassuring voice, "Don't worry. I did not mean it literally. My husband's sperm that had impregnated me contained genes inherited from his mother. I was displeased that inside of me a baby was growing that was partially a derivation of my mother-in-law."

In spite of this reassurance the idea seemed bizarre to me and, in a different context, I still would have considered the possibility of

schizophrenia. In fact we know that in preschizophrenics and also schizophrenics, certain expressions used metaphorically are forerunners of delusions. In these cases the delusion eventually denotes literally what was previously meant in a metaphorical sense. However, in this case nothing else was schizophrenic or schizophreniclike. I had to rely on my clinical experience with schizophrenics to evaluate the clinical picture in its totality and exclude such a possibility. The future development of the case supported my clinical evaluation that there was no schizophrenia.

The patient gave birth in September, and the symptomatology of a depression first manifested itself in a mild and later in a very pronounced form. The childbirth represented a focal point from which the whole manifest symptomatology originated and irradiated in various directions. For a long time Lisette could not even talk about the birth of Clare in more than fleeting remarks. The episode of the birth itself, as experienced by Lisette, was painful to such a tragic degree as to prevent discussion of it until the groundwork had been prepared by treatment. However, at this point it may be useful to evaluate what we already know about Lisette’s case and to delineate some basic constructs.

In the life of the patient there was a dominant other, and this person was not the husband but the mother; the mother so much needed for approval, and from whom approval was so uncertain; the mother with whom

she would like to identify, but no longer could.

This dominant mother as a basic construct had, so to say, a satellite in the mother-in-law. The patient did not have to be as careful in her conceptions about the mother-in-law as she had to be in reference to her mother. Without guilt or compunction of any sort, and strengthened by some realistic facts, Lisette displaced to the mother-in-law some of the bad characteristics of her mother, and also the feeling that she had for her mother. The mother-in-law was not only vulgar and disapproving, but she herself had made Lisette become a mother. The mother-in-law became, although at a quasi-metaphorical level, the phallic mother who entered Lisette and made her pregnant. The husband was totally dismissed; the mother-in-law who had made her become a mother was a monstrous distortion of Lisette's own mother. It was almost as if, by accepting her pregnancy, Lisette had to accept her mother and her mother-in-law and what they stood for. If they stood for motherhood, it was a motherhood that she wanted to reject. Accepting their type of motherhood would mean being as they were and giving up her self-image, a cognitive construct about herself which was cherished and gratifying. However, the fact remained that during her pregnancy Lisette was apparently all right. It was the childbirth itself that precipitated the condition; but Lisette did not want to talk about the birth for a long time.

Nevertheless, from the beginning of treatment I got the impression that

Lisette could open up to me. I was immediately accepted by her as a dominant third; and when she trusted me fully and saw me as an undemanding, accepting, and not disapproving person, I became a significant third. I had the feeling that although she did not consider me to be a source of love, she saw in me a source of strength, clarity, and hope.

For several months the sessions were devoted to studying her relations with her mother, and how Lisette lived for her mother's approval. A look, a gesture of disapproval, would make her sink into a deep state of depression. To be disapproved of by mother meant utter rejection and unworthiness. She required her mother to take care of and fuss over her as grandmother had done. Grandmother was really the person to whom the patient was close. Her affection was profuse, a steady flow, without fear of interruption because of sudden disapproval. In contrast, mother's approval could always end abruptly whenever she decided that Lisette had committed an infraction, no matter how little. There was no doubt that the patient put in operation manipulations and other characteristics, as Bonime (1976) has described. However, there was in addition this constant need for mothers' approval, as Bemporad (1970) has illustrated. Not only did she want to be mothered by mother, but she wanted mother to have a good opinion of her. Mother seemed to be the only person who counted in her family constellation, and yet many actions or words of mother were interpreted in a negative way by Lisette—not with the suspicious distortion of the paranoid, but with the adverse

appraisal of the depressed. For instance, when mother said that the patient had been lucky in comparison to her, she implied that the patient was spoiled and had an easy life. When mother said how wonderful Jack was, she meant that Lisette did not measure up to her husband. If mother was making a fuss about Clare and called her darling, Lisette would become very depressed, wishing mother would refer to her in that way. She resented mother terribly and yet she could not even contemplate the idea of being left alone with Clare if mother went back to Australia. Then she would be overwhelmed by her duties and feel completely lost.

Using the formulation of Bemporad (1970), I repeatedly pointed out to Lisette that at present she was incapable of autonomous gratification. Any supply of self-esteem and feeling of personal significance had to come from mother. Mother was not just a dispenser of love, but was put in a position to be almost a dispenser of oxygen and blood. By withdrawing approval, the supply would end and she would become depressed. At the least sign of forthcoming disapproval, it was as if the supply was interrupted. Disapproval brought about not only depression but also guilt feelings, because she felt she deserved disapproval. And yet a part of her wanted to be like her mother, although mother was not like her grandmother.

I explained to Lisette that she sustained a first important trauma after the birth of her brother, when she was sent away from the depressed mother

and she experienced a feeling of deprivation. Moreover, she associated deprivation, loss of love, and depression with childbirth. I have found that in postpartum psychoses of both schizophrenic and depressed types, the patient makes a double identification with her mother and with her child. Inasmuch as Lisette identified with her mother, she was a mother incapable of giving love, a mother who would become depressed, a mother who would only love an intruder like Clare. Little Clare became the equivalent of Lisette's brother, who had once deprived her of mother's love: if Lisette identified with the child, she felt deprived as a child feels who is deprived of love. All these feelings were confused, and of course self-contradictory.

Lisette came to experience the treatment as a liberation from mother. Mother's disapproval gradually ceased to mean loss of love and loss of meaning of life. Indeed, treatment was a liberation from mother; not so much from mother as a physical reality, but from mother as the mental construct of the dominant other. The relation with the analyst as the significant third permitted her to stop identifying with mother without losing the sense of herself as a worthwhile human being. Moreover, anticipation of maternal disapproval no longer brought about depression or guilt feelings. At the same time that mother lost importance, the satellite constructs of the mother-in-law, as well as of the upper-middle class of the little town, lost power. During the early periods of the treatment, in fact, when Lisette talked about the people in her home town she was still worried about what they would think

of her in spite of the distance of ten thousand miles. At the same time that the mother, as an inner object, and the related constructs were losing value, the husband was acquiring importance. The patient had always admired and respected her husband, but she had never put him in a position where his withdrawal of approval would be of vital importance. Now the husband could be enjoyed as a source of love. Lisette's desire for sexual relations returned. The patient also became more capable of sharing interest in Jack's professional and scientific activities. Before she had been interested only in humanistic subjects, as mother was.

Up to this point, treatment had consisted of changing the value of some basic constructs so that their loss would not be experienced as a psychological catastrophe and new, more healthy constructs could replace the disrupted and displaced ones. In other words, the patient was searching for and finding a meaning in life which was not dependent on the old constructs and not connected with pathological ideas. She was now astonished that she could have had certain thoughts and feelings. For instance, she remembered that when the newborn Clare was sucking at her breast, she would become more depressed. She did not want to nurture her; she herself wanted to be nurtured, perhaps by her mother. She also remembered that she had been angry at Jack when he would tell her to look after the baby. He should have told her to look after herself. She realized that her depression, as well as her identification with the baby and her rivalry

with the baby, had made her regress to an unbelievable degree.

After several months of treatment we felt that the patient could manage her life alone and that mother could return to Australia. The patient had a mild fit of depression caused by their separation, but no catastrophe occurred. After awhile Lisette was asking herself how she could have tolerated her mother in her home for so long.

It took some time after mother left for the patient to bring herself to talk about a most important issue—the experience of childbirth. Lisette told me that when she discovered that she was pregnant, she decided to take a course for expectant mothers on natural childbirth. According to the basic principle of natural birth, the woman in labor does not succumb to the pain; she maintains her grip on herself. The woman in labor should not scream; the scream is ineffectual despair, it is being no longer on top of oneself. What happened instead? In spite of the preparation, Lisette in labor could not bear the pain and screamed. It was a prolonged, repeated, animal-like scream. While she was screaming, she wanted to kill herself because to scream meant to give up as a human being, to disintegrate. But she screamed, she screamed, she screamed! What a horror to hear herself screaming, what a loss of her human dignity.

During many sessions the patient discussed her cognitive constructs

about childbirth. She resented being a biological entity, more an animal than a woman. Biology was cruel. Women were victims of nature. They became the slaves of the reproductive system. You started with the sublimity of romantic love and you ended with the ridiculous and degrading position of giving birth. While giving birth, you were in a passive, immobile position which was dehumanizing. Nurses and doctors who meant nothing to you saw you in an animal-like, degrading position. You revolted and screamed and lost your dignity. Lisette wanted her husband to be present in her moment of greatness during her childbirth, and instead he was witness to her descent to utmost degradation. Childbirth was the death of love, the death of womanhood. You were no longer you, but a female of an animal species. You became what these dominant adults made you; and what is even worse, you needed them. You were no longer yourself, you were already dead because the ideal of yourself—what you were or what you wanted to become—was no longer tenable. You gave up the promise of life; you went through a dissolution of thoughts and beliefs. The pain increased, became insurmountable.

Eventually Lisette felt not only physical pain, but also moral pain. She could not think any more. She felt depressed, and the waves of depression submerged her more and more. But at the periphery of her consciousness, some confused thoughts faintly emerged: she did not want to be a mother, she did not want to take care of the child, she would not be able to take care of the child, she could not take care of her home, she should die. It was impossible

for her to accept what she had become—a mother—and the concept of mother did not have for her the sublimity that culture attributes to it, but all the mentioned negative animal-like characteristics. She felt she had probably become an animal-like mother, as her mother-in-law was.

At an advanced stage of the treatment Lisette was able to recapture all these thoughts that had occurred to her during and after the birth of Clare—thoughts which had become more indistinct, almost unconscious, as the depression occupied her consciousness more and more. In treatment the ideas emerged that had precipitated the depression and which the depression had made unconscious.

Although these thoughts appeared in an intricate confused network when they were revealed to me, it was not difficult for me to help Lisette disentangle them and to get rid of them because we had already done the preliminary work. Once we dismantled mother as the inner object of the dominant other and as an object of identification, it was easier to bring the associated ideas back to consciousness. It became easier for Lisette to understand that when she gave birth she strengthened her identification with her mother who, when she gave birth to Lisette's brother, had become depressed and epileptic. But she no longer could accept identifying with mother, at least to that extent. In order to reject that identification, she had to reject motherhood as well. But now that the treatment had helped her to

remove the need to identify with her mother, she could accept motherhood and herself as she was, and as what she had become —a mother.

In the beginning of treatment Lisette gradually became aware that her suffering was partially due to her not having received approval and gratification from her mother; but later she became aware that her greater suffering was due to the twilight of her basic constructs which had not been replaced by others. Lisette realized that the depression had been so strong as to prevent her from searching for other visions of life. She understood that the physical pain which she sustained during childbirth was symbolic of the greater and more overpowering pain caused by the incoming twilight of the basic constructs. Eventually the therapy permitted her to accept the loss of these constructs without experiencing depression. Even her attitude about being a member of an animal species changed greatly. She came to accept that we are animals and procreate like animals because we can transcend our animal status. And there is beauty in our animal status, provided that we are able to fuse it with our spiritual part; and that together with our animal status, we retain our status as persons. This last point was clarified by the analysis of some dreams, as shall be seen shortly.

The analysis of her dreams was another interesting aspect of her therapy. From the very beginning of treatment, most of them had to do with childbirth. Here are a few typical ones. She was in labor and in a state of

terror. She was swollen like a balloon. Somebody pricked the balloon. She felt deflated. Shame and horror continued. Discussion of the dream revolved around how pregnancy had made her a person which she did not want to be. The bodily transformation was, both in real life and in the dream, symbolic of an inner transformation which she was experiencing.

In another dream the patient realized that she was pregnant for a second time and told herself to be passive, not to fight the pregnancy. All of a sudden she found herself in prison. She looked at the street through the bars of the window and saw it full of garbage cans. There was another girl in jail, in the same cell. This other girl was courageous, not fearful like the patient. Lisette knew that she was going to be executed by hanging. She looked at her face in a mirror and thought, "How shall I look when I am dead? I want to look the same." She was wearing a beautiful nightgown, and she was concerned not with dying, but with how she would look after her death. The ensuing discussion revealed that the dream repeated how she had felt in the past and to a certain extent how she was still feeling about becoming a mother. Motherhood would make her a prisoner: her real self, the real Lisette, would die and she would become another, not authentic woman. She could not be like her cell-mate, her ideal self, brave even in adversity.

In another dream the patient saw a woman in labor. Her cheeks had become withered and wrinkled. They had actually changed in the moment in

which she gave birth. A man, the husband of the woman, was smoking and talking about a party which he wanted to give to celebrate the birth. The patient thought he was hateful and cruel because he did not know what the wife was going through.

In her associations the patient said that nobody, not even a loving husband, can understand what a woman goes through in those moments. When the patient was asked to focus on the fact that the cheeks of the woman had become withered and wrinkled, she winced and in an anguished voice said, “That face had a strong resemblance to my mother’s face, when I saw her during the epileptic attack. My mother became epileptic when she gave birth to my brother.”

These dreams and others not only repeated the themes which were discussed earlier, but revealed other aspects which otherwise would‘have received only secondary consideration. The last dream I mentioned disclosed resentment not only toward a husband, but toward a male world or a patriarchal society which does not know what women go through. Male society does not know either the pain of labor or the status to which women are relegated. Pregnancy and child-rearing practices in some respects enable society to keep women in a secondary position, stressing their biological roles and depriving them of many opportunities available to men. Pregnancy becomes a prison, as one of Lisette’s dreams symbolized, and leads to the

death of existence as a total person (being hanged). Although difficult for her to admit, Lisette retained a certain resentment at having left her country in order to enhance her husband's career. The resentment grew when the pregnancy, the labor, and anticipation of having to take care of the baby pointed out life's limitations for which she was not psychologically prepared.

Lisette's case obligates us to see some connection—perhaps not fundamental, but nevertheless important—between postpartum depressions (or possibly all postpartum psychiatric disorders) and the status of women in a patriarchal society. Possibly postpartum disorders occur more frequently at times and in places in which women are less willing to accept the traditional role. Pregnancy and labor may make a woman feel as if she is confined to the biological role of reproduction.

Lisette was able to reassess old meanings in a nonpathological frame of reference, and to accept new meanings. She made rapid progress in treatment. My fear that it would be difficult to change the husband's role in Lisette's life proved unfounded. Contrary to the other males, the father and brother who were not significant figures, the husband rapidly acquired importance and was fully experienced as a source of love, communion, and intimacy.

I asked Lisette whether I could publish her case report, and she said, of

course. I told her then that whoever reads her story will be reminded by her that we are barely out of the jungle; we can easily resume an almost-animal status, not because we are animals—which we are—but because we are human beings with ideas. Certain ideas that we adopt can make us feel and act like animals—that is, as biological entities which have lost a personal image. The study of life circumstances is important, I told her, but her story shows that even more important is the study of our ideas about these circumstances; because it is with these ideas that we lay foundations for life which eventually may not be able to sustain the weight of our existence. I also told her—and she agreed—that her story shows we can change even basic ideas and their accompanying feelings, and thus restore the promise of life and move again toward fulfillment.

Lisette and her family have returned to their native country. In a span of ten years there have been no relapses.

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