

Surviving Postpartum Psychosis for Mother, Baby, and Therapist

Dana Sinopoli, Ph.D.

Rose was in her mid 20s when she began experiencing great sadness and significant loneliness. Her first baby was then two months old. One month later she was hospitalized with auditory hallucinations that told her to break the television set. She presented as disorganized, paranoid, unable to sleep, and had told her husband, "If I loved you, I would kill you, so I must not love you very much." Fourteen days later she was discharged, with a diagnosis of Major Depressive Disorder with psychotic features. Strikingly there was little mention of her having recently given birth.

Rose was re-admitted to our inpatient unit two weeks after this discharge, following continued decompensation. She was discharged six days later to our intensive outpatient program. Looking at the record in preparation for this paper, I noticed that Rose had told the intake coordinator she was hospitalized because, "I wasn't giving myself enough space." I did not realize, until returning to her chart almost two years later, how much this awareness of "space," in both a psychological and physical sense, would be the foundation of our work. Even now as I write this, I am moved by Rose's insight into her need for a sense of self that included her new role as mother without being consumed by it.

In this paper I will discuss my work with Rose, from the perspective of an intern and resident dealing with what was an initially unrecognized postpartum psychosis. I will look at the professional and personal issues this treatment raised for me and conclude with some observations about the status and recognition of postpartum problems in our current field.

I had my first session with Rose 28 days after starting my internship. Looking at her chart for the first time, I saw the list of possible diagnoses she had been given including Psychotic Disorder NOS; Schizoaffective Disorder; Major Depressive Disorder; and postpartum psychosis. And she frequently experienced homicidal ideation towards her newborn. I recall more than simply feeling over my head, anxious that perhaps there was a young life at stake.

While rereading my notes, I recalled how quick I was to engage in more behavioral interventions in the very beginning of treatment. While I defended this in supervision as an attempt to "contain Rose's anxiety," I soon realized this was actually an attempt to contain my own anxiety. I recall worrying, What could she tolerate? Would I break her? Could I send her back to the hospital if I pushed too far or asked the wrong question? Clearly these were fears for myself as well: What could I tolerate? Am I capable of a psychotic break? What would I learn about my own thoughts of motherhood?

I will not soon forget my supervisor's repeatedly reminding me, sometimes to the point of great frustration for both of us, not to expect grand changes. As an intern, filled with the hope that I could save my patients, I placed great expectations on myself to "make things happen" and I feared going into supervision without clear indications of my competency as a therapist. "Just be with her," my supervisor told me repeatedly. But what did that actually mean?

As our session frequency increased to twice/week, Rose shared thoughts of "wanting to get rid" of her son. Her sadness while sharing this was evident. She described thoughts of putting him up for adoption, wanting her husband to take him, and wanting her son to die as a result of her own suicide. She also spoke of her husband's anger about her inability to successfully get their son to sleep at night, which paved the way for the identification of Rose's fear that she was utterly incapable of being a good mother.

The fear of incompetence made sense to me as I thought about being a mother, especially after the birth

of a first child. It was Rose's intense longing to rid herself of her child that made bearing witness to her struggle difficult. I found myself distracted by the fear that any missteps in the treatment would result in the death of Rose's child. My unconscious uncertainty of who was the "mother" of Rose's infant became evident in my initial use of behavioral interventions and frequent safety check-ins. I had yet to realize that in order to truly be with Rose, I had to accept the reality of never knowing with complete certainty what was going to happen. And the likelihood that the fear I experienced was in some way connected to the fear that Rose herself experienced.

As a woman with no children of my own, I struggled to make sense of this mother's rage and fantasies to "get rid of" her son. My supervisor encouraged me to look at the words of nursery rhymes to understand how deeply rooted maternal rage towards a newborn can be:

Hush-a-by baby, On the tree top. When the wind blows, The cradle will rock. When the bough breaks, the cradle will fall. And down will come baby, cradle and all.

We spent time thinking about nursery rhymes and that a melody used to lull a baby to sleep, is also filled with destructive lyrics. Clearly our culture was telling us that a mother could experience a myriad of feelings towards her infant. I realized that Rose's experience can be commonly felt by first-time parents in some form and I saw now how central the concept of shame would be in our work.

In her seminal paper, Kraemer (1996) writes of how psychoanalysis, and I would say our culture in general, suffers from not acknowledging the full range of maternal anger, aggression, and in Kraemer's phrase "ordinary maternal hate (766)." While commenting on Winnicott's work with mothers, Kraemer explores the lack of discourse on the feelings of shame, confusion, self-reproach, and anger when mothers do not always feel satiated and fed by their experiences with their babies. Kraemer writes, "What does the mother do with those parts of herself that are inevitably not empathically identified with her baby, even during this time of acute holding? How does the mother survive the moments in which she discovers that she has emotionally dropped her baby or wishes to do so (771)?"

Kraemer (1996) goes on to discuss the ways in which the mother may "feel temporarily obliterated in her giving, devoured by her newborn baby's need and greed" (771). This brings to mind Kernberg's (1976) description of the lower level of borderline organization which is characterized by a fear of annihilation or loss of self. I cannot help but wonder if being a new mother is, in its rawest of forms, at times truly crazy-feeling. Kraemer argues that motherhood "strains the ability of all mothers to tolerative ambivalence" and that the "inescapable reality of the baby's greater dependence and need for the mother" (768), which often goes unexplored and/or deemed an absolutely positive experience, renders the mother without a sense of personal subjectivity. What is it like for a mother to be in a constant care taking position? What about the "anger or despair she may feel when she balances her needs against those of her baby and nearly always loses (771)?" As I juxtapose this with Rose's experience, I wonder about the secondary gain of hospitalization: she was given a break from her newborn baby and from her husband who had relegated parenting responsibilities to her. Her initial response to the intake coordinator that she was hospitalized because "I wasn't giving myself enough space" conjures up the possibility that a part of Rose wanted to be taken care of; to have even a few moments alone. In 1940 Winnicott (1960) famously uttered, "There is no such thing as an infant!" In a moment of daydreaming while writing this, I found myself wondering if the new mother ever feels, "There is no such thing as a mother!" I recall in my analytic treatment at this time wondering if my own mother ever had thoughts of "getting rid" of me. Surely this line of questioning became open to me because of my work with Rose and my growing awareness of the importance of normalizing Rose's rage and frustration towards her new role of motherhood. It also illuminated aspects of my own development. My younger sister, who was born severely mentally retarded, was moved to a developmental center better equipped to meet her needs than our family could, when I was 15 and she was 13. I always consciously understood this as an act of

love for my sister, whose needs my parents and we could never meet without painful and unfair sacrifice. I began to wonder if there were parts of me that unconsciously experienced this as my sister being “gotten rid of.” It did sometimes feel that one day she lived in our home, and the next day she did not. Additionally, this also raises the question if there was ever an unconscious part of my own self that wanted to get rid of my sister. This connection was not consciously available to me at the time with Rose, but it is a reminder that our work with patients can resurface and continue to inform our work (both with patients and as patients) long after treatment has ended.

As we began our third month together, Rose told me that she had been unable to control her urination the past couple weeks and urinated on herself in the kitchen the previous night. She reported feeling “ashamed, frustrated, and annoyed,” particularly with “having to clean up the mess after.” I was curious about what had gotten in the way of her sharing this with me before now, but was also aware of not wanting to compound the shame she was already feeling. I echoed the feelings Rose used to describe the experience: “ashamed, frustrated, annoyed,” and commented that she had also used these feelings to describe being a mother. I felt motivated to offer myself as someone who could be with her in her process of “cleaning up the mess,” and thought to myself that this is often what therapy is: An experience of not being alone in the chaos, confusion, and shame of one’s mind and outside life. We talked about the “urge to let something out” and Rose shared that she had found herself much more quiet than before having her child. She described her history of being yelled at by various family members, and more recently by her husband, and her experience of feeling “forced” into having a baby by him. I noted how her disposition changed over the course of the session. This was the first time Rose felt safe enough for me to see her more fully. She began the session with a developmental regression and ended it more as an adult. At the very end of the session, with a laugh Rose compared therapy to “a toilet. Only better. It’s okay for things to come out here.” Against my analytic inclination to dissect the comparison of therapy to using a toilet, I decided to simply let it be. Yes, it is okay for things to come out here. Rose’s capacity to control her urination returned not long after this. Through her courage to be seen by me, I began to develop a more formulated understanding of our work. After this session, I began to think of our work as an opportunity for Rose to find her voice and develop a stronger sense of self.

As treatment continued into the second half of our first year and the necessary ambivalence towards motherhood continued to develop, the baby became less of an issue. Rose began to feel more competent in caring for her son and proudly began bringing in pictures of him. During one session, she remarked that she was looking at her son and thought, “I made that,” and felt proud. She began to express healthy maternal frustration and to recognize that this did not preclude her being a good mother. We spoke about how permitting herself to have these feelings actually increases the likelihood of responding to her son in a healthy way. In hindsight, giving voice to Rose’s anger, shame, and doubt seemed to make way for other aspects of her life to come through.

Over the remainder of our first year together, Rose explored wanting to improve her support system and joined a “cleaning co-op.” She also recalled joyful memories of being on the crew team in high school and began to wonder about joining an extra-curricular rowing team once her son was a bit older. She expressed regret over never finishing college and thought about completing her degree.

As I look back on what was happening during this part of treatment, I believe Rose was connecting with the parts of herself that existed outside of her role as mother. She also began using her mind more creatively and seemed less afraid of her own thoughts. An example of this involved her reflection of her hospitalization, marked by feeling as though this was “so long ago,” along with a hovering fear that she could be rehospitalized at any time. During this conversation, Rose asked if I would visit her if she was to be hospitalized again, which marked the first time our relationship and interactive process was overtly acknowledged.

Another area of Rose's life that emerged was her relationship with her family, particularly her mother. Rose grew up in a small city, the youngest after three older brothers. Her parents, who were never married, were unfaithful to one another and had children with outside partners. When Rose was 20, her mother died in a car crash, apparently intoxicated. I am not sure exactly what facilitated the progression of her awareness of her mother as our work unfolded, but over time Rose shared bits and pieces of her memories of her mother's own psychotic disturbances and depression and began to feel safe enough to wonder if the car crash was not just a drunken accident.

Rich (1976) writes of the "excitement of long buried feelings about one's own mother" (17), as part of the confusion that a mother might experience both within herself and towards her new baby. What did it mean for Rose to have lost her mother? Did her mother express wishes to get rid of Rose, either overtly or unconsciously? Was the anger and pain Rose felt towards her mother's death displaced onto her child? During our work together, Rose commented that she was "getting the help I wanted [my mother] to get." She also over time began to express her sadness that her mother never met Rose's son, which enabled the process of mourning both the loss of her mother as mother and the loss of her mother as grandmother. Throughout this process, my supervisor and I realized that I seemed to be assuming a grandmother-like role as Rose increasingly began showing me photos of her growing son. There was less interpretation of the transference and more of a process of using the transference to help Rose move along.

In revisiting my notes, I realize that as my capacity to "just be" with Rose grew, my descriptions of each session gradually evolved from a notation of symptom description to an understanding of Rose as a person, struggling to make sense in and of her world. I learned, from Rose, from my supervisor, and even from my own treatment, what it meant for Rose to have a space to be herself, even when that self hated her child, her husband, her mother, her therapist, or her own self. I felt significantly aware of this when Rose was able to express disappointment towards me when I was 15 minutes late to a session during our second year. This verbalization of her needs and her trust in the strength of our relationship to tolerate negative feelings towards me was especially indicative of transformation.

Rose's relationship with her husband became an increasingly important topic. She described an unequal distribution of care taking and attention to household chores, and her husband's continued anger about Rose's inability to successfully "get" their child to sleep each night. As we looked at their interaction style, we noticed a tendency for Rose's husband to respond to her as though she were a child and I became increasingly aware of her child-like presentation with me as she spoke about this. Rose's guilt over having negative feelings towards her husband was reminiscent of the guilt over having negative feelings towards her son. We revisited what Rose did with her feelings and the importance of giving herself permission to feel without shame.

Rose's sense of agency came into focus at this point in treatment. She initially described herself and her situation using passive words and identified her only option as continuing with her marriage in its current state "for forever." Interestingly, around the beginning of our second year of work together, Rose's husband was fired and Rose began working in an office management position at her father's company and was now contributing to the majority of the family's finances for the first time. Rose's husband became depressed, while continuing to angrily invalidate her competency as a mother. I noticed myself feeling incredibly angry towards Rose's husband and in supervision, we explored the possibility that I was feeling the anger that she did not permit herself to feel.

Around six months into treatment, Rose informed me that her husband wanted to speak with me. I was surprised by this and asked Rose what she imagined he wanted to talk about, to which she assumed he wanted to know "how I'm doing." And how do you think you're doing? I asked. Rose described feeling better than before she started therapy and it was clear that the messages of incompetency she was

receiving from her husband were inconsistent with her internal growth. Rose gave me permission to speak with her husband, but it remained unclear if she felt as though she had any choice in the matter. I clearly articulated my alliance to Rose and that the purpose of this conversation was to listen to what her husband had to say, not to divulge what had been discussed between Rose and myself.

During our phone conversation Rose's husband expressed frustration that Rose was not keeping the house clean and that she had given their baby "scalding hot" milk that could have burned him. He demanded my opinion of whether or not Rose was "improving" as she did not seem much better to him. I felt cornered and as though I needed to defend not only Rose's ability to be a good mother but also my ability to be a good therapist. While feeling pushed to, I did not share details of our work, other than my observation that Rose seemed well equipped to handle the difficult demands of being a mother and a wife. I felt confused, as the Rose described by her husband did not match the Rose I knew in session. Rose's husband seemed to have no patience for Rose's experience and I wondered if he had forgotten that she was hospitalized on an inpatient unit not long ago. I noted feeling exasperated by the end of the conversation and glad it was over. It was hard to imagine going home to him each day, as Rose did.

In the next session, Rose told me that her husband had identified five points he would like Rose to improve upon before deciding whether or not to separate from her. In the middle of relaying this, Rose looked at me and stated, "You look so sad for me!" and became tearful. I was not aware of my facial expression at the time. I do know that my feelings about Rose's marriage and how she saw herself within her marriage were surfacing strongly.

As Rose spoke about her marriage falling apart, it was clear that she struggled to see herself as valuable without her husband. I found myself frustrated, annoyed, and angry at times with Rose's inability to stand up to her husband and hated the thought of her being kicked around. My supervisor and I butted heads during this time as he focused on the destructive potential of my wanting to impose myself onto Rose and her marriage and I found myself feeling kicked around in supervision, my own ability to stand up to my supervisor wavering. This parallel process was multi-dimensional as I now recall how much I struggled to question my analyst's interpretations in my personal treatment and I seemed to accept everything she said as the ultimate truth. I have always assumed that I was experiencing the anger that Rose felt unable to express in her marriage. Now I wonder, was Rose the target of the anger I felt unable to express in my supervision and analysis? It seemed both of us wanted a place for our own voices and to have some feeling of validation in that regard.

Throughout this period, Rose was sometimes child-like and seemed to cling to her husband and other times she was whimsically optimistic about their marriage. But she also expressed wanting to tell him to "just leave then!" There were also many sessions when Rose spoke about everyday things happening in her life and I felt significant uncertainty of what to do with these sometimes agonizing surface level sessions that didn't feel deep enough for therapy. However, something happened in these moments when Rose relayed her day to day life with me as she slowly began to question herself less, to think about her husband's behavior more objectively, and to acknowledge her right not to agree with her husband when he put her down. Not surprisingly, as Rose became more secure, her husband began to threaten that he would leave her, saying that he remained unsatisfied with her housecleaning, cooking, and attention to him. For the first time, we explored what it would be like if Rose did not have her husband, which required her to accept this as a possibility and tolerate thinking about what largely felt intolerable.

Amazingly, while there was a clear termination date based on the ending of my post-doctoral position, Rose initiated and guided the process herself. Around five months before my position ended, Rose introduced the possibility of meeting every other week as she was becoming "too busy" with work and generally living her life. She identified her fears and she imagined the impact this might have on our

relationship and on her mental functioning. But she also wanted other forms of support and activity “that is just for me,” to continue meeting the needs that were met in treatment.

As we headed towards ending, Rose’s reactions to her husband were marked by an awareness that she was not fully responsible for her husband’s feelings and actions. There was a spontaneity that was not there when we first began our work together and her sense of humor indicated a relatedness and social maturity that allowed us to interact with one another as two adults. Rose’s son also had his second birthday three months prior to our final session and this anniversary held many reasons to celebrate. As our last session neared, Rose expressed ambivalence towards me (“Why can’t you stay here?” and “I’m sure you’re tired of me”); towards termination (“I’ll work with someone else, so I’m not that sad” and “Why can’t I pay you and hire you?”) and towards treatment (“I don’t really have anything to keep working on” and “I need to keep talking to someone.”). The process of termination contained all of this and I shared that it would take getting used to for me as well, as our work was special to me too.

I will remember for a long time a particular session near termination during which Rose commented on the orchid growing in my office. The majority of the session focused on our shared appreciation for flowers and how difficult it can be to keep orchids, a beautiful and particularly stubborn and needy flower, alive. Quite a metaphor for parenthood, I commented at the end of the session. Rose got it. Moreover, she brought me a bouquet of flowers on our last session.

It is important to note that this treatment existed within a larger system of treaters. In addition to seeing me individually, Rose met with a psychiatrist every two weeks and was initially involved in an intensive outpatient group program. I worked closely with her psychiatrist and I believe our mutual respect for each other was imperative to the provision of cohesive and caring treatment. My supervisor and I also worked closely on this case, the security of which contributed to my own sense of safety and willingness to think about the case and my interventions and reactions openly and honestly. I must also highlight how committed to her treatment Rose was. She remained in contact with me if she was going to be late or needed to cancel and, although her ambivalence around medication was present at times, she never missed an appointment with the psychiatrist and generally took her medication as prescribed. Additionally, Rose’s intelligence served as a protective factor and permitted the more dynamic work to occur.

While acquiring Rose’s consent for me to have access to her record in preparation for this paper, she requested that I call her as she wanted to find out a bit more about what I would be using her information for. Good thinking! I thought. She picked up my call and greeted me with an enthusiastic hello and commented that she was at the library with her son. I could hear him happily talking to himself in the background. It was a gift to hear both of them. During our conversation, Rose volunteered that she was still taking her medication and that the psychiatrist who resumed therapeutic work with her after I left had been very helpful, but that they have been speaking about connecting Rose with someone who could meet with her every week “like we used to.”

Rose also shared that she had decided to divorce her husband after finding out he was unfaithful to her. She acknowledged things had been difficult for a while but that she was doing fine. I quickly felt myself filled with what I imagine a proud mother would feel as I reflected on the Rose I was now speaking with in comparison to the Rose I first met four years ago. I thanked Rose for sharing this with me and expressed that I felt completely confident in her capacity to continue making good decisions for herself and her son. It was a very brief conversation, but it felt as though it held two years worth of work.

Rose’s postpartum case is one of very severe difficulties and presentation. Certainly not all mothers who present with postpartum concerns experience the same level of intensity and for the majority of women,

pregnancy is a wonderfully joyous event, the outcome of which may actually be an increase in self-esteem and enhanced connectivity with one's partner and family. What makes the postpartum topic so important is that the unrealistic expectation that motherhood is experienced, in all of its mental, psychological, and bodily demands, as completely desirable at all times often leaves many women feeling ashamed of all the mixed, complicated and sometimes quite negative feelings they may have towards being a new mother. This shame can contribute to much hesitancy to look for support, including formal mental health care or informally reaching out to friends and family, which can lead to a cycle of increased shame and further isolation. When mothers do present for mental health services, it may take some time for the woman's true feelings towards motherhood to come out and professionals may be inclined to miss the connection between the presenting concern or clinical presentation and the new role of mother as was the case with Rose in her initial hospitalization, even in her extreme presentation. And there may also be a tendency to miss the more nuanced examples of postpartum struggling if we are only looking for extreme presentations of depression or psychosis. The day to day reality of motherhood not matching one's ideal fantasy can lead to feelings of sadness, failure and incompetence, all of which is meaningful regardless of whether the presentation meets the requirements for a postpartum diagnosis. It is important that we approach the topics of pregnancy, parturition, and motherhood with an absence of judgment, assumption, and expectation so that the mother feels safe to share her true range of feelings about this tremendous shift in her life.

While Rose's case was certainly an extreme presentation, I hope that this work suggests the necessity of approaching motherhood from an understanding that this role does not exist in a vacuum. Whether pregnancy was planned, accidental, forced, or any combination; whether the woman is single or partnered and the dynamics that exist around this area of her life; the context of her relationships with her own mother or parental figures; if the baby is healthy or unhealthy; the cultural expectations around motherhood; the list could go on and on but all of this plays a role in the understanding of motherhood and deserves a space in the course of treatment.

While thinking about this case and the topic of "Conflict with the Real World," I am reminded of Rose's struggle, which I think many mothers experience, to find a space for her feelings that did not align with the real world's messages about motherhood. Psychoanalysis asks us to bring to the surface that which we are (internally, interpersonally, and culturally) pressured to push deep down. And treatment not only asks us to acknowledge the existence of our conflicts and the parts of ourselves we do not want to see, but to open the door and invite these parts in for coffee. As our work evolved, Rose developed an increased capacity to think about her feelings and to feel her feelings without shame.

When I was talking with my own mother about this paper, she was reminded of an interaction we had when I was very young. We were eating dinner and I asked for her last bite of food. Without hesitation, she gave me everything she had left on the plate. I imagine I had no concern if she was still hungry and was only worried about feeding myself. After I finished her food, I apparently told my mother that I did not want to have children because I didn't want to have to give them my last bites. As we laughed about this interaction together as adults, my mother commented this is "just part of being a mom" and I continue to think about the experience vs the expectation of sharing vs sacrificing one's food/needs/wants/body/time/space/energy for another and how muddled maternal expectations, fears, and wishes can be. As I think about my mother's sentiment with relation to Rose, successful treatment seemed contingent on supporting the part of Rose that wanted to give of herself to her newborn and on accepting, and facilitating Rose's acceptance of, the part of her self that did not want to give up her "last bites of food."

References

Hoffman, I. Z. (1983). The patient as interpreter of the analyst's experience. *Contemporary Psychoanalysis*, 19, (3), 389-422.

Kramer, S. B. (1996). "Betwixt the dark and the daylight" or maternal subjectivity: Meditations on the Threshold. *Psychoanalytic Dialogues*, 6 (6), 765-791.

Nicolson, P. (1999). Loss, happiness and postpartum depression: The ultimate paradox. *Canadian Psychology/Psychologie Canadienne*, 40 (2), 162-178

Pines, D. (1972). Pregnancy and motherhood: Interactions between fantasy and reality. *British Journal of Medical Psychology*, 45 (4), 333 - 343.

Rich, A. (1976). *Of woman born*. New York: Norton.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. *The International Journal of Psychoanalysis*, 41, 585-594.