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PSYCHODYNAMICS OF POSTPARTUM DEPRESSION

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Although there are numerous articles and books about postpartum depression, few are psychoanalytically informed, and the psychodynamics of women suffering from postpartum depression are overlooked in most of these publications. Psychoanalytic reports concerning postpartum depression are few, but clinical experience and the literature suggest that a triad of three common, specific emotional conflicts is typical of many women who develop postpartum depression. For simplicity, these are dependency conflicts, anger conflicts, and motherhood conflicts. The dependency conflicts typically have a counterdependent form, the conflicts over anger characteristically include a great deal of guilt and inhibition, and there are often problematic identifications with the woman's own mother (and father) with associated conflicts about motherhood. The frequent counterdependent attitude tends to limit participation in extensive psychotherapy, contributing to the paucity of psychoanalytic contributions on this subject.

Keywords: postpartum depression, postnatal depression, counterdependent, anger, motherhood, psychodynamics

In recent years, postpartum depression (PPD) has received a great deal of attention in both the medical literature and the popular press, and is now the subject of discussion even in state legislatures. The Pennsylvania House of Representatives in May, 2005, approved a bill that "would require doctors or midwives to give pregnant women information about the symptoms of prenatal depression, postpartum depression, and psychosis," and related bills have been passed or are pending in other state legislatures (Burling, 2005). Both the *New England Journal of Medicine* and the *Journal of the American Medical Association* reviewed this syndrome in 2002 (Wisner, Parry, & Piontek; Miller). A spate of books on the subject has been published for the general reader (e.g., Kleiman & Raskin, 1994; Huysman, 2003), celebrities have written books about their experiences with postpartum depression (Osmond, Wilkie, & Moore, 2001; Shields, 2005a), and guides for clinicians (Dunnewold, 1997; Altshuler et al., 2001) have appeared. None of these materials, however, take account of the psychodynamics of the women suffering with this disorder.

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At the same time, postpartum depression has received relatively little notice in the psychoanalytic and psychodynamic literature. In this article, I will argue that postpartum depression is frequently characterized by three specific dynamic features: dependency conflicts, typically with a counterdependent adaptation; guilty inhibition of anger toward others; and conflicted identifications of the patient with her mother. I will further suggest that prompt psychotherapeutic attention to these matters often facilitates rapid symptomatic recovery.

I will start with a brief review of the typical symptoms of postpartum depression, discuss the literature on the subject, and then describe the typical dynamic constellations noted above. Finally, I will present a detailed initial interview with a patient struggling with postpartum depression to illustrate the appearance of these usual conflicts in the clinical setting.

Typical Symptoms

Postpartum depression must first be distinguished from baby blues and from postpartum psychosis. Baby blues occur in the few days after birth and are characterized by sadness, tearfulness, and irritability. Although baby blues appear to be heavily influenced by the huge changes in hormone levels that have just occurred, psychological factors must always be assumed to be present as well—after all, few things change a woman's life more than having a baby. In their connection to hormonal changes, baby blues may be analogous to premenstrual syndrome (PMS). Baby blues are very common and are usually transient, but if severe or persistent, they can develop into postpartum depression (Hannah, Adams, Lee, Glover, & Sandler, 1992; Henshaw, Foreman, & Cox, 2004).

Also important to distinguish from postpartum depression is postpartum psychosis, in which frank loss of reality testing occurs, with the presence of delusions and/or hallucinations. Postpartum psychosis is much less common than postpartum depression, but it is an urgent matter requiring prompt consultation, institution of anti-psychotic medication, and, potentially, hospitalization. Although reactive, transient psychoses do occur, often a postpartum psychosis represents new onset or recurrence of manic-depressive or schizophrenic symptoms. Although some postpartum psychoses may share dynamic features with postpartum depression, they are not the subject of this article. Neither are those postpartum depressions which are part of a manic-depressive syndrome. When a postpartum depression represents a new onset or recurrent episode of manic-depression (bipolar disorder), the biologically propelled, manic-depressive features of manic excitation or depressive hypersomnia and anergia may be dominant, eclipsing the various psychological features. But since most postpartum depressions are unrelated to manic-depression, the characteristic struggles concerning dependency, anger, and conflicted maternal identifications are generally readily visible to the informed observer.

Postpartum depressions are common. Incidence rates depend on the population studied and instruments used; estimates are often given in the 10–15% range (Kumar & Robson, 1984; Robertson, Grace, Wallington, & Stewart, 2004), but incidence reports of 3.6% (Van Ballestrem, Strauss, & Kachele, 2005), 23% (Baker et al., 2005), and even higher (Howell, Mora, Horowitz, & Leventhal, 2005) can be found. There are no specific, generally accepted criteria for time after delivery for a depression to be considered a postpartum depression, but typically these depressions occur within the first nine months after the baby's birth, often within the initial weeks or months. Postpartum depressions occur with increased frequency in those who have experienced depression previously and

in those who have become depressed during pregnancy (Robertson et al., 2004), but often occur in women with no prior recognized history of depression. Outwardly, the depression may have very typical depressive features including sadness, crying, insomnia, or excessive sleep, low mood, low energy, loss of appetite, agitation, and self-critical thinking. There is often a substantial component of anxiety; sometimes anxiety or exacerbated obsessive and compulsive symptoms may be the predominant features of a postpartum adjustment problem with relatively little depression. One must always be concerned as to whether a depressed patient may be suicidal, and with a postpartum patient it is sometimes also necessary to inquire tactfully about fantasies of injuring the baby.

Literature Review

The medical and general psychiatric literature contains articles exploring the etiology of postpartum depression, risk factors for it, and treatment of it. Although consideration of psychodynamics in this literature is quite uncommon, and a comprehensive review of this rapidly expanding body of literature is beyond the scope of the article, selected aspects of it are important to note here.

As PPD is descriptively like other depressions, some authors (Riecher-Rossler & Hofecker, 2003) have recently questioned if the use of the term "is still justified in light of recent research." They conclude that "Although postpartum depression is not a specific entity from an etiological point of view, the diagnostic term. . . should not be abandoned, as depression in the postpartum period confronts us with specific needs for care." Most contributors to the PPD literature have not questioned the use of the term, but many have attempted to understand it without a focus on concerns specific to motherhood. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; 4th ed.) does not list PPD as a distinct disorder, but offers the possibility of adding a "postpartum onset specifier" to other mood disorder diagnoses. Maternal psychology has had no place in strictly descriptive diagnosis. In contrast, Brooke Shields, in her book about her postpartum depression, immediately acknowledges her doctors specifically "for their support and expertise with regard to my journey into motherhood" (2005a, p. ix) and begins her book with a parable of "a little girl who dreamed of being a mommy" (p. 1).

Noting the major hormonal changes that occur with birth, much of the general psychiatric literature has focused on biological inquiries into etiology. Numerous studies have examined the potential roles of estrogen, progesterone, testosterone, prolactin, oxytocin, cortisol, biogenic amines, and other physiological agents in relation to postpartum depression (Zonana & Gorman, 2005): "However, despite extensive investigations, there has been no major study demonstrating a direct association between these [hormonal] changes and subsequent major depression" (Harris, 2002, p. 407). Similarly, "studies of various neurotransmitter systems and other neuroregulators have not provided evidence that any one distinguishes women with postpartum depression from women without postpartum depression" (Llewellyn, Stowe, & Nemeroff, 1997). The strongest evidence so far for a biological contribution to PPD, it seems to me, is the finding that some women may have an elevated mood reactivity to hormonal changes, and that a history of premenstrual dysphoric disorder or of mood symptoms with oral contraceptive use appears to predispose to PPD (Bloch, Rotenberg, Koren, & Klein, 2005). Although constitutional factors no doubt contribute, and more compelling biological findings may yet be discovered, they will not address the fact that postnatal depression has been

observed in adoptive mothers (Bental, 1965), and increasingly is noted in fathers (Matthey, Barnett, Ungerer, & Waters, 2000; Goodman, 2004; A. Bergman, 2004; L. Blum, 2004).

Numerous predisposing factors have been identified in epidemiological studies of PPD. Prior depression and prior postpartum depression are well-established risk factors for PPD. Additional risk factors include depression or anxiety during pregnancy, low levels of social support (especially in the marriage), and experience of stressful life events during pregnancy or the early postpartum period (Robertson et al., 2004). Unwanted pregnancy, not surprisingly, is also found to be a risk factor (Leathers & Kelley, 2000). Potentially contributing but less well established variables include Caesarian birth (Hannah et al., 1992), a history of infertility, illness in the infant, isolation from family and friends, and a poor match in temperament between mother and child (Herz, 1992). As mentioned above, prior premenstrual dysphoric disorder and of "mood symptoms" with oral contraceptive use have recently been correlated with later PPD (Bloch et al., 2005). Persistence of PPD in an inner city population was correlated with the presence of additional young children at home (Yonkers et al., 2001).

Of particular note to this essay are a handful of studies that point to specific psychodynamic factors that are closely related to the dynamics under discussion here. Uddenberg and Nilsson (1975) found self-reports of poor relationships of women with PPD with their own mothers, but until recently studies concerning maternal psychology seem to have received little attention. Gotlib, Whiffen, Wallace, & Mount (1991) used a measure of perceptions of care received from respondents' mothers and fathers and found that compared to controls, women with PPD "demonstrated significantly more negative perceptions of the amount of caring they had received from their own mothers. . .and fathers." McMahon, Barnett, Kowalenko, & Tennant (2005), using self-report measures, found that "reports of low maternal care in childhood, marital dissatisfaction at 4 months, an attachment style characterized by anxiety over relationships and immature defense styles were significant predictors of clinically elevated depression scale scores at 12 months." Matthey et al. have found that not only was a woman's relationship with her mother correlated with postpartum mood, but that for the father, too, his reported relationships with his mother and his father were correlated with postpartum mood (2000). It appears that studies using self-report scales have begun in this instance to offer data of increasing psychodynamic relevance, and which clearly correlate with the third of the three factors emphasized here. Although I can find no empirical study that addresses the role of anger and guilt or of counterdependency in PPD, occasionally authors have picked up on a pattern of unrealistic expectations to be an idealized mother who selflessly and capably takes care of children, home, partner, job, and so forth (Adcock, 1993). Usually, this has been viewed almost as much a societal expectation as something emotionally driven that some women impose upon themselves.

Closely related to psychological factors, cultural factors are clearly important in PPD, as evidenced by crosscultural variability in incidence rates, differences in how and whether postpartum disturbances are regarded as illness, and differences in risk factors such as an increased tendency toward PPD with the birth of a female child in some societies (Adewuye, Fatoye, Ola, Ijaodola, & Ibigbarni, 2005). The crosscultural literature on PPD is burgeoning (Affonso, De, Horowitz, & Mayberry, 2000; Posmontier & Horowitz, 2004) but beyond the scope of this essay.

Despite the paucity of biological findings and the increasing evidence for psychological factors from both childhood and current life, the medical and psychiatric literature emphasizes the former and frequently overlooks the latter. The following, from the Expert

Consensus Guideline Series (Moline, Kahn, Ross, Altshuler, & Cohen, 2001), remains typical of psychiatric and medical commentary: "We don't know exactly what causes postpartum depression, but research points toward hormonal factors that may in turn affect brain chemistry." The authors add that "Research is being done to find out about other biological and social problems that may be involved." Psychology, and the mind, are unmentioned. It is worth noting that in the nonanalytic literature, even when psychology is acknowledged, analytic ideas tend to be overlooked. In an article entitled "Theoretical Perspectives of Postpartum Depression and Their Treatment Implications," Beck (2002) discusses the medical model, feminist theory, attachment theory, interpersonal theory, and self-labeling theory. Two of these, attachment theory and interpersonal theory, are derived in part from psychoanalysis, but analytic ideas per se, particularly of intrapsychic conflict, are nowhere to be found.

With regard to treatment, two studies have compared medication and cognitive-behavioral therapies for PPD, and in both studies both treatments were effective (Appleby, Warner, Whitton, & Faragher, 1997; Misri, Reebye, Corral, & Milis, 2004). The majority of women with PPD appear to be more accepting of (and willing to participate in studies of) individual psychological treatments than of medication or group therapies (Cooper, Murray, Wilson, & Romaniuk, 2003). Studies of psychological treatments of PPD are growing in number and have been recently reviewed (Kopelman & Stuart, 2005). Most nonpharmacological treatment studies in psychiatry employ cognitive–behavioral therapy, or occasionally, interpersonal psychotherapy (O'Hara, Stuart, Gorman, & Wenzel, 2000), but the PPD literature is notable for including other interventions, such as "non-directive counseling" and home-visits from health care workers. Nurses providing such counseling are trained to listen nonjudgmentally to whatever concerns may occupy the new mother. Two studies have found home visits centered on this intervention to be highly beneficial (Holden, Sagovsky, & Cox, 1989; Wickberg & Huang, 1996). The typical psychological situation in PPD, as I suggest above and elaborate later, is of conflicted, denied, and often reversed wishes to be taken care of, often with a feeling of having been unsatisfactorily cared for by one's own mother. It makes sense that nondirective counseling home visits from sympathetic nurses, which could help to address dependent wishes without obliging patients to acknowledge them any more than they can, would show significant therapeutic potential. Although nondirective counseling may be a reasonable first approximation for the early stages of a psychoanalytic approach, it was contrasted to "psychodynamic psychotherapy" in the one study purporting to employ psychodynamic psychotherapy. Each was carried out (along with a more behavioral approach and "routine primary care" as the other two groups in the study) in 10 weekly sessions, and the "psychodynamic psychotherapy" was relatively directed so that "an understanding of the mother's representation of her infant and her relationship with her infant was promoted by exploring aspects of the mother's own early attachment history" (Cooper, Murray, Wilson, & Romaniuk, 2003). (There is of course an irony in giving a therapy aimed at exploring a specific subject the unqualified name, "psychodynamic psychotherapy.") At the end of the treatment phase, all three psychological interventions were superior to the control on the Edinburgh Postnatal Depression Scale, and "psychodynamic psychotherapy" also demonstrated a significant reduction in depression on the Structured Clinical Interview for *DSM–III–R* (3rd ed., revised). By several months after the treatments had ended, there were no longer significant differences, as increased numbers of the control group recovered. Even with a recent, sophisticated study such as this one, the numbers were small from a statistical viewpoint, and from a psychoanalytic

perspective, the treatments were very brief, and it is difficult to know, psychologically, what actually happened in them.

Popular Literature

The popular books on PPD tend to be less medically reductionistic than the majority of the medical and psychiatric literature. They provide good descriptions of what women with PPD consciously feel and experience, are often agnostic about etiology, and emphasize the importance of medication, social support, and counseling in treatment (e.g., Kleiman & Raskin, 1994). A few of the books, especially the first person accounts (e.g., Osmond et al., 2001; Shields, 2005a), begin to suggest a dynamic picture that is typically unremarked in much of the medical and psychiatric literature. The authors describe a pattern of counterdependent care-taking of others, at times with elements of cheerful martyrdom where anger might be expected. Entertainer Marie Osmond, toward the end of her book about her postpartum depression and recovery, comments that "women, who are so good at finding solutions for other people's problems, would have tremendous power if we would acknowledge our own needs as well" (Osmond et al., 2001, p. 184). Actress Brooke Shields (2005a) describes reassuring an anesthetist that her pain was improving as it became increasingly excruciating. (Her doctor later discovered that the drug delivery system was not connected.) The degree to which her life and career were minutely directed by her mother is well known, and the book describes her sudden rage at her mother's self-concerned reaction to her difficulties, as well as the difficult struggle to become psychologically independent of her mother that was precipitated by the birth of her baby. Despite this, also visible in Shields' writing (and she is not unusual in this respect), is the inclination at times to take comfort in the denial of psychological factors and the promotion of the idea of simple biological causation. In her much-discussed *New York Times* op-ed reply to Tom Cruise, Shields stated flatly that "Postpartum depression is caused by the hormonal shifts that occur after childbirth" (2005b).

The popular literature, in summary, thus appears to corroborate some of the psychological findings in the empirical literature; further, all three of the conflicts emphasized in this article can be discerned in it, even if they are not noted as such.

Psychoanalytic Literature

This review of the psychoanalytic literature begins with a historical vignette.[1] A young woman gave birth to her first child and was then overcome by loss of appetite, vomiting, insomnia, and anxiety; she was unable to adequately nurse the baby. After weeks of struggle, to prevent further risk to the mother and the baby, the baby was given over to a wet-nurse to feed (this being the early 1890s and baby formula not yet having been invented.) Three years later, with the birth of a second baby, the same symptoms recurred. On the fourth day of frightful postpartum struggle, Dr. Sigmund Freud was called to visit (Freud, 1892/1953).

Freud visited the new mother that evening. He hypnotized her and provided the typical posthypnotic suggestion that from then on everything would go well, her symptoms would

[1] This vignette is discussed in detail in a paper by Harold Blum (1979), "The Curative and Creative Aspects of Insight."

disappear, and she would eat well and nurse the baby readily. For half a day after Freud's departure, the woman ate sufficiently and nursed satisfactorily. A return visit the next evening found the woman again overcome by the same difficulties. On this occasion, Freud provided a much more psychologically intuitive, different sort of hypnotic suggestion: "I told the patient that five minutes after my departure she would break out against her family with some acrimony: what had happened to her dinner? Did they mean to let her starve? How could she feed the baby if she had nothing to eat herself?" Freud returned the following evening to find that everything was fine, with his patient eating well and with plenty of milk for the baby, although the husband commented that he had thought his wife's behavior after Freud's departure the prior evening to have been rather odd.

In contrast to many more recent publications noted above, here is a description of an intervention that takes into account the mother's mind, specifically her emotional conflicts. Freud's intervention explicitly attends to the mother's own sense of needing to be taken care of, and to her anger if she feels she's not being taken care of. He apparently sensed that she was reluctant to ask to be taken care of and had difficulty acknowledging and expressing her anger over this unmet wish or need. Freud was well aware of the importance of biological factors, although hormones had yet to be discovered. But in this instance, while making observations that laid the foundations for the later development of psychoanalysis, he intuitively took note of essential psychological factors in postpartum disorders.

Although they are relatively few, later psychological descriptions of patients with postpartum depression demonstrate these same concerns. Gilman (1965) reported a case of a woman with a postpartum depression. Quickly discerning that her counterdependent adaptation could not sustain her in a time of surpassing need, he asked her whether she might in this instance reasonably allow some of her relatives to help her out. She did, her depressive symptoms quickly remitted, and she promptly reverted to form, insisting that she needed no further help from Gilman. Raphael-Leff (1996) reported a case of a woman with postpartum depression with similar features to those described here. An important additional factor in that instance was the woman's hatred of the baby's father. Halberstadt-Freud (1993) presented the thesis that "the woman's unresolved *symbiotic illusion* [italics original] with her mother plays a central role in postpartum depression. A few years later, Halberstadt-Freud (1998) reported the case of a different patient whose struggles were characterized by dependency and who, in the course of treatment, became aware of how much anger she had at her neglectful mother, whom she supported. Earlier authors emphasized psychosexual conflicts. Orens (1955) described a case of postpartum depression highlighting female castration conflicts. Rose (1962) mentioned a case of postpartum depression in which "depression was largely based on need for punishment for the unconscious oedipal gratification of the transference pregnancy and birth."

Several analysts have described the tendency toward postpartum depression following the birth of a child with congenital defects (Niederland, 1965; Castelnuovo-Tedesco, 1981; Mintzer, Als, Tronick, & Brazelton, 1984). Although Helene Deutsch did not discuss postpartum depression per se, she was the first analyst to write extensively about motherhood. Much of her theorizing has not aged well, but some of her observations are pertinent to the present essay, for example, "women who have not received maternal love in their childhood—whether from their mothers or substitute persons—develop less motherliness than others" (1945).

The most sophisticated and detailed discussion of a patient with postpartum depression in the psychoanalytic literature is in a paper by H. Blum (1978). The report is notable for the careful reconstruction of a strained early relationship between the patient and her

mother, aggravated by traumatic conditions surrounding the birth of a sibling when the patient was two years old. Intertwined difficulties with separation-individuation and psychosexual development are emphasized. In most respects the patient fits the profile of patients with postpartum depression that I have seen repeatedly and describe here. She had pronounced oral-dependent concerns, difficulty regulating her anger, and very conflicted identifications with her mother. The main difference is that while this woman had some features that might be regarded as counterdependent, these were not marked in comparison to the strength of her inclinations to seek help and love, to eat and incorporate. This balance toward the dependent, rather than counterdependent, side may be part of what enabled this woman to engage in a psychoanalysis, rather than to dispense with assistance at the first possible moment, as do so many patients with postpartum depressions, including Gilman's, and also the patient to be described here. It may be precisely this counterdependent tendency to minimize treatment that has led to the paucity of psychoanalytic articles on PPD.

Menos and Wilson (1998) carried out what appears to be the only empirical study of psychoanalytic ideas in postpartum depression. They hypothesized that women with postpartum depression would exhibit regression in affect tolerance, affect expression, and sense of personal agency as measured by the Epigenetic Assessment Rating Scale. Comparing groups of women with postpartum depression, nondepressed postpartum women, and a control group, they found that women with PPD demonstrated a tendency toward "earlier modes" of affect tolerance, affect expression, and personal agency compared to controls. Postpartum nondepressed women were similar to the control group on most measures, but in response to a "high stress" projective stimulus, these women scored similarly to PPD women on some measures. Menos and Wilson suggest that these results show that the postpartum state indeed prompts a regressive trend, but that in a healthy person adaptive flexibility is present and the regressive trends are reversible.

The psychoanalytic literature thus notes a broad range of conflicts associated with PPD. A couple of authors in the 1950s and 1960s connected oedipal and female castration conflicts with PPD, while later commentators have more consistently emphasized "pre-oedipal" conflicts. Counterdependency is noted in several instances, and problematic relationships with mother in several others. It is likely that in a particular case any of a variety of conflicts may be contributory. Analytic case reports are important in identifying the pertinent intrapsychic conflicts in PPD, and the psychoanalytic literature seems to me to be quite consistent with the heuristic triad presented in this article. A larger number of analytic clinical reports would assist in the process of assessing what conflicts are most typical and thus of confirming or disconfirming the arguments made here.

Three Principal Emotional Conflicts

In the course of 20 years of independent practice of psychoanalysis and psychiatry, I have had the opportunity to evaluate and treat many women suffering with PPD. Literature, theory, and experience lead me to suggest that clinicians caring for pregnant and postpartum women should keep in mind a triad of emotional conflicts concerning dependency, anger, and motherhood. The prominence of each of these varies from one person to another, as does the admixture of other conflicts that contribute to individuality; of course, circumstances such as the marital relationship, difficulties conceiving, and so forth, also vary widely. In every case I can recall, at least two of these conflicts have been prominent.

Dependency Conflicts

Freud's insightful, second intervention with his patient highlights what in my experience is the most common conflict troubling women with postpartum depression: dependency conflicts. In order to care for a baby, it helps if the woman herself feels taken care of. As dynamically informed clinicians know, every human being has dependency wishes and needs. No one fully outgrows the infant's and child's pleasure in being taken care of. These wishes, however, become conflictual, and rather early in development come to be regarded as juvenile or embarrassing. (The ubiquitous childhood put-down, "You suck!" speaks to the usual antagonistic feelings toward childish, oral-dependent wishes.) But a recent mother, in order to do all the work and endure all the deprivations involved in caring for a newborn, needs to be taken care of. She must also cope with her own emotional reactions to the baby's needs and demands. The baby may arouse the mother's own unconscious needy wishes and stir up envy of the baby's advantageous position in having these wishes to be cared for and fed realized. If she can accept her dependent needs and ensure that she is in fact taken care of, and if she can tolerate her baby's dependency and her reactions to it, she is unlikely to develop a postpartum depression. If she cannot, she may be at risk.

Some people, including many health professionals, fend off awareness of uncomfortable dependency wishes by taking care of others: "I don't need to be taken care of; see, I'm taking care of you." This type of "counterdependent" adaptation works well for many people. But if the number of people and things to be taken care of become too great, and if one's own unfulfilled needs to be taken care of become too raw and too great, the counterdependent system breaks down. This is the case for many women who develop postpartum depression. A husband, home, job, and a child may be manageable, but one more child may be the "straw that breaks the camel's back." At the postpartum visit, the obstetrician is surprised: a patient who looked like she could handle everything is suddenly falling apart. The patient, of course, may be equally surprised. But women who need to prove they can handle everything, with no assistance, may be especially vulnerable and require special attention.

A second group of women at risk for postpartum depression is more apparent: those who have no one available to take care of them, those with few familial and social supports. Their dependent wishes to be taken care of will go sadly unfulfilled whether they acknowledge them or not.

Anger Conflicts

Freud's intuitive intervention with his patient also took into account a second characteristic struggle of women with postpartum depression: difficulty with anger. Freud's patient apparently was hesitant to express her angry feelings and did so only after Freud used his medical authority to suggest that she should. Expressing them was useful: her family responded by taking better care of her, enabling her to take care of the baby. She may also have felt less guilty and frightened about her anger once it was no longer hidden and smoldering inside her.

Many women with postpartum depression have difficulty handling anger. They sometimes feel they do not have a right to be angry, feel guilty about being angry, or are frightened about expressing it. Yet they may have a lot to be angry about, from both the past and the present. Worse, much of the intolerable anger may be focused on the baby. It is the baby who has come along and turned the woman's life topsy-turvy, deprived her of sleep and numerous other customary satisfactions, been fed and cared for while the

mother hasn't, and done little, so far, but drain her. If the new mother can acknowledge and tolerate these feelings, or use them to help get herself some assistance, or a bit of time for herself, she will likely fare well. If she feels excessively guilty or afraid of these angry feelings, she may become increasingly preoccupied with anger at the baby and may develop obsessive thoughts of harm coming to the baby or of harming the baby herself. A significant number of mothers have reported fantasies of microwaving their babies, demonstrating not only the murderous anger, but also suggesting oral, incorporative wishes (related to the dependency conflicts noted above). Accompanying obsessive thoughts and compulsive rituals may serve in disguised fashion to protect against (and also to express) the angry wishes.

The mother may berate herself for her angry and murderous feelings and wishes toward the baby and become depressed, in severe cases suicidal. Many women who develop postpartum depression have rather harsh consciences or superegos, have very stringent expectations for themselves, and visit their anger on themselves just as vigorously as they protect others from it. Although overcontrol of anger, with repression of it and/or guilty self-reproach for it, is a problem, loss of control is an opposite risk, especially in those who tend toward impulsiveness. Occasionally loss of control threatens to follow from overcontrol, as internal pressure builds up. Feeling the anger, tolerating it, and judiciously putting it into words, easy for the clinician to say, is the difficult and essential task for the mother.

Motherhood Conflicts

Many women who develop postpartum depression describe very problematic relationships with their own mothers. They may feel that their mothers were not interested in or did not enjoy taking care of them. As much as she wants to, it can be difficult for a woman to provide the tender, loving care to a baby that she feels (consciously or not) that she herself was denied when she was little. It is easier when the new mother has a positive sense of her own mother somewhere in her own mind and being.

Some women with postpartum depression describe mothers who were physically or verbally abusive. Such women often have vowed never to be like their own mothers, unaware how much their vows suggest their mothers' status as their principal internal models. They have little in the way of a positive image of mother on which to draw, and they struggle against the inevitable similarities that arise between any daughter and mother. Motherhood itself then can become a conflicted, difficult undertaking.

Although many women in this circumstance manage to be much better mothers than their own mothers were, this often takes a lot of effort. Although "motherhood conflicts" such as those noted here may not be universal, and in a brief treatment one may not get the opportunity to know much about them, they are common in cases of postpartum depression. They make the usual conflicts of motherhood, such as deciding the balance between caring for the child(ren) and working outside the home, or setting limits for a child, much harder to negotiate.

Illustrative Case: Mrs. Z

I present here the first and only session with Mrs. Z, in as near-verbatim a format as I can reconstruct. Mrs. Z represents something of a modal case in my experience, perhaps the most frequent or typical picture from within a spectrum.

Mrs. Z is a woman of about 30, casually attired, adequately groomed, and looking tired, sad, and a bit nervous. She speaks readily, with a combination of anxiety and relief.

Patient: I assume this is postpartum depression because the baby's almost 5 months old and I've never gone through this before. This is my third. I'm not enjoying the kids. Everything's a hindrance. I've no interest in sex. My first child weaned at 7 and a half months, the second at a year. My husband thinks I should stop nursing; then I could take antidepressant medication without worrying about it. Everything feels like a gray cloud. I'm tired and drained. Now I have headaches. [She tells me that she takes an occasional fioricet for them.]

Patient: I feel ashamed to come here. I should enjoy the kids; I yell at them. [Tears appear].

I feel so guilty. I go to bed feeling mean. I vow to be better and I'm not.

My husband says, "What can I do for you?" Nothing. He helps. And with everything going on in the world! [that is, "how can I be here complaining"] I feel weak. I cry, complain. It's petty. I don't like to feel dependent. I know people do it [that is, manage things].

Analyst: You sound very dedicated to being independent, strong, not needing help.

Patient: I take pride in handling things myself. I don't ask my father and stepmother to take the kids. My mother's in [a distant state]. I see friends get help. Maybe we need it. My father has heart failure, my stepmother's wacko. I'm uncomfortable to leave the children alone with her. My sister just got a new job. My husband's family I don't want near my kids.

I'm supposed to handle it all myself!

I next learn that she has been married 7 or 8 years, and had a miscarriage before her first child. She describes her husband's work, and her own before staying home with children. On the subject of her husband she adds:

Patient: My husband worries about me; I don't want him to. I'd never harm the children or myself, but he worries.

In contrast to her husband, I get the sense from Mrs. Z that she can be taken at her word on this matter, that she would convey it if she felt these were dangers, and that these are not her main concerns. Somewhere in this part of the interview I ask her if she gets much time for herself, and she estimates that she has about an hour per month, which she uses to get her hair cut.

Analyst: What else should I know? [I also point out that she's said nothing about her background.]

Patient: It was just me and my sister. My parents divorced when I was seven. I moved in with my father at age 10 because I wanted to. Lived with him until I got married. My mother was mean! [Tears]. Mother favored my sister. I was a Daddy's girl. Mother would dance around the house saying he wouldn't come home.

One day my mother beat me with a hanger after my pants got lost in the wash. I told my teacher who called my mother who yelled at me. I told my father; he said he believed me, but did nothing. [Lots of tears.] My father got married to my stepmother. If you want to live with us, my father offered, tell me. After my mother and I fought, I said, "Daddy said I could live with him." My mother said, "If you want to, go." I called him and he picked me up. So I was at my father's; my sister, three years younger, was at my mother's. Everything I fought for, she was given. When mother met my stepfather, my sister and I were at her parents in [another city]. We flew home and mother wasn't there to meet us; the stewardess had to wait. She ran down the corridor with this man following her—what

a jerk, asshole, alcoholic. Had three children of his own. One night he got real drunk and beat mother in front of all of us. Then he went to rehab. They were together 10 years until I was 20. He molested my sister, who said nothing about it until years later.

Thinking, (and a bit later explaining to Mrs. Z) that it did not seem difficult to account for her illness as much as to account for her (until recent) health, I wondered if her earlier years had provided a more solid foundation.

Analyst: Do you have any sense of how things were in your early years?

Patient: I recall my father's back went out; he was in pain and was snippy with us.

Analyst: And your mother?

Patient: I guess she was OK. After my father left—I was 7—she was very mean. He left and came back. He left again the next morning. I was devastated. I never ever forgot. My father said, "I don't love your mother anymore." My mother said, "He met your stepmother." Mother was stay-at-home until I was 5, then back to work. After school, we went to a neighbor's, Mrs. Y.

She described Mrs. Y in favorable terms. I still wondered about potential positive things in her first few years.

Analyst: Do you have any notion, when you were younger, of whether your mother liked being a mother or liked taking care of you and your sister?

Patient: OH, MY GOD, I'M MY MOTHER! I always swore I wouldn't be!

She has surprised and shocked herself (and incidentally contributed more again to understanding her illness than her health). Time permits little further discussion of this important matter. I ask if she's seen anyone in my line of work before; she's had no previous treatment.

Analyst: Are you aware of having a sense of harshness with yourself, severe expectations of yourself?

Patient: I guess so. I should be able to do it with a smile.

I tell Mrs. Z that I agree with her that she has a postpartum depression. I point out to her that she seems to feel the need to do everything herself, that she is reluctant to get help, and feels guilty if she accepts any. This lack of help, however, leads her to feeling angry and resentful, taking it out on her children, and then feeling still more guilty. I say that she seems to me to be very harsh with herself if she does not meet the most exacting expectations, pointing out, for example, how little time she takes for herself. She acknowledges this, I pause, and she waits for me to continue. I add that she also seems worried about similarities to her mother, and that it must be difficult to provide to her children generous, loving care while feeling that this had never been given to her.

Patient: I feel like a light's gone on and I can see that I need to get or accept some help. I want to do this on my own without resorting to medication—I am a nursing mother!

Noting to myself the contradiction and compromise in her response, I ask her thoughts about a further appointment.

Patient: I want to try to manage things on my own, before I make another appointment.

Analyst: So you're doing things now the same way or differently?

Mrs. Z laughs heartily as she sees what she's doing. She obviously feels greatly relieved, but her primary adaptation is, expectably, little changed. As her preference not to have another appointment does not change even with her recognition of her pattern, I ask Mrs. Z to call me in two weeks to let me know how she's doing. She, of course,

compliantly agrees to do so, although I think it unlikely that she will. Not surprisingly, she does not call. I call her three weeks after our meeting and she reports that she is doing very well.

Discussion

I believe that Mrs. Z's counterdependent adaptation, guilt over anger, and problematic identifications with her mother are amply demonstrated by her own comments in the vignette above. Her counterdependent stance is obvious in her comments that she should be able to handle everything herself (and with a smile). She cries when talking of her parents, but mentions no anger in relation to them. Apparently unconsciously identifying with the aggressor, she visits her anger, contrary to her conscious wishes, upon her children, whom she also experiences as her current abusers and deprivers—and then she is intensely guilty. She closely resembles Gilman's patient (and perhaps also Freud's) in her prompt symptomatic recovery and continued counterdependent adaptation. The suggestion from a benign authority that one can accept help, and the acceptance of the minimum necessary amount, is sometimes both therapeutically sufficient and all that is possible. Although this sort of response is not uncommon, obviously many patients need and accept further treatment, and some require medication.

Treatment, of course, must follow from the needs of the patient. When counterdependency is present, it must be addressed immediately, both because it is essential to helping the patient with her struggles and because otherwise no treatment is possible. Those patients who are able to accept additional assistance will typically need help with conflicts concerning anger. As with other depressed patients, many women with PPD have harsh consciences and difficulty tolerating their anger, which frequently is turned against themselves. Some postpartum women, with or without depression, experience an outbreak of obsessive–compulsive symptoms, as they try to control angry, destructive, and murderous feelings and wishes. These symptoms may be short-lived or extended, depending on the woman's premorbid adjustment, how well she responds to the difficulties adapting to motherhood that foster the anger, and on whether she gains increased tolerance of the anger as a result of psychotherapeutic interventions. In brief treatments one may hear relatively little about the mother's experience of her own mother and father. Even when memories of these experiences are close to the surface, they may be painful and difficult to tolerate; their urgent presence may lead some patients to avoid treatment, with its risk of acknowledging them as well as the further, unconscious expectation of repeating them in relationship with the therapist. Others may want desperately to begin to discuss these matters and use this exploration to assist with their development as mothers. In my experience, only relatively few patients become interested in in-depth treatment, and these tend to be instances in which counterdependency is not a marked component.

A significant portion of PPD patients make speedy symptomatic recoveries. Perhaps in some this is assisted by an inner resilience, but I think that counterdependent character lends itself to this. A little bit of help facilitates a quick return to a prior adaptation in which the patient still tries to do as much as she can herself. Now allowing some limited help, she abstemiously gratifies substantial unconscious dependent wishes, and simultaneously denies this as she resumes the position of not needing help and of doing for others. Character is not significantly changed, but crucial symptomatic changes occur quickly. Psychoanalytic therapies have the reputation of taking a long time, but this is an important instance in which rapid recovery is aided by psychoanalytically informed interventions. In

most areas of therapeutic endeavor, the more specific the treatment in relation to the problem, the better the result. I believe that this principle obtains both in psychoanalysis and in short-term psychotherapies. Although I would not recommend a directive treatment based on the emotional conflicts of counterdependency, anger, and parental identifications, I hope that alertness to the frequency in which they are present may help clinicians to make more specific, useful interventions as the material from patients reveals the need and opportunity to do so. More rapid recovery and mastery of the difficulties should be facilitated. Empirical confirmation of specific analytically derived interventions might facilitate their broader acceptance, and with sophisticated enough means (Ablon & Jones, 1998), this could be studied.

Although the psychodynamics of depressions are heterogeneous, the particular dynamics identified here as characteristic of PPD are obviously common elements in other cases of depression. Conflicts over anger and guilt are likely universal in depression, and certainly concerns about internalized relationships with parental figures are typical. Counterdependency, however, seems to me to be an important feature seen much more often in PPD than in other depressions. I suspect that this is true particularly in more economically stable and advantaged populations, rather than in inner city clinic populations, in which social supports are more lacking and needs more pronounced and unmet. (A counterdependent adaptation would seem difficult to maintain at all if one is scrambling to pay the rent.)

There is much less literature concerning postpartum anxiety reactions than PPD, and my experience with them is more limited. It is possible that there will prove to be a characteristic set of dynamics associated with postpartum anxiety reactions, but at this point the literature and clinical experience offer little beyond the suggestion to be alert to the struggles with anger that often seem to propel obsessive–compulsive symptoms.

I would like to summarize the research supporting the heuristic triad of psychological concerns discussed here. Counterdependence is noted in several psychoanalytic reports but has received no apparent attention in empirical research. Among the many personality scales used clinically and in research, I was unable to discover one for counterdependency. Such a scale would, I believe, have immediate utility in investigating the role of counterdependency in PPD. It is one thing for psychoanalytic clinicians to recognize counterdependency clinically, and another for the larger medical and therapeutic community to recognize its importance.

The role of anger and guilt in depression is well established in psychoanalytic literature, and PPD may be similar to other depressions in frequently having this element as an important part of the composite picture. I am not aware of empirical studies specifically addressing the role of anger, guilt, and inhibition of expression of anger in PPD, although I believe they would be useful in the same way that studies of counterdependency would be.

Conflicts concerning motherhood in relation to PPD are well described in the psychoanalytic literature and are now noted in some empirical research as well. Mothers' relationships with their fathers are receiving increasing attention in both areas of the literature, as is depression in new fathers.

Beyond the three factors emphasized here, it is clear that other intrapsychic concerns (e.g., oedipal conflicts or sequelae of childhood losses) are likely to be important in individual cases, and there may prove to be factors that contribute with regularity that have not yet been noted.

Recent attention to postpartum depression is leading to efforts to identify and treat cases early as well as to thoughts of prevention. Preventive and therapeutic efforts, if

successful, have the potential to be helpful beyond the expectant parents, as the detrimental effects of PPD on children are well-documented (e.g., Hay et al., 2001). Although in a recent study (Murray, Cooper, Wilson, & Romaniuk, 2003) the measurable benefits of limited, early interventions to children of mothers with PPD were small, psychoanalytic and psychiatric contributions suggest that efforts to prevent and treat PPD may potentially help not only the mother's (or father's) children, but perhaps future grandchildren as well.

I hope that a convergence of psychoanalytic and empirical research will foster improved treatment for the many people subject to postpartum depression. And I hope that the heuristic triad of factors discussed here can be helpful to both clinicians and patients, as well as to suggest paths for future inquiry.

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