O MOTHER, WHERE ART THOU:
EXPLORING THE TERRAIN OF POSTPARTUM PSYCHIATRIC DISORDER

by

DOLORA DOSSI

A clinical case study
submitted in partial fulfillment
of the requirements for the degree of

DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

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This clinical case study has been accepted for the faculty of the
Institute of Imaginal Studies by:

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Clinical Case Study Advisor
EPIGRAPH

The Great Mother herself spins and weaves because she is the primal embodiment of the triad of the weavers of all things earthly, of growth, of time, of destiny. The primordial lady spins out of her own being the thread of time and weaves it to make the tissue of things, just as the woman spins in herself the tissue of another being’s flesh.

Eithne Wilkins

*The Rose Garden Game*
ABSTRACT

O MOTHER, WHERE ART THOU:
EXPLORING THE TERRAIN OF POSTPARTUM PSYCHIATRIC ILLNESS

by

Dolora Dossi

Postpartum psychiatric illness has been pondered since Hippocrates referred to a postpartum fever in 460 BC. During the 19th century, a systematic approach to identifying postpartum psychiatric disorders was developed. This research advanced theories regarding the etiology, classification, and treatment of postpartum psychiatric illness and promoted the idea that postpartum psychiatric disorders warranted a distinct diagnosis from general psychoses or mood disorders. Since then, progress diminished for nearly 100 years. As of 1980, a resurgence in the study of postpartum psychiatric disorders has emerged. However, the Diagnostic and Statistical Manual of Mental Disorders fails to recognize postpartum psychiatric disorders as a distinct entity. This Clinical Case Study explores the on-going therapy of a young woman who was a first-time mother experiencing symptoms of postpartum depression (PPD).

The literature on postpartum psychiatric illness fails to generate consensus regarding the biological etiology or treatment protocol for postpartum disorders. This lack of agreement lends opportunity for alternative deliberations.
Therapeutic methods in this case study included the use of ritual, hypnosis, art-making, embodiment, and cognitive and narrative techniques. The client fully engaged in therapy and found working with images and hypnosis helpful. She benefited from exploring her life as a mythic narrative.

This study’s major learning explored postpartum depression as a voice of soul. The shift in emphasis from cure of a symptom to care enabled a broader search into the meaning of postpartum depression. Postpartum depression is viewed not only as a personal pathology, but also as one with cultural and archetypal implications. Tracing the Great Mother myth’s gradual decline throughout history provided a mythic parallel to the modern experience of motherhood.

The emphasis on postpartum depression as a distinctive entity accentuates the need for the psychiatric community to reconsider PPD as a separate classification replete with the understanding of the unique circumstances of motherhood.
ACKNOWLEDGEMENTS

I gratefully would like to acknowledge the following people for their exceptional and generous contribution to this initiatory process. You all have been the elders on the other side of the fire.

Jim Toner proved himself to be an excellent writing teacher through his absolute lack of involvement in the writing process. His detachment was maddening and infuriating at times, but it granted me the opportunity to assert myself as the author of this study. I have the utmost respect for his wisdom and cherish his belief in me as a writer.

Claire James was instrumental in deepening my understanding of the terrain I was traveling. Her insights, thoughtfulness, and support were invaluable throughout this entire journey. Her capacity to embody The Friend propelled me into territories that enlivened not only this study, but also my very soul.

To the client, who as the focus of this study gifted me with the stories of her life and the opportunity to expand my appreciation of motherhood and its unique pathos, I extend my heartfelt gratitude. I am humbled in the presence of her trust.

To everyone involved in my education at the Institute of Imaginal Studies, I am indebted to the many ways they enriched my being. Aftab Omer confirmed my belief in the primacy of imagery and the power of words. I thank him for his dedication and sacrifice. Because of him, I go to the market place with bliss bestowing hands.

And lastly, I offer my love and appreciation to my son, Liam Toner. His existence enabled me to feel—from the bones out—the profound and life-altering experience of motherhood.
**CONTENTS**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>v</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>vii</td>
</tr>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Topic</td>
<td></td>
</tr>
<tr>
<td>Exploration of Topic/Subject Choice</td>
<td></td>
</tr>
<tr>
<td>Framework of the Treatment</td>
<td></td>
</tr>
<tr>
<td>Confidentiality and Ethical Concerns</td>
<td></td>
</tr>
<tr>
<td>Client History and Life Circumstances</td>
<td></td>
</tr>
<tr>
<td>Progression of the Treatment</td>
<td></td>
</tr>
<tr>
<td>Learnings</td>
<td></td>
</tr>
<tr>
<td>Personal and Professional Challenges</td>
<td></td>
</tr>
<tr>
<td>2. LITERATURE REVIEW</td>
<td>25</td>
</tr>
<tr>
<td>Introduction and Overview</td>
<td></td>
</tr>
<tr>
<td>Biological Perspective on Postpartum Psychiatric Disorders</td>
<td></td>
</tr>
<tr>
<td>Cognitive/Behavioral Perspective on Postpartum Psychiatric Disorders</td>
<td></td>
</tr>
<tr>
<td>Psychodynamic Perspective on Postpartum Psychiatric Disorders</td>
<td></td>
</tr>
</tbody>
</table>
Imaginal Approaches to Postpartum Psychiatric Disorders

3. PROGRESSION OF THE TREATMENT .......................... 78
   The Beginning
   Treatment
   The Therapy Journey
   Legal and Ethical Issues
   Outcomes

4. LEARNINGS ............................................................. 113
   Key Concepts and Major Principles
   What Happened
   Imaginal Structures
   Primary Myth
   Personal and Professional Development
   Applying an Imaginal Approach to Psychotherapy

5. REFLECTIONS .......................................................... 146
   Personal Development and Transformation
   Impact of the Learnings on My Understanding of the Topic
   Mythic Implications of the Learnings
   Significance of the Learnings
   The Application of Imaginal Psychology to Psychotherapy
   Bridging Imaginal Psychology
   Areas for Future Research
Appendix

1. INFORMED CONSENT FORM .............................. 162

2. TREATMENT CONSENT FORM 1 ......................... 164

3. TREATMENT CONSENT FORM 2 ......................... 165

4. TREATMENT CONSENT FORM 3 ......................... 167

5. HYPNOSIS SCRIPT 1 ........................................ 169

6. HYPNOSIS SCRIPT 2 ........................................ 173

7. HYPNOSIS SCRIPT 3 ........................................ 177

8. HYPNOSIS SCRIPT 4 ........................................ 184

9. HYPNOSIS SCRIPT 5 ........................................ 191

10. THE EDINBURGH POSTNATAL DEPRESSION SCALE 195

NOTES ............................................................. 198

REFERENCES ..................................................... 237
CHAPTER 1

INTRODUCTION

Clinical Topic

A woman in my town is missing. Her husband and five-year-old son were sleeping as she slipped out the back door of her house wearing only a black nightgown, a butcher knife in her hand. Search crews are scouring the area. Bits and pieces of information are being whispered. The woman had been agitated. She was not sleeping. She was teary, irrational. She seemed confused and was talking nonsense. No one said anything to her for fear of seeming disrespectful, rude, or meddlesome.

A woman in my town was found, dead. Her body, stained with blood, was discovered this morning. A kitchen knife was at her side, her feet floated in a small stream near her home. The local paper will not print this. It will report that the cause of death is not known. Now, there are more whispers. She was delusional. She was grief-stricken from suffering a late-term miscarriage. People close to her knew she was in trouble, but looked the other way. The day she killed herself, her husband and best friend witnessed her having a psychotic break. She was not in treatment.

This story unfolds in my community, not as some abstract news story in some other town, but as a real-life woman, Jennifer Mellera, who lived among us. After gathering information from her family and friends, I learned that Jennifer—following a late-term miscarriage—began exhibiting symptoms attributed to postpartum psychosis.
She was manic, unable to sleep for several nights, agitated, and had an expansive and irritable mood. She was experiencing auditory hallucinations and her grasp of reality was greatly diminished. Given these facts, it appears likely that Jennifer was suffering from a postpartum psychiatric illness.

Jennifer is far from being alone. There are many other tragic stories that have captured the headlines in recent years. In 2001, a Texas woman, Andrea Yates, drowned her five children in their bathtub.iii In South Carolina, Susan Smith rolled her car into a lake with her two young sons inside, drowning them both.iv In Hollywood, Tom Cruise, on the Today show, publicly denounced Brooke Shields and other women as being weak and misinformed for taking medication specified for the treatment of postpartum depression.v And most recently, the image of pop star Britney Spears’ shaved, bald head appeared internationally in the media. It has since been reported that Spears has been suffering from a postpartum psychiatric disorder.vi

While the Today show, the Associated Press, and my small town newspaper move on to the next, more immediate story, the issue of postpartum psychiatric illness continues to have relevance in the United States. According to Rita Nonacs, postpartum depression (PPD) affects 10 to 15 percent of childbearing women.vii Another article by Sarah Fields reports that PPD affects 20 percent of new mothers.viii Brooke Shields’ book, in which she chronicles her experience of and treatment for postpartum depression, remains a bestseller three years after its publication.ix The image of the sorrowful mother, whether in its overwhelmed state of weakness and fragility or one of determined rage and madness, seems to captivate the culture’s fascination.
Postpartum depression, although recognized as far back as 460 BC, remains a complex subject to explore. According to Kathryn Leopold and Lauren Zoschnick, “…debate continues about [PPD’s] cause, definition, diagnostic criteria, and even its existence as a distinct entity.” There appears to be little conformity as to what causes postpartum psychiatric illness. Leopold and Zoschnick state, “Multiple investigations into the etiology of postpartum depression have not reached a consensus.” Theories from the fields of biology, medicine, anthropology, sociology, and psychology represent the diversity of researchers studying the root causes of postpartum depression. As stated by Laura Stephens, “…while biological, psychosocial and cultural theories have been investigated, the exact causes of postpartum depression are unknown.”

The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV) does not recognize postpartum psychiatric disorders as being diagnostically distinct from their nonpuerperal or non-birthing counterparts. The DSM-IV does allow the addition of a postpartum-onset specifier to be attached to a diagnosis of Mood Disorders. According to the DSM-IV, a specifier is “…provided to increase diagnostic specificity and create more homogenous subgroups, assist in treatment selection, and improve the prediction of prognosis.” The diagnostic criterion for postpartum depression is the same used for Mood Episodes, Depressive Disorders, Bipolar Disorders, as well as other Mood Disorders. The one distinction the DSM-IV makes for postpartum depression is acknowledging that the onset of the current mood disturbance occurs within four weeks after the birth of a baby; otherwise, the DSM-IV treats postpartum depression like any other Mood Disorder.
According to James Alexander, Patricia Neel, and Barbara Parry, the lack of a DSM classification for postpartum psychiatric disorders results in a communication disaster. Women with postpartum psychiatric illnesses are lumped together with the general population of people suffering from any Mood Disorder. Alexander, Neel, and Parry suggest that terminology must be updated to represent the unique symptoms and qualities presented by women with PPD. No universally recognized nomenclature exists for the variety of symptoms recognized as postpartum psychiatric illness.

Although postpartum depression, as stated by Leopold and Zoschnick, has received much less attention in medical literature, training, and clinical practice than other birth-related illnesses, it is estimated that of the approximately four million births occurring annually in the United States, 40 percent are complicated by some form of a postpartum mood disorder. In a study conducted by Cheryl Tatano Beck and Richard K. Gable, the United States leads the rest of the world in reported cases of PPD, with an estimated 400,000 women diagnosed yearly. A study by Valerie Raskin found that one in four first-time mothers had depressive symptoms. Yet screening new mothers for depressive symptoms, according to Karen Kleiman and Raskin, is uncommon in the United States. Kleiman and Raskin assert that a post-natal examination might include a few questions regarding depression, with the new mother likely being told she is going through “a period of adjustment.” Again, Kleiman and Raskin purport that new mothers are sent home to deal with their depressive symptoms—symptoms mislabeled as the baby blues, hormonal surges, or a passing phase.

However, in recent years a cross-section of lawmakers, physicians, clinicians, and concerned citizens appear to be addressing the seriousness of postpartum psychiatric
disorders. In April of 2006, the state of New Jersey passed legislation requiring physicians to educate pregnant women and their families about the signs and symptoms of PPD and to screen new mothers for the disorder. In the fall of 2007, the United States House of Representatives passed a bill, H. R. 20: The Melanie Stokes Postpartum Depression Research and Care Act, with an overwhelming majority. The bill, if passed in the Senate, will provide funding for postpartum depression research, screening, treatment, and public education. A recent study by Beck and Gable showed the effectiveness of detecting a postpartum mood disorder through the use of the Postpartum Depression Screening Scale (PDSS). Another screening tool, the Edinburgh Postnatal Depression Scale (EPDS) was developed in 1987 and is used in several countries, including the United States.

For the purposes of this Clinical Case Study, postpartum psychiatric disorders will be considered from the position of five perspectives in the Literature Review chapter. The five sections outlined are the biological, cognitive-behavioral, psychodynamic, and sociocultural perspectives and an imaginal approach. In each of the five sections, the relevant literature pertaining to postpartum psychiatric illnesses and related subjects, such as motherhood, will be examined.

Each perspective provides relevant and significant revelations concerning postpartum psychiatric disorders. The main focus of the biological perspective involves a search for an etiological cause of postpartum psychiatric disorders, their classification into subgroups, and the treatment of each disorder. The literature from the cognitive-behavioral perspective examines the efficacy of cognitive-behavioral therapy as a form of treatment for postpartum psychiatric disorders. Distortion of thought, as it pertains to the
postpartum woman, is addressed in terms of relevance to the subject of postpartum psychiatric illness. The psychodynamic section is devoted to ascertaining the benefits of a psychodynamic-centered therapy in ameliorating symptoms of postpartum depression. The significance of the role of motherhood is examined as a way to deliberate psychoanalytic theory and its possible role in advancing the notion of mother as determining factor in a child’s psychological development.

The sociocultural perspective looks at the relevance of a culture’s beliefs, customs, and social behaviors regarding motherhood and whether these activities have any bearing on postpartum psychiatric illnesses. The level of support given to the new mother from family, friends, the culture at large and its institutions is considered and related back to the incidence of postpartum depression. Finally, the Literature Review includes the imaginal approach to postpartum psychiatric disorders. From this approach, postpartum psychiatric disorders are considered as a possible critique, not only of the personal life of the individual, but also of the culture she inhabits and the universal motifs inherent in motherhood.

When the client Elizabeth Strong (pseudonym) and I worked together, we addressed many of the significant points of interest contained in the five aforementioned perspectives. From a biological perspective, Elizabeth presented with classical symptoms of depression: depressed mood, lack of pleasure or interest, sleep disturbance, loss of energy, agitation, feelings of worthlessness and guilt, diminished concentration, and suicidal ideation. She also had recently given birth and was breastfeeding her newborn, two biological factors that contribute to dramatic hormone imbalances.
When considering cognitive-behavioral aspects, Elizabeth’s thought patterns mirrored examples of the distorted thoughts of women experiencing some form of postpartum psychiatric illness. These distorted thought patterns included all manner of criticism regarding Elizabeth’s ability to function adequately as a mother. From the psychodynamic viewpoint, Elizabeth carried inflated expectations on herself in the role of motherhood. She buried herself beneath guilt and insecurity over the caretaking and shaping of her baby’s physical and psychological livelihood. She also presented with a host of interpersonal conflicts—with her mother, father, sisters, brothers, and husband—that seemed to be contributing to her lack of well-being.

The dearth of social and cultural support Elizabeth received after the birth of her baby seemed to have an adverse effect on her emotional stability. She felt abandoned by not only her family and friends, but also from an absence of community, both in her literal community of place and a larger community of knowledge or information that might inform and recognize her motherhood. From an imaginal approach, her symptoms appeared to suggest a disconnect between Elizabeth’s desires and the actual situation of her life. She seemed to be carrying forward many themes and patterns from her genealogy, the culture she lived in, and the universal plight of mothers.

Although working with Elizabeth was challenging and enriching, I was not drawn to this particular case as a focus for the Clinical Case Study. At a writing group meeting with two other Institute of Imaginal Studies students, I wondered aloud why the topic of postpartum depression, above all the interests I possessed and the variety of topics that were available to me, kept asserting itself. One of the students said to me, “You still think that you choose the topic?” Her implication was that I do not choose the topic; rather, the
topic chooses me. I felt profoundly the truth in this statement. Ever since I became pregnant six years ago, the subject of motherhood has followed me around: first, as a dissertation topic about the postmodern experience of motherhood and now as the subject of this Clinical Case Study. Elizabeth’s awareness of the fact that she was suffering something unique to the experience of motherhood awakened a similar knowing within me. My interactions with other mothers, both professionally and personally, were informing me of some condition, of some valuable information about the inimitable phenomenon of motherhood.

**Personal Exploration of the Subject/Topic Choice**

Although it appears as if there is growing awareness about the seriousness of postpartum depression, my experience as both a mother and clinician speaks to the inconsistency of information regarding PPD and a woman’s alertness to her own symptoms of postpartum depression. When I was a new mother, I began meeting with other mothers. Our polite talk centered around the challenges of motherhood, but mostly we were a baby-centered crowd, eager to shrug off the toll that our situations exacted, such as sleep deprivation, lack of support, boredom, physical complications, emotional fluctuations, and the signs of an overwrought and frazzled mind. As trust and comfort developed between us, it did not take us long to reveal the vulnerability that lay hidden beneath the stoicism of motherhood. Once permitted, we were eager to confess our innermost burdens and the intolerable images inhabiting the halls of our psyches—moments of feeling hatred for our spouses, fantasies of hurting our babies, or of packing our bags, leaving everyone, never to return.
While I did not personally experience what would be termed clinical postpartum depression, acquaintances of mine did. None of them sought treatment. They assumed that their inability to cope was unique to them. Their solution was to suck it up, put one foot in front of the other and get through the day. And although I did not meet the clinical criteria for PPD, I shared the women’s sense of overwhelm, doubts, and insecurities about the experience of motherhood and the ability to be effective.

In my practice as a psychological assistant, I work with pregnant women and new mothers. The mothers-to-be tend toward the idealistic and naïve, projecting a stereotyped 1950’s style interpretation of life after the baby comes: house always clean, daddy full of responsibility and smiles, mom fresh and able to juggle many tasks with ease. This peaceful image quickly is replaced by the jagged experience reality affords once the baby is born. Clients report being overwhelmed, under-supported, exhausted, and lacking time to do anything other than the bare minimum to get by. They describe very cogently the life of a new mother in realistic terms.

My therapeutic goal has been to provide a nurturing, compassionate space where these mothers can talk freely about their experiences. Often I hear that healthcare providers dispense lectures or prescriptions when clients express their ambiguous feelings about motherhood. It seems these mothers are seeking a new model of care instead of being talked or medicated out of their experience. One mother stated that what she needed most was someone to listen to her story without judgment. What the postpartum woman appears to be seeking is compassion and information.

When Elizabeth Strong called to make an appointment with me after the birth of her baby, I knew very little about postpartum psychiatric disorders. Being a relatively
new mother myself, I possessed an intimate understanding of her life situation in terms of
the overwhelming quality she was experiencing in relation to motherhood. My
compassion ran deep; my information, however, was much more limited.

Shortly after Elizabeth contacted me for treatment, a close friend of mine told me
that she suspected she had been suffering from a postpartum depression for several
months. She described feeling like she was sleepwalking through her life, disembodied,
and numb. She expressed fear of being exposed as a horrible mother. The conversation
we shared reminded me of Elizabeth’s story. Elizabeth too had confessed an
overwhelming anxiety that people would find out she was a failure as a mother. These
conversations led me to re-examine the unique role that motherhood played in
conjunction with symptoms of depression.

Several threads began to weave together, leading me to focus on postpartum
depression as a Clinical Case Study topic. One thread was Elizabeth’s struggle to make
sense of her life within the new context of motherhood. Another was my friend’s phone
call, helping me to connect Elizabeth’s situation with postpartum depression. A third
thread was being exposed to a friend’s doctoral dissertation in which she discussed the
devaluation of the sacred feminine and how that felt connected somehow to Elizabeth’s
plight. In addition, when I was working on my doctoral dissertation, the focus was on
motherhood in the postmodern world. This work sprung from my frustration as a new
mother over feeling that no one or nothing had prepared me for this rite of passage. When
I began reading up on postpartum depression, I felt that this topic encompassed all of
these interconnected events somehow, and I was eager to explore further their
relationship.
Framework of the Treatment

I began seeing Elizabeth Strong after her nurse midwife referred her for hypnosis and counseling intended for labor and birth. I was trained in hypnosis at the Institute of Imaginal Studies by Lorna Cutler and later completed a certification program at Sonoma State University. Cutler, as well as the instructors at SSU, taught an extensive unit on utilizing hypnosis for mother/infant bonding and labor and birth preparation. I have been working for over three years with a local midwife, offering this service to her patients.

When Elizabeth and I began our therapeutic work, I was working as a psychological assistant in a private practice. I worked part-time, seeing no more than a total of ten clients per week. Elizabeth contacted me directly by telephone to set up an initial appointment. Over the phone, we discussed the nature of my work and some of the circumstances of her life, including that she was six months pregnant, married, and had been molested as a child.

We spent about twelve hours together, from November 9 to December 13 of 2005, sometimes one-on-one and sometimes with her husband joining us. Generally, we would meet once a week for one-and-a-half to two hours each session. Elizabeth contacted me again after the birth of her baby. We began meeting on April 9, 2006 on a weekly or bi-weekly basis for one to two hours each session. The majority of our work together occurred from April 2006 to April 2007. Oftentimes, when she called to schedule an appointment, we would discuss her situation for a few minutes. There were a few occasions where we met inadvertently in public, but at those times, we did not discuss therapeutic concerns.
As mentioned earlier, I initially worked with Elizabeth using hypnosis. Occasionally, we would return to this modality when working together after the birth of her baby. There are art materials in the office, which we used on a few occasions to explore a dream image or some aspect of Elizabeth’s symptoms. I lent Elizabeth several books from the lending library in the office with subjects ranging from homebirth to Affect Theory. We also employed the use of ritual at the beginning of each session by sitting in silence and lighting candles.

Confidentiality and Ethical Concerns

I live in a small town. Anonymity is not an option here. There is a saying here that there exists only two degrees of separation between oneself and anyone in our community. With that denoted, I have taken every precaution to preserve Elizabeth’s right to privacy and to keep her privilege of confidentiality protected. One method I employed was to imagine that someone both Elizabeth and myself knew was reading the case study: would this person be able to discern whom the case study was about with the information provided? If the answer leaned toward yes, then I changed that information to something comparable. There were several instances when I altered the data to protect Elizabeth’s identity. When I felt that specific information was needed to convey the intricacies of our work together, I first consulted Elizabeth about any reference to her person or her life circumstances. She was adamant that she had no concern about anonymity and gave her approval to use the information as needed.

Throughout the Clinical Case Study (CCS), the client is referred to by the pseudonym Elizabeth Strong. This name bears no similarity in spelling, initials, or any
other identifying qualifiers to that of the client’s true name. The client’s name was never
mentioned in the supervision that I received while working as a psychological assistant,
nor was it discussed in the writing group that I attended with two other Institute of
Imaginal Studies students. The only time the client’s name was used was for the original
consent form, which was seen by the client, employees at the Institute of Imaginal
Studies, and myself.

When I felt sure that I wanted to pursue postpartum depression as the topic for the
Clinical Case Study, I approached Elizabeth about serving as the subject. A concern I had
about asking Elizabeth was that she might feel singled out and therefore special to me,
like a teacher’s pet. I did not want this to have a negative influence on our work together,
such as her feeling that she needed to impress me or perform in any way. We spent over
an hour discussing the particulars of the Clinical Case Study. I showed her a copy of the
CCS guidelines and a sample of the consent form. I told Elizabeth that her decision to
consent or refuse would have no influence over our continued work together. I asked
Elizabeth to think about this proposal for a while before giving an answer. She was ready
to consent at this meeting, expressing no reservations over being the subject of the CCS.
At our next meeting (about two weeks later) she reiterated that she was willing to be the
subject of the study and had no concerns at this time.

During my work with Elizabeth Strong, my supervisor was Galyn Savage. Galyn
is a licensed clinical psychologist with an orientation in both Jungian and Cognitive-
Behavioral approaches. She has spent the majority of her career providing psychological
evaluations in clinical and institutional settings, such as hospitals, prisons, and county
mental health. She has an incredible breadth of clinical knowledge and is highly respected in her field.

Galyn and I worked together previously at County Mental Health where she was employed as a clinical psychologist. I was an intern there, and Galyn provided my supervision. When I decided to return to work, I asked several other licensed psychologists if they would supervise me, only to be turned down each time. The psychologists unanimously named the fear of lawsuits as their primary reason why they no longer supervised interns. I was apprehensive to ask Galyn to supervise me for a variety of reasons. Two reasons are of import to note: 1) Galyn and I had socialized in the past, causing a blurring of boundaries in our working relationship; and, 2) I was intimidated by her. I felt I had no choice but to ask her for help as there literally, in my small town, was no one else.

Initially, she turned me down, seeing little personal benefit to providing my supervision. It was the sudden death of her brother that changed her mind. She explained to me that it opened her heart to others in need of her help. I was grateful for this change, although part of me was apprehensive to renew our working relationship.

Initially, Galyn and I agreed to meet once a week for one hour in individual supervision. Occasionally we would meet with Galyn’s other intern in group supervision for two hours. At first, we kept to our weekly schedule of meeting, but soon fell out of this consistency. I blame myself partly in that I did not pursue Galyn with much enthusiasm. Also, Galyn took several vacations, had a series of family emergencies, and was dealing with the closure of the hospital where she worked full-time.
Galyn was very helpful to me in the beginning of this case study. She assisted in clarifying my goals and to look honestly at some of the ways I was sabotaging myself in relation to moving forward with the CCS. Another asset to Galyn’s supervision was that her clinical knowledge is vast, and she was able to assist me in diagnoses, treatment planning, as well as help with any ethical or legal problems that arose. As our meeting times became less frequent, I found myself relying more on other colleagues.

Client History and Life Circumstances During Therapy

Elizabeth Strong is a 26-year-old female born March 31, 1981, in Sacramento, California. She grew up in a lower, middle-class household with her mother, father, two sisters, and for part of the year, her two, older stepbrothers from her father’s previous marriage. Her father was a correctional officer at a prison, and her mother was a homemaker. Elizabeth describes her family as dysfunctional. At age three, Elizabeth’s stepbrother repeatedly molested her and an older sister. At four, Elizabeth’s mother turned herself in to Child Protective Services after she bruised Elizabeth, beating her with a wooden spoon.

When Elizabeth was eight years old, her father was fired from his job on sexual harassment charges. He found employment in a rural town in Northern California. For a year and a half he lived in an RV, Monday through Friday, while the rest of the family stayed in Sacramento. She describes her parents’ marriage as strained and unhappy from this point on. The day before school started, Elizabeth moved where her father had been living. The family lived in a shabby motel for a few months while they looked for a house to purchase. Elizabeth describes this time as extremely difficult. She went from attending
a private, Catholic school to a rural, public school. She stated that it was the first time she recognized having a “financial identity.” xxx She wore a uniform before, and all the kids in school appeared the same. In the new school, she felt singled out because of her hand-me-down clothing and living in a motel.

She spent her adolescence escaping her household, using drugs and alcohol, and suffering from depression. She was in a head-on collision when she was 15, which severely injured her mother and father as well as the teenagers who hit them. Her younger sister tried to kill herself twice, resulting in hospitalizations. During her senior year of high school, Elizabeth was a foreign exchange student in Sweden. She describes this time as a fantasy life. She had a supportive relationship with her host family and was able to travel to other European countries to experience different cultures.

When Elizabeth returned home, her parents divorced, her younger sister had been expelled from school, and the small town life seemed stifling after her experiences abroad. She moved to Santa Cruz for half a year with some friends. She moved back home briefly when her sister became pregnant. While watching television, she saw an advertisement for a massage school in the San Francisco Bay Area. She moved there in 2000 and completed her studies in a year. She worked in a spa for a short time.

At 19, she moved away to Southern California to attend a community college. There she became depressed, smoked marijuana on a daily basis, and failed her classes. At 21, she moved back to her hometown, continued to drink and smoke marijuana, and worked as a receptionist. She met her husband in a bar where they were both drinking heavily. She became pregnant shortly thereafter, and they married. After the birth of their
daughter, Elizabeth was unable to tolerate her husband’s continued, excessive drinking. They separated and are now divorced.

Currently, Elizabeth lives in a rural town a few miles from where she spent her later childhood and adolescence. She rents a small house and lives with her 18-month-old daughter, with whom she has custody. She works part-time as a massage therapist and as a peer counselor for La Leche League. She attends a community college where she is pursuing an Associate’s Degree. Her long-term goal is to become an obstetric nurse and midwife.

Elizabeth began counseling at three years old after she told her parents that her stepbrother molested her. She remembers counseling as playing games in a room with other children. This continued for about six months. Approximately five years later, she and her older sister attended a group for girls who had been sexually abused. She remembers writing letters to her abuser, doing art projects, and having her feelings listened to and acknowledged. Between the ages of 12 and 13, Elizabeth began seeing another therapist for two years, twice a month for one-on-one sessions. She recollects a playroom, crying a lot, and venting her feelings.

At 15, Elizabeth, her parents, and sister were in a head-on collision resulting in a long rehabilitation for her father, mother, and the carload of young adults who hit them. She experienced flashbacks from the accident and took the initiative to call her former therapist. They met twice weekly for one month, and then continued seeing each other once a month for six more months. Two years later, at 17, Elizabeth saw the same therapist about six times over two years.
When Elizabeth went away to college, she began experiencing serious depression. She described herself as hopeless, unable to concentrate, sad, and sleeping most of the day. When she turned 21, she scheduled phone appointments with her former therapist, which lasted for six months, once a week. Elizabeth expressed that the phone appointments helped her feel connected to her hometown and history. She felt she received from her therapist the support she was longing for, but did not receive, from her family.

The next time Elizabeth sought counseling was when she found out she was pregnant. By this time, she was 23 years old and once again living in her hometown. She joined a woman’s empowerment and recovery group for adult survivors of sexual abuse facilitated by the local women’s shelter. Her concern was that her past molestation experience might surface somehow while she was pregnant and interfere with her ability to bond with her baby.

Elizabeth began attending Al-Anon meetings shortly after the birth of her daughter. She was seeking help in conjunction with her husband’s alcohol addiction. She has attended meetings for nearly two years and continues to do so on a weekly basis.

**Progression of the Treatment**

In November of 2005, Elizabeth Strong initially sought treatment to prepare for the birth of her first child. She was under the medical care of a nurse midwife and planned to have a homebirth. She wanted to learn relaxation and pain control techniques through the use of hypnosis. At this time her main clinical concern was regarding a past molestation experience. Elizabeth’s older stepbrother repeatedly molested her when she
was three years old. Her fear was that somehow this traumatic event would hinder her ability to bond with her newborn.

During her pregnancy, Elizabeth experienced mild post-traumatic stress symptoms, such as distressing dreams similar to the original event, feeling detached from others, an exaggerated startle response, difficulty concentrating, and a sense of dread about her future. She described having flashbacks of being inappropriately fondled, heightened sensitivity and feelings of profound vulnerability, and an aversion to sexual relations with her husband.

The initial treatment plan was to follow a set of hypnosis scripts with particular attention paid to the scripts intended for bonding. A hypnosis script is a written out guideline aimed at specific goals. I utilize the scripts that Lorna Cutler designed for her private practice and hypnosis classes. Elizabeth and I spent approximately 12 hours together, sometimes joined by her husband. Our sessions would last from an hour to two hours. At this time, there were no crises that required immediate attention or intervention. I did not expect to work with Elizabeth after the birth of her baby.

In April of 2006, Elizabeth contacted me again to resume treatment. At the initial session, she described herself as overwhelmed and feeling lost and uncertain about all aspects of her life. She was experiencing symptoms of depression, such as depressed mood, lack of pleasure and energy, sleep disturbance, indecisiveness, and feelings of worthlessness and guilt. She was unhappy with her marriage and quite concerned about her husband’s drinking problem. We agreed to meet, on average, every other week for one-and-a-half to two hours per session.
During our first few sessions, Elizabeth described herself as depressed. She was feeling anxious, fearful, sorrowful, extremely uncomfortable with her life, and full of dread. She described moments of feeling like a failure as a mother and fearing that people would find out she was a bad mother. She admitted to having occasional thoughts of killing herself, but was very clear that she would never follow through with those thoughts.

During the time that I was beginning to see Elizabeth again, a friend of mine gave me Brooke Shields’ book about postpartum depression. I began wondering if Elizabeth’s symptoms fit the description of postpartum illness. I knew very little about postpartum depression, nor did my supervisor or other professionals with whom I sought advice. I ordered a few books and read articles on-line about postpartum depression.

On the Internet, I found the Edinburgh Postnatal Depression Scale (EPDS), a scale developed to detect postnatal depression. The EPDS consists of 10 short statements. The mother underlines one of the four possible responses that are closest to how she has been feeling. The validation study showed that mothers who scored above a threshold of 92.3 percent were likely to be suffering from a depressive illness. I had Elizabeth provide responses for the EPDS. She had a high score indicating the presence of a postpartum disorder.

Several books on postpartum disorders name a mother’s lack of social support as one factor that contributes to a predisposition towards postpartum depression. Keeping this in mind, the treatment plan for Elizabeth was to continue creating a safe, trusting, and supportive environment in which she could bring all of her experiences. We thoroughly explored her life story, not just as facts, but as a biography or narrative that contained
mythic elements. We looked at her self as composed of many characters, each caught in its own suspended narrative. We began seeing patterns and themes running throughout not only her life, but that of her parents’ and grandparents’ as well. Elizabeth was able to see the situations and symptoms of her life in context with the family and cultural myths she uncovered.

Some significant subjects explored during the treatment included Elizabeth’s past molest, the role of alcohol and drug use in her life and the lives of her parents and husband, postpartum depression, motherhood, debt, legal troubles, and marriage. Some other topics of import were her family’s history of sexual inappropriateness, issues of self worth, infidelity, and anxiety. We focused on Elizabeth’s relationships with her parents, siblings, mother-in-law, husband, daughter, and ultimately, to herself.

At the height of Elizabeth’s despair, she became curious about medications. She wondered if anti-depressants would help ease her depressive symptoms, such as the weight of sorrow, the lack of joy she was experiencing, or the feeling that everything was crashing in on her. At this point, I gave Elizabeth the names of a local psychiatrist and two licensed psychologists in case she wanted to pursue this course of treatment. Elizabeth chose to see one of the psychologists who worked in a hospital setting who could be paid through her Medi-Cal insurance.

During the course of treatment, Elizabeth decided to leave her husband. Her husband consistently and inappropriately continued to use alcohol and marijuana. Elizabeth felt that she could no longer live in an environment where alcohol and drug use were the norm. She believed staying would eventually put her baby at risk. Elizabeth and
her husband were able to separate amicably and she pursued legal action regarding divorce and custody.

Elizabeth has stated that our work together has helped her in a variety of ways. I believe she has gained a tremendous amount of insight into her life. In becoming aware of her life story (and the stories of her parents and ancestry) she has been able to detect why she has made the choices she has and discern what aspect of her self was in the driver’s seat at various times of her life. Rather than feeling aimless and like life was beyond her control, she now takes responsibility for the course of her life.

**Learnings**

Before meeting Elizabeth or beginning the Clinical Case Study, I possessed little to no knowledge about postpartum psychiatric disorders. I knew that occasionally women experienced depression after the birth of a child. Working with Elizabeth and completing the Clinical Case Study has given me multiple understandings about the complexity of postpartum psychiatric illness.

Aside from the obvious and practical fact of getting to know a subject, I have gained a deeper affinity towards mothers from this study. I have cultivated a reverence for myself as a mother, for my own mother, my friends who are mothers, and all the mothers who have both succeeded and failed at this awesome endeavor. I have found a certain comfort in knowing there exists a vast community of thinkers, policy makers, scientists, scholars, activists, and advocates who believe that motherhood is worth exploring, supporting, and revering.
I also am aware of the gaps in understanding. Postpartum illnesses are not recognized as a distinct psychiatric entity. The causes of postpartum illnesses are unknown. Mothers continue to be under-supported by both their families and society in terms of practical help. Policy does not reflect the importance and inherent value of mothering as evidenced by lack of maternity leave, childcare, or health care benefits. There is no ritual in place to educate, protect, support, and celebrate the new mother.

This picture of postpartum life seems to suggest a devaluation of the feminine and a diminished regard for birth and motherhood. The insignificance of the feminine in American culture seems to be connected to the high incidence rate of postpartum depression in the United States. Perhaps the prevalence of postpartum depression is underscoring the importance of re-examining our relationship to the feminine, to birth as a sacred event, and to motherhood as a profound rite of passage.

**Personal and Professional Challenges**

When Elizabeth came to me feeling overwhelmed, exhausted, and under-supported over her role as a new mother, I could empathize personally with her feelings, but I had no clinical understanding of the depression she was experiencing. I stumbled into or was led mysteriously to the subject of postpartum depression. When I sought counsel about PPD, the professionals with whom I spoke offered little to no assistance or enlightenment about this topic. Neither the doctors, nurses, psychologists, nor psychiatrists I questioned knew much about postpartum psychiatric disorders. I was unable to find a prescribed handout addressing this issue. I became frustrated that no one
I knew could help me or guide me into knowing what to do with specific reference to postpartum depression.

The challenge before me was to find out about postpartum depression. I began researching the topic, ordering books, and reading articles and studies affiliated with the subject. I had a steep learning curve. Little by little my knowledge on the topic grew, my understanding of postpartum psychiatric illnesses expanded, and I began to wonder what my particular contribution to the study of postpartum depression might entail. As an Institute of Imaginal Studies student, I felt I had an opportunity to lend a unique voice to the conversation.

As a new, first-time mother myself, Elizabeth’s case held elements that mirrored my own experience. I was aware of the challenge to stay objective and to develop my capacity for reflection. I did not want to push any particular agenda on Elizabeth, especially as I became more drawn to one theory over another in relation to PPD. I especially wanted to prevent myself from falling back on simple, formulaic solutions when Elizabeth and I found ourselves amidst the unknowns of postpartum depression.

For several years now, I have sensed the Siren’s call in connection with motherhood as a clinical topic. As much as I tried to stop up my ears and change course, the call kept resounding. When Elizabeth returned to seek my help, the call became an exhortation I was unable to ignore. I realized that I must pursue the topic of motherhood, and in particular the voice of postpartum depression. I was beckoned to follow this voice’s lead and to discover its personal, cultural, and universal territories.
CHAPTER TWO

CLINICAL LITERATURE REVIEW

Introduction and Overview

The literature relevant to a clinical case study on postpartum psychiatric disorders (PPPD) is vast and varied. The literature review considers postpartum psychiatric illness from a personal, cultural, and archetypal position. For the purposes of this study, postpartum psychiatric illness is observed from the vantage point of four perspectives and one approach. The first three perspectives—biological, cognitive-behavioral, and psychodynamic—are of the personal domain. The biological perspective focuses on the body of the woman suffering from PPPD, whereas the cognitive behavioral and psychodynamic perspectives pertain to the woman’s mind and biography, respectively. The fourth perspective, sociocultural, takes into account the cultural influences that might have a connection with PPPD. Finally, the imaginal approach considers the archetypal or universal themes relevant to a study of postpartum psychiatric illness.

The biological perspective of postpartum psychiatric illness surveys the history of PPPD from its earliest recorded mention by Hippocrates in 460 BC to the present day. The majority of research regarding postpartum psychiatric illness has been carried out in the field of medicine. Therefore, the topic is investigated and described from a Western medical viewpoint. The biological perspective includes the medical definition of each subgroup within the broader heading of postpartum psychiatric disorders. From this
medical position, the possible biological causes of PPPD are deliberated with attention paid to relevant research studies in this area. Medical treatment options for postpartum psychiatric disorders are also considered.

From the cognitive-behavioral perspective, the study of postpartum psychiatric disorders shifts focus from the body to the mind. In this section, a discussion of the literature includes an examination of the problematic thought patterns of women suffering from PPPD and how these thoughts might influence mood. An explanation of how cognitive-behavioral therapy might help alleviate symptoms of postpartum psychiatric disorders is considered. Research studies conducted to test the efficacy of cognitive-behavioral therapy in treating PPPD are reported and analyzed.

In the psychodynamic perspective, another shift occurs as the study moves from the thoughts of the new mother to her biography. The review looks at the two main branches of psychodynamic therapy, psychoanalysis and brief psychodynamic therapy, and examines their relevancy as treatment options for postpartum psychiatric disorders. Research studies designed to rate such efficacies are cited. This section then considers, through a psychodynamic position, the role of motherhood, its importance and influence, and the implications this role has on the woman inhabiting it.

The sociocultural perspective moves out of the personal realm and considers the wider net cast by the cultural context of the new mother. In this section, a culture’s beliefs, customs, and social behaviors are explored in relation to motherhood and postpartum psychiatric disorders. Consideration is given to how a society defines the role of motherhood and the expectations this places on new mothers. A study of birth practices and rituals are regarded in terms of their possible influence on rates of
postpartum psychiatric illness. Public policy is reviewed as a potential expression of a
culture’s regard for mothers as well as its practical application in providing assistance.
Related to this, the sociocultural perspective entails the exploration of how people and
institutions support new mothers and explores the connection between support and
postpartum psychiatric illness.

The literature review’s final section, the imaginal approach to postpartum
psychiatric illness, enters into the territory of universal motifs. This section regards
postpartum psychiatric illness not only from the notion of body, mind, biography, and
culture, but also from the depths of a universally shared experience. The imaginal
approach to postpartum psychiatric disorders offers a distinct voice to the conversation of
PPPD. From this vantage point, the study looks at postpartum psychiatric disorders as a
potential voice of the soul. This section examines the literature supporting therapy as care
of the soul. The soul’s relationship to psychological symptoms is also explored. The
components of identity are explained, and the role of ritual in supporting the individual is
considered. Through the language of myth, the Great Mother archetype is explicating in
relation to its relevance to postpartum psychiatric illness.

**Biological Perspectives of Postpartum Psychiatric Disorders**

This section will consider the history of postpartum psychiatric disorders from a
biological perspective including its medical definition and categorization into subgroups,
the treatment options available for each subgroup, and the theories purporting possible
causes of postpartum psychiatric illness. In order to review the various biological
perspectives concerning PPPD, it is vital to understand what is meant by biological.
Webster’s New Collegiate Dictionary defines biology broadly as “a branch of knowledge that deals with living organisms and vital processes.” In this clinical case study, biological perspectives are considered more specifically as the internal, organic, and physical processes involved in generating postpartum psychiatric disorders.

Postpartum psychiatric disorders have been recognized since before the time of Christ. According to Valerie Thurtle, in 460 BC Hippocrates described a *puerperal fever* stemming from the suppression of lochial discharge, which then was carried to the brain producing “…agitation, delirium and attacks of mania.” Meir Steiner tells of an 11th century gynecologist, Trotula of Salerno, who reasoned, “…if the womb is too moist, the brain is filled with water, and the moisture running over to the eyes, compels them to involuntarily shed tears.”

During the 19th century, a more systematic approach to identifying postpartum psychiatric disorders was developed. According to James Alexander Hamilton, Jean Etienne Dominique Esquirol was instrumental in the study and classification of postpartum illnesses. In 1838, Esquirol summarized his findings in the book *Des Maladies Mentales*. Esquirol divided postpartum illness into three groups: those with onset during pregnancy, those whose symptoms were evident shortly after birth, and those developing symptoms weeks after giving birth. He suspected that the occurrence of postpartum illness was much greater than that reported by hospitals. Esquirol believed many women were suffering at home, alone.

In 1847, a New York physician, James MacDonald, studied 68 postpartum cases. He distinguished postpartum psychosis, a disorder beginning shortly after birth, from postpartum depression, the onset of which is delayed sometimes weeks or months after
The symptoms he attributed to each disorder are similar to what is noted today. He described patients with early onset as restless, irritable, unable to sleep, exhausted, and confused. When in the acute phase, these patients exhibited extreme agitation, hallucinations, delusions, mania, occasional violent behavior, with a high degree of changeability. The later onset patients’ symptoms were marked by a depressed mood, which MacDonald described as beginning insidiously and deteriorating gradually.

Another important contributor to the understanding of postpartum psychiatric disorders was Louis Victor Marcé. In 1858, he published *Traite de la Folie des Femmes Encientes*, a study based on his observations of 78 cases of his own and hundreds from other hospitals and studies. Like Esquirol and MacDonald, Marcé divided his samples into subgroups: those with symptom onset during pregnancy, those during the six weeks after delivery, and those whose symptoms began after the sixth week post delivery.

Marcé’s contributions to the study of postpartum psychiatric illness are especially noteworthy. According to Hamilton, Marcé left a precise record of study with detailed observations and descriptions of symptoms and disease patterns. He was instrumental in insisting that postpartum psychiatric disorders were unique, contrasting their diagnostic criteria to that of general psychoses or mood disorders. Marcé also provided exhaustive research linking the characteristics of postpartum disorders to a physical etiology. As Marcé explains:

That which gives puerperal psychosis its special quality is the coexistence with it of a functional and organic modification of the uterus and related organs…The coexistence of this organic state raises an interesting question of pathologic physiology: one immediately asks if there exist connections between the uterine conditions and the disorders of the mind…
According to Hamilton, Marcé’s 1858 book would remain the primary authority on postpartum psychiatric disorders for the rest of the 19th century.\textsuperscript{liv}

The progress that was made in the diagnosis and treatment of postpartum psychiatric disorders in the 19th century abruptly came to a close.\textsuperscript{lv} Hamilton maintains this closure was due to the development of psychiatric nomenclature that placed disorders into three broad categories based on behavior patterns and symptom clusters.\textsuperscript{lvi} Because postpartum psychiatric illnesses did not fit neatly into the categories that were outlined, the term \textit{postpartum} was removed from the terminology.\textsuperscript{lvii} The final death knell for a separate classification for postpartum disorders sounded in 1940 when Edward Strecker and Franklin Ebaugh stated in their definitive psychiatric textbook, “All others (in addition to ourselves) who have studied this problem are unanimous in the belief that there is no psychosis which may be designated as ‘puerperal.’” \textsuperscript{lviii}

In 1952, the first edition of the \textit{Diagnostic and Statistical Manual of Mental Disorders} (DSM) was published.\textsuperscript{lix} As Hamilton points out, Strecker was a member of the committee in charge of nomenclature.\textsuperscript{lx} The word \textit{postpartum} and any of its synonyms were dropped from the official terminology.\textsuperscript{lxi} As Hamilton states:

\begin{quote}
The doctrine which holds that psychiatric illness after childbearing is not significantly different from psychiatric illness unrelated to childbearing is expressed unequivocally in the official nomenclature handbook, the \textit{DSM-III}, with the statement, “There is no compelling evidence that postpartum psychosis is a distinct entity.” \textsuperscript{lxii}
\end{quote}

The current \textit{DSM-IV} has no classification for postpartum psychiatric illnesses. The only reference to the word \textit{postpartum} appears as a diagnostic specifier to identify that the onset of a mood disorder occurred within four weeks of giving birth.\textsuperscript{lxiii}
It was not until 1980 that interest increased and studies about postpartum psychiatric disorders occurred. According to Neel and Hamilton, Ian Brockington is credited for this reawakening. Brockington organized an international conference on postpartum disorders, which later spawned the inception of the Marcé Society, an international scientific organization focused on advancing knowledge about postpartum psychiatric illness. At about the same time, the 1985 publication of Carol Dix’s *The New Mother Syndrome* was met with a wide audience, as evidenced by its many editions and translations into several languages. According to Neel and Hamilton:

Scientific papers and the media began to converge on a few central themes: mild postpartum symptoms, if not more severe disorders, are of fairly frequent occurrence; there may be much more to postpartum illness than a vagary of the mind; these conditions are not reflections of mental incompetence or character weakness; most patients recover completely; appropriate treatment and support hastens recovery; and responsibility must be borne by family members, health care professionals, and a variety of societal institutions, not the new mother alone.

Since the 1980s, several international support groups evolved, namely Depression After Delivery, Postpartum Support International, and Post and Antenatal Depression Association. Many books have been written on the subject of postpartum psychiatric illnesses, from scientific explorations on the topic to first-hand autobiographies by the women who suffered from PPD. Multitudes of studies have been conducted worldwide to gain understanding about the etiology, prevention, and treatment of postpartum psychiatric illnesses; consensus on any of these topics has not been realized.

The classification of postpartum psychiatric illnesses is one area of disagreement. Michael O’Hara states that emotional disturbances in the postpartum period are usually divided into three groups: postpartum blues, postpartum depression, and postpartum psychosis. Others, Brockington among them, argue to include postpartum anxiety,
obsessive-compulsive, and posttraumatic stress disorders within the postpartum psychiatric disorder heading. For the purpose of this Clinical Case Study, an explanation of all categories will be made, but the primary focus will be on postpartum blues, postpartum psychosis, and postpartum depression.

By far the most commonly experienced postpartum disorder is known as postpartum blues. Kathryn Leopold and Lauren Zoschnick note other names for this disorder are the baby blues or maternity blues. According to Shoshana Bennett and Pec Indman, the baby blues is not a disorder because it affects 80 percent of new mothers and therefore is a natural outcome to giving birth. In contrast, a study by J. A. Thirkettle and R. G. Knight found that between 30 to 84 percent of women experience postpartum blues after the birth of a baby.

The literature describing the baby blues is unanimous with regard to onset, symptomatology and treatment. According to a study undertaken by Kendall, Connor, McGuire, and Cox, the onset of postpartum blues usually occurs within three to five days after delivery. Thirkettle and Knight, along with Bennett and Indman, note that symptoms include weepiness, irritability, ambiguous or negative feelings about the baby, restlessness, confusion, sadness, poor concentration, and anxiety. Karen Kleiman and Valerie Raskin state that postpartum blues resolves itself usually within a few weeks and requires no intervention.

Cross-cultural studies have been conducted in relationship to postpartum blues suggesting a common biological etiology for the disorder. According to Jan Campbell, several studies suggest no correlation between incidences of maternity blues and a woman’s social class, marital status, psychosocial stressors, obstetric conditions,
racial considerations, or economic situation. Campbell notes that these findings may suggest a biological cause for postpartum blues.

Bill Deakin extrapolates that the endocrine system, whose foundations are the hormones and glands, may play an important role in postpartum blues. Deakin notes that levels of the hormones estrogen, progesterone, and cortisol increase throughout pregnancy, reaching a peak prior to delivery, and then sharply declining 24 to 48 hours after birth. According to Campbell, this rapid drop-off may influence the incidence of maternity blues, but more research is needed to form any definitive conclusions.

If postpartum blues can be referred to as the most common and benign postpartum disorder, postpartum psychosis (PPP) is seen as the least common, yet most severe. According to Ann Dunnewold and Diane Sanford, one or two new mothers in one thousand exhibit psychotic behaviors. Yet, postpartum psychosis is likely the most recognized postpartum psychiatric illness due to the high profile media cases that catch the public’s attention. Several stories involving a new mother killing her children have made headlines from the 1990s through the new century.

According to Hamilton, Harberger, and Parry, postpartum psychosis usually occurs within the third to fifteenth day after giving birth. Kathleen Tackett and Glenda Kantor report that the symptoms of PPP may include heightened or reduced motor activity, hallucinations, marked deviation in mood, severe depression, mania, or both, confusion, delirium, and sleeplessness. Rita Nonacs reports that the mother may have thoughts about hurting herself or her baby; therefore, risks for suicide and infanticide are high among women with untreated postpartum psychosis.
Postpartum psychosis is considered a psychiatric emergency, and as such, states Nonacs, hospitalization is required.\textsuperscript{lxxxviii} Common in-patient treatments include mood-stabilizing drugs, such as lithium, valproic acid, or carbamazepine in combination with antipsychotic medications and benzodiazepines (tranquilizers).\textsuperscript{lxxxix} According to J. Sneddon and R. J. Kerry, the treatment for postpartum psychosis lasts between five to six months.\textsuperscript{xc} Richard Snaith reports that the majority of women who receive treatment have a good prognosis for recovery.\textsuperscript{xci}

Although several studies have been conducted to pinpoint the causes of postpartum psychosis, many researchers agree that more studies are needed to determine its etiology. Michael Araco summarizes current research findings by noting that there does not appear to be a single factor that causes PPP.\textsuperscript{xcii}

Ramesh Kumar has concluded from his research that postpartum psychosis appears to be a biological disorder.\textsuperscript{xciii} He asserts that the prevalence of PPP remains consistent across cultural and ethnic divides.\textsuperscript{xciv} Also, Kumar maintains that clinical data and historical evidence suggest an unchanging incidence rate for postpartum psychosis over the past 150 years.\textsuperscript{xcv} He stresses that these two factors strongly suggest an endogenous etiology for PPP, although he acknowledges that further research is needed to form a decisive conclusion.\textsuperscript{xcvi}

The relationship between hormones and postpartum psychosis is the subject of several studies on the etiology of PPP. J. C. Davis and M. T. Abou-Saleh note that the dramatic changes after childbirth in circulating hormones, such as estrogen and prolactin may be a contributing factor for postpartum psychosis.\textsuperscript{xcvii} They also note that other hormones, such as cortisol and thyroxine may be indicated as well.\textsuperscript{xcviii} According to C.
J. Chuong and D. M. Burgos, higher rates of postpartum psychosis were found in women with premenstrual syndrome (PMS), a disorder long associated with fluctuating hormones. However, Elizabeth Herz has stated that the data has not consistently supported the connection between PMS and a predisposition to postpartum psychosis.

Other authors have suggested that a woman is more likely to experience a postpartum psychotic episode if members of her family have a history of bi-polar illness, depression, anxiety, schizophrenia, or postpartum illness. According to Bennett, if a woman has had a previous psychosis or bipolar disorder, or a family history of either, she has between a 20 and 50 percent chance of experiencing postpartum psychosis.

Laurence Kruckman and Susan Smith argue that most researchers agree that hormonal research has not shown a direct correlation to postpartum psychosis. They assert that the evidence regarding the role of progesterone, estrogen, prolactin, cortisol, oxytoncin, thyroid, and vasopressin in postpartum illnesses continues to be inconclusive. They go on to say, “…only additional research will clarify any biological links to the origin of the illness.”

The third category of postpartum psychiatric illness is postpartum depression. Like the DSM classification for major depressive disorder, PPD presents along a continuum from mild to moderate to severe. Ronald Rosenberg, Deborah Greening, and James Windell note several issues complicating the clear diagnosis of PPD. One reason is that mild to moderate PPD shares diagnostic features with postpartum blues, which may prevent a woman, her family or friends, and caregivers to suspect a more serious illness. Another impediment is the variability of symptoms within postpartum depression. PPD can present as an acute period of depression to a prolonged major
depression. A woman’s mood can be very low all the time or swing dramatically between periods of despair to feelings of elation within a short amount of time. As summarized by Joyce Venis and Suzanne McCloskey:

[PPD] can start during pregnancy…and may continue on after you give birth. It can happen to women after an abortion, miscarriage,…or stillbirth. It can strike women who had easy pregnancies and deliveries and no history of emotional problems or depression. Women who adopt babies have developed PPD, and some women experience it months and even years after giving birth…The symptoms vary with each individual and appear in differing degrees. [PPD] can last for several weeks, or if left untreated…can linger on for two years…postpartum depression is a different experience for everyone.

Postpartum depression occurs in roughly 10 to 40 percent of women, according to a study by Thirkettle and Knight. Tackett and Kantor note that the symptoms of PPD last longer and are more severe than that of the blues. Symptoms include (but are not limited to) tearfulness, feelings of inadequacy, numbness, sadness, reduced appetite, feelings of hopelessness and helplessness, over-sensitivity, anxiety and despair, irrational fears about baby, insomnia, suicidal ideation, and despondency. The onset of PPD typically occurs within the first year postpartum with duration of at least two weeks.

Many articles and books on postpartum depression suggest that there is a definite biological cause linked to this disorder. However, research has been inconclusive. According to Kruckman and Stern, researchers have not established that postpartum biological changes cause PPD. Kendall-Tackett and Kantor agree and assert that many studies used small sample sizes and had serious methodological inconsistencies, including lack of control groups and double-blind design. Herz makes the following assertion:
The generally presumed contributory role of physiologic changes on the development of postpartum illness is still without conclusive proof. Extensive studies evaluating gonadal hormones, prolactin, cortisol, thyroid hormones, tryptophan, and neurotransmitters have produced inconclusive results… no uncontested longitudinal cause-effect relationship between a physical factor and PPD has been established. It is generally acknowledged that an etiologic explanation of postpartum illness relying solely on physiologic changes is insufficient.

Although a strictly physiologic explanation for postpartum illness has been refuted, researchers continue to seek connections between the biological processes of pregnancy and childbirth to PPD. According to Kendall-Tackett and Kantor, the hormonal theory of PPD has been one of the most researched by clinicians. Of the hormones studied, the greatest focus has been on the role of progesterone and estrogen because of the sudden drop in their levels after childbirth. More recently, Jan Campbell has also examined the roles of the adrenal steroid cortisol, the hormone prolactin, and tryptophan in conjunction with PPD.

According to Kendall-Tackett and Kantor, O’Hara, Schlechte, Lewis, and Varner conducted the most carefully controlled and comprehensive study regarding the levels of the hormones estrogen, progesterone, prolactin, and cortisol. The researchers drew blood and urine samples from 173 women at various intervals both pre- and post-delivery and examined levels of the hormones. The authors found no significant differences in levels between depressed and non-depressed subjects. The authors concluded that there was little evidence of a hormonal influence upon postpartum depression. They also cited that more research was necessary in this area.

Campbell cites several studies in relation to cortisol, prolactin, and tryptophan and their possible role in postpartum illness. Like progesterone and estrogen, Campbell reports cortisol levels increase two to three times normal levels during pregnancy and
labor and then decline rapidly 48 hours after birth. Christiane Northrup describes cortisol as a key hormone produced by the adrenals that helps regulate mood and maintain emotional stability. A study by S. L. Handley, T. L. Dunn, and G. Waldron suggests that an elevated cortisol level at 38 weeks of pregnancy correlated with more severe outcomes of postpartum depression. In subsequent studies, V. Kuevi and associates and P. R. Gard and colleagues found no evidence to support a relationship between high cortisol levels and PPD.

According to Campbell, the relationship between prolactin, a pituitary hormone needed for lactation, and postpartum depression is being studied. In a study by I. Mastrogiacomo and others, the data collected did not support the relationship between prolactin and postpartum depression. However, V. L. Susman and J. L. Katz in an in-depth study noted a connection between weaning (equal to a drop in cortisol levels) and postpartum mood.

Another area of study, as referred by Campbell, has been in how the dietary amino acid tryptophan may be related to postpartum depression. As described by Leopold and Zoschnick, tryptophan is the main precursor for serotonin, a neurotransmitter believed to play a role in mood stability. In three separate studies cited by O’Hara, low tryptophan levels were noted in women suffering from PPD. However, O’Hara also remarks that in a double-blind, placebo-controlled trial replacing tryptophan, there were no effects in symptom reduction.

Kendall-Tackett and Kantor conclude that more comprehensive and carefully controlled studies are needed to support the connection between postpartum depression and hormones. They suggest that research should examine the effects of individual
hormones within the framework of the complete endocrine or limbic systems.\textsuperscript{cxlii} Additionally, Campbell notes that further study is necessary to draw any definitive conclusions.\textsuperscript{cxliii}

Although a comprehensive biological cause for postpartum depression is still unclear, a common form of treatment, according to Kruckman and Smith, is the use of psychopharmacological interventions.\textsuperscript{cxliv} Stephens suggests that postpartum depression is treated similarly to other types of mood disorders, namely with antidepressant medication.\textsuperscript{cxlv} Before the initiation of treatment, as indicated by Stephens, a thorough assessment including medical history, physical examination, and laboratory tests is warranted.\textsuperscript{cxlvii}

According to Nonacs, the course of treatment depends on the classification of the disorder.\textsuperscript{cxlviii} For mild to moderate postpartum depression, individual or group psychotherapy may be effective.\textsuperscript{cxlix} For moderate to severe cases of PPD, Nonacs suggests medication.\textsuperscript{cl} For severe postpartum depression, inpatient hospitalization may be indicated.\textsuperscript{cl} In some cases, as reported by Nonacs, electroconvulsive therapy (ECT) has proved safe and effective for severe PPD, especially in women with suicidal ideation.\textsuperscript{cli}

The drugs of choice for postpartum depression, as reported by Kruckman and Smith, are selective serotonin reuptake inhibitors (SSRIs).\textsuperscript{clii} These might include flouxetine (Prozac), sertraline (Zoloft), and Paxoxetine.\textsuperscript{cliii} Kruckman notes that some advantages to the SSRIs are fewer side effects, their safety in overdose situations, and that they are taken once a day.\textsuperscript{cliv} Monoamine oxidase inhibitors (MOA), according to Kruckman, are prescribed less often than SSRIs due to the obligatory dietary restrictions
and their negative interaction with other medications.\textsuperscript{clv} Several research studies address the efficacy of antidepressants for eliminating or lowering the symptoms related to PPD and has drawn contradictory or inconclusive evidence.\textsuperscript{clvi}

The National Institute of Mental Health (NIMH), as reported by Venis and McCloskey, is currently sponsoring clinical trials to establish the effectiveness of estrogen therapy for treating postpartum depression.\textsuperscript{clvii} A double-blind, placebo-controlled study by A. J. Gregoire, R. Kumar and B. Everitt reported that women treated with an estrogen patch showed a significant, rapid, and stable fall in their depressive symptoms.\textsuperscript{clviii} Treatments involving the use of progesterone injections have been the subject of a study by Katharina Dalton.\textsuperscript{clix} According to Robert Filer, Dalton’s study lacked a control group and nothing was done to eliminate the placebo effect; however, use of progesterone was shown to lower the incidence of postpartum depression.\textsuperscript{clx} Uzzi Reiss claims that in his 20 years of obstetrical experience, 90 percent of all cases of postpartum depression were resolved by administering a progesterone injection, and only a few patients required additional psychiatric help.\textsuperscript{clxi}

Venis and McCloskey caution that the use of hormone therapy to treat PPD remains tentative due to possible risks involved, inconclusive reports on its value, and the limited amount of research that has thus far been implemented.\textsuperscript{clxii} Kruckman concurs, citing the need to determine minimum effective doses, length of treatment, and the means of efficacy.\textsuperscript{clxiii}

In cases of mild to moderate postpartum depression, several authors, including Nonacs, Bennett, and Rosenberg, recommend some form of psychotherapy for the treatment of PPD.\textsuperscript{clxiv} A longitudinal study by Peter Cooper, Lynne Murray, Anji Wilson,
and Helena Romaniuk evaluated the long-term effect that psychological treatment had on the reported symptoms of PPD.\textsuperscript{clxxv} They concluded that psychological interventions, namely non-directive counseling, cognitive-behavioral therapy, and psychodynamic therapy, improved maternal mood in the short term.\textsuperscript{clxxvi} (For further discussion, see sections titled Cognitive/Behavioral and Psychodynamic Perspectives.)

Although postpartum blues, postpartum depression, and postpartum psychosis are considered by many authors to be the triumvirate of postpartum psychiatric illnesses, it is important to mention other categories that exist in the literature. Rosenberg, Greening, and Windell cite postpartum obsessive-compulsive disorder (PPOCD) as an illness in the PPD spectrum.\textsuperscript{clxxvii} In addition to PPOCD, Kleiman and Raskin mention panic disorder when discussing postpartum anxiety disorders.\textsuperscript{clxxviii} Bennett adds post-traumatic stress disorder to the list of postpartum illnesses, while Venis and McCloskey include postpartum mania.\textsuperscript{clxxix}

According to Bennett, postpartum obsessive-compulsive disorder exists in approximately three to five percent of new mothers.\textsuperscript{clxx} Bennett describes obsessions as “…unpleasant or intrusive thoughts that can repeat over and over in your mind for no apparent reason.”\textsuperscript{clxxi} She cites compulsions as behaviors that your mind fools you into believing you must do repeatedly.\textsuperscript{clxxii} Bennett provides a checklist of the top obsessions and compulsions for PPOCD, which include the need to count and/or check things repeatedly, the desire to clean and organize, germ phobias, images or thoughts of harming the baby or watching the baby being harmed, behaving in ways to prevent such imagined harm from occurring, and distrust of self, especially related to being alone with the
baby. Bennett proposes that psychotherapy and medication are useful in treating PPOCD.

Dunnewold and Sanford define postpartum post-traumatic stress disorder (PPPTSD) as a condition that unearths past experiences that cause anxiety and depression. The checklist of symptoms Dunnewold and Sanford provide for PPPTSD include panic attacks in response to specific situations, previous trauma (either recent or long ago), a sensation of returning to the traumatic event, nightmares about the trauma, and emotional numbness. Bennett adds the symptoms of fear, startling easily, and extreme sensitivity and awareness of surrounding stimuli. Bennett estimates that one to six percent of postpartum women suffer from PPPTSD. As in postpartum obsessive-compulsive disorder, Bennett recommends therapy and medication.

Kleiman and Raskin state that about two percent of postpartum women will develop postpartum panic disorder (PPPD). They describe PPPD symptoms occurring usually without prior warning and include being unable to catch one’s breath, a racing heart, trembling hands, hot flashes or chills, foreboding, dizziness, choking sensation, stomach pains or nausea, fear of leaving the house or being alone, or feeling like you are going to die or have a heart attack. Their recommendation for treatment is a medical examination to eliminate physical illness and being evaluated by a mental health practitioner.

Venis and McCloskey describe postpartum mania as another distinct postpartum illness. Others, including Bennett, refer to this syndrome as postpartum bipolar disorder. According to Venis and McCloskey, postpartum mania is brought on by the hormonal changes after birth. They cite a perceived need for less sleep, bursts of
energy followed by the need to get many things done, racing thoughts, irritability and excitability, rapid speech patterns, and disorganized thinking as some of the symptoms for postpartum mania. As indicated by Venis and McCloskey, successful treatment includes medication and therapy.

From micro-classifications to an absence of recognizing postpartum disorders as a separate psychiatric entity, the road to understanding postpartum psychiatric illness has been varied. It began over two millennia ago with observations made by Hippocrates. The medical community has continued to research PPPD for over two centuries, but so far has not arrived at any firm conclusions as to the etiology of or treatment for postpartum psychiatric illness. Even attempts at categorizing the illness lacks consensus. However, Venis and McCloskey state that the medical community’s growing interest in this area of research could ultimately clarify the causes of postpartum psychiatric illness as well as provide insight into prevention and effective treatments.

Cognitive/Behavioral Perspectives on Postpartum Psychiatric Disorders

Cognitive-behavioral perspectives on postpartum psychiatric illness focus on two primary areas: problematic thought patterns of new mothers that might influence mood and the efficacy of cognitive-behavioral therapy (CBT) in the treatment of PPPD. According to Nonacs, a cognitive-behavioral approach in therapy could be defined as a clearly structured and focused treatment with an emphasis placed on facilitating positive changes in the client’s negative thought and behavioral patterns.
Gerald Corey, two commonly practiced methods include Beck’s cognitive therapy model and Meichenbaum’s cognitive behavior modification.\textsuperscript{cxv}

Aaron Beck’s cognitive therapy model is rooted in the assumption that what people think determines how they will feel and act.\textsuperscript{cxvi} For Beck, the most direct course for altering dysfunctional emotions and behaviors is in adjusting inaccurate and dysfunctional thinking.\textsuperscript{cxvii} In treating depression, Beck’s method focuses on the content of the person’s negative thinking.\textsuperscript{cxviii} He emphasized three factors contributing to a person’s sense of depression: 1) clients hold a negative view of themselves; 2) they interpret experiences in a negative way; and 3) they possess a negative vision about their future.\textsuperscript{cxix} Through therapeutic techniques, Beck challenges the client’s negative self-view, supports problem resolution, and/or explores alternative points of view.\textsuperscript{cxi} In Beck’s therapeutic model, therapists tend to take the lead in assisting clients with making lists of their responsibilities, setting priorities, and creating a realistic plan of action.\textsuperscript{cxii}

Donald Meichenbaum’s cognitive behavior modification (CBM) therapy is similar to Beck’s cognitive therapy. The premise of both is the necessity for cognitive restructuring.\textsuperscript{cxiii} For Meichenbaum, a client’s self-statements affect behavior.\textsuperscript{cxiv} In CBM, a client must notice how they think, feel, and behave and how their actions affect others in order to change their behaviors.\textsuperscript{cxv} Meichenbaum developed a three-phase process consisting of self-observation, changing internal dialogue, and learning new skills.\textsuperscript{cxvi} The first phase involves the client observing their behaviors, thoughts, feelings, physiological reactions, and ways of reacting to others.\textsuperscript{cxvii} In the second phase, clients learn to recognize their self-talk and change this internal dialogue to fit their new, desired
outcomes. Lastly, the client learns new coping strategies that are practiced in real-life situations.

Cognitive behavioral therapy is one of the recommended treatments for mild to moderate postpartum psychiatric illness. CBT’s focus on here and now issues and problem-solving, as well as its consideration as a short-term therapy, inspires professionals to use this method for PPPD. According to Rosenberg, Greening, and Windell, a cognitive behavioral approach relies on the premise that people can control and change the way they feel.

Kleiman and Raskin agree with the idea that a person must learn to change the way they respond to certain situations and modify their thinking in order to manage the overwhelming emotions they feel. When working with women suffering from postpartum psychiatric illness, they utilize many cognitive behavioral methods. They might focus on a woman’s negative thought patterns and support them in creating a positive list of affirmations to counter-balance the damaging thoughts. Another consideration for Kleiman and Raskin is a woman’s distorted self-perceptions. In therapy, they might help the client replace these distortions with positive statements.

Rosenberg, Greening, and Windell suggest that therapy for postpartum psychiatric illness “should be oriented toward problem solving.” They cite that a cognitive behavioral approach to PPPD strengthens coping skills that may enable a woman to return to a higher level of functioning. They provide a list of practical behaviors and thoughts that CBT could address:

- How you’re sleeping
- The positive role of exercise…
- What your diet is like…
- How much stress you feel and how you’re coping with your stress
• Setting goals and establishing priorities
• Developing routines and providing needed structure in your life
• Managing your fears...
• Decreasing perfectionism and developing realistic expectations…

Venis and McCloskey argue that cognitive behavioral therapy may not be indicated for some women with postpartum psychiatric disorders. They note that typically CBT is considered a short-term therapy, lasting approximately from ten to fifteen weeks. They state, “…women with postpartum depression almost always need longer than the ten to fifteen weeks of treatment.” Also, they explain that a woman needs to be highly motivated and able to perform weekly assignments in order to benefit fully from CBT methods; therefore, they contend a depressed mother needs less work and keeping track of her thoughts and behaviors might prove too formidable a task.

For those practitioners using a cognitive behavioral approach, Bennett stresses focusing on the client’s distorted thoughts, bringing these thoughts to conscious awareness, and helping the client to change them. Bennett mentions common thought distortions of new mothers, such as “I’m a bad mother” and “I’m a failure.” She recommends a four-step practice to follow in order to change the pattern of negative thinking.

For Bennett, the first step in combating thought distortions is being able to recognize them. She suggests that when a PPPD sufferer feels most low, chances are she is telling herself something negative. Step two involves congratulating yourself when you are able to recognize any negative thoughts. The premise here is that it is better to catch yourself in the middle of a negative rant than to continue mentally beating yourself. Bennett proposes that in the next step, the woman apologizes to herself for the mean thoughts she has had. She believes it is vital to treat oneself as well as
another; the average person usually would apologize after uttering the types of negative statements that a PPD sufferer says to herself. The last step in Bennett’s model is for the woman to speak the truth. Bennett states that the mind gets healthier when you repeat positive and true affirmations, thus assisting in changing mood and behavior.

Kleiman and Raskin provide a list of negative thoughts commonly experienced by PPD sufferers. They include such examples as:

- I should always enjoy being a mother
- I am a bad mother
- I’m weak if I ask for help
- I should feel loving towards my baby at all times
- I should be able to do it all
- If I have needs, I’m selfish
- I’m all alone; no one understands me
- I should know what to do

Kleiman and Raskin, like Bennett, maintain the importance of recognizing negative thoughts and replacing them with positive statements. They suggest that in reinforcing positive statements, eventually they will replace the automatic negative thought patterns, which in turn might affect mood and behavior.

Researchers have conducted studies to ascertain if what practitioners like Kleiman, Raskin, and Bennett contend—that cognitive behavioral therapy is effective in treating PPD—can be scientifically proven. An oft-cited study by Peter Cooper, Lynne Murray, Anji Wilson, and Helena Romaniuk looked at the short- and long-term effects of different psychological treatments, including cognitive behavioral therapy. In this randomized, controlled trial, 194 first-time mothers with postpartum depression were placed in four treatment groups. The four groups consisted of routine primary care, non-directive counseling, cognitive behavioral therapy, and psychodynamic
The therapy sessions occurred for one hour, once a week for 10 weeks. Women were assessed immediately after the treatment phase of the study and then again at 9, 18, and 60 months postpartum.

The results of Cooper et al.’s study indicated that all three treatments had a significant impact on maternal mood at four-and-a-half months. The benefit of treatment however was no longer apparent by nine-months postpartum, nor did it reduce subsequent episodes of postpartum depression.

A rebuttal to Cooper’s study by P. J. McGrath, F. J. Elgar, C. Johnston, D. J. A. Dozois, and S. Reyno addresses the issue of treatment focus. The authors maintain that Cooper et al used cognitive behavioral techniques focusing on mother-infant interactions, rather than on treating depression. The exclusive focus of the study, the authors claim, prevents one from knowing the efficacy of CBT for postpartum depression; therefore, the study is misleading in its assertion that CBT has no long-term effect in relieving PPD symptoms. Cooper and Murray responded to this criticism by reiterating the legitimacy of their study and stating, “The findings of our study, along with the broad failure of the trials of preventive treatments for [PPD], would seem…to be cause for pause and reflection, rather than instinctive defensiveness.”

A randomized controlled double-blind trial by Louis Appleby, Rachel Warner, Anna Whitton, and Brian Faragher examined the efficacy of cognitive behavioral therapy compared to the antidepressant drug fluoxetine in the treatment of non-psychotic postpartum depressive illness. A group of 87 women with PPD were divided into four treatment groups: fluoxetine or placebo plus one or six sessions of cognitive-behavioral counseling. The study concluded that both fluoxetine and CBT were
effective treatments for postpartum depression. An important finding of this trial was that no benefit was found in combining the use of fluoxetine with CBT, and therefore, women with PPD who are reluctant to take medication could choose cognitive-behavioral therapy, which was found to be as equally effective as the antidepressant medication in treating postpartum depression.

Another study by Shaila Misri, P. Reebye, M. Corral, and L. Millis explored whether the addition of cognitive behavioral therapy to standard antidepressant therapy offered any further benefit in the treatment of PPD. Thirty-five women with postpartum depression were randomly assigned to one of two treatment groups. The first group received antidepressant-only treatment; the second, antidepressant therapy plus 12 sessions of CBT. The results showed both treatment groups having a significant improvement in mood and anxiety symptoms. However, no additional benefits were found in combining antidepressant therapy with cognitive behavioral interventions. The authors note that further research in this area is recommended.

A more recent study by Jeannette Milgrom, Lisa Negri, Alan Gemmill, Margaret McNeil, and Paul Martin investigated the benefit of psychological interventions versus routine primary care for the management of postnatal depression. A group of 192 women with PPD were divided into three treatment options: cognitive behavioral therapy, counseling, and routine primary care. The interventions occurred over 12 weeks, including three sessions with partners. The results of the study suggested that women receiving psychological interventions, in this case CBT or counseling, had a significant reduction of depression and anxiety compared to those receiving routine care.
According to research conducted by Sarah Bledsoe and Nancy Grote, cognitive behavioral therapy, both alone and in conjunction with antidepressant medication, produced positive effects in treating non-psychotic major depression during the postpartum period.\textsuperscript{cclx} Again, as in the findings of Appleby \textit{et al} and Misri \textit{et al}, the authors did not find significant differences between antidepressant therapies used alone or in conjunction with CBT.\textsuperscript{cclxi} Also, cognitive behavioral therapy was one of several psychological treatments that were found to be equally effective in relieving symptoms of PPD.\textsuperscript{cclxii}

A cognitive-behavioral approach to postpartum depression appears to be effective in some treatment strategies, as evidenced by the aforementioned studies.\textsuperscript{cclxiii} However, it is important to note that researchers, including Cooper and Misri, have concluded the need for more trials in this area to ascertain a richer understanding of how CBT can be used to benefit the new mother suffering from postpartum psychiatric illness.\textsuperscript{cclxiv} Some practitioners, namely Kleiman and Raskin, as well as Rosenberg, Greening, and Windell, have supported the use of cognitive-behavioral therapy because of its focus on present time issues and on the negative thinking patterns and maladaptive behaviors that complicate the symptoms of PPD.\textsuperscript{cclxv}

\textbf{Psychodynamic Perspectives on Postpartum Psychiatric Disorders}

A psychodynamic perspective on the subject of postpartum psychiatric illness has two, distinct divisions: one rooted in practice, the other in theory. Within practice, the psychodynamic perspective surveys the separate models of psychodynamic therapy, offers definitions for these practices, and investigates their function as a treatment option
for postpartum depression. The theory component looks, through a psychodynamic lens, at the role of motherhood and the importance this role occupies for both mother and child. The study explores how the perceived importance of the mother might be connected to postpartum psychiatric disorders.

The term *psychodynamic* is attached to two models of therapeutic practice. One model is closely aligned with psychoanalytic tradition; the other, although bearing some resemblance to psychoanalysis, includes a modern interpretation of classical analytic thought. It is important to understand the distinction between these two terms because, in the case of postpartum psychiatric illness and as stated by Kleiman and Raskin, one model is considered a viable treatment for PPD, while the other is not.\textsuperscript{cclxvi}

As referenced by James Chaplin, the psychoanalytic model is a branch in depth psychology that seeks to understand human behavior by exploring conflict and motivation deep within the client’s unconscious.\textsuperscript{cclxvii} As indicated by Misri, most psychodynamic theories focus on childhood experiences in order to understand present-day issues.\textsuperscript{cclxviii} Misri states that therapists who use psychodynamic theory tend to collect a far-reaching amount of information about their clients.\textsuperscript{cclxix} A psychodynamically trained therapist might want to know about the client’s present situation, along with their past experiences, their relationships with others, and their behaviors and thoughts over time, according to Misri.\textsuperscript{cclxx} Traditionally, as indicated by Rosenberg, this type of psychodynamic therapy requires a long-term commitment and could take years to complete.\textsuperscript{cclxxi}

The second model mentioned is *psychodynamic therapy* or *brief dynamic therapy*. Hanna Levenson describes brief psychodynamic therapy as a more rapid process than
traditional psychoanalysis, with an emphasis on the here-and-now issues of a client rather than a deep perusal of underlying material.\textsuperscript{cclxxii} According to Levenson, brief psychodynamic therapy singles out the most important issues in the client’s life.\textsuperscript{cclxxiii} The therapist and client decide to work on one major focus, which in turn creates structure, identifies a goal, and provides a treatment plan.\textsuperscript{cclxxiv} Levenson states that traditionally, 25 sessions is considered the maximum limit for brief dynamic therapy, while the range may be from as little as one session to 40.\textsuperscript{cclxxv}

When considering a treatment for mild to moderate postpartum psychiatric illness, some experts in the field agree that a psychoanalytic model, with its orientation towards unconscious drives, repression, and the past, proves an inappropriate option for treating an illness requiring rapid symptom relief.\textsuperscript{cclxxvi} Several authors, however, cite brief psychodynamic therapy as a worthwhile treatment for PPD.\textsuperscript{cclxxvii} Bennett provides a useful metaphor that supports brief psychodynamic therapy’s emphasis on symptom relief over the unearthing of long-term problems through psychoanalysis.\textsuperscript{cclxxviii} She asks the reader to imagine a house on fire due to faulty electrical wiring; she then questions, “Would you rewire your house…and then put out the fire, or would you put out the fire first and then rewire the house?”\textsuperscript{cclxxix}

Kleiman and Raskin reiterate Bennett’s point, stating that the initial stage of treatment for PPD should focus on today’s issues, rather than exploring the client’s past or childhood significantly.\textsuperscript{cclxxx} They support the notion of working on immediate, short-term goals in order to carry on with the daily practicalities of motherhood.\textsuperscript{cclxxxi} Rosenberg concurs: “A therapist should be oriented toward problem-solving. When you have [PPD], it’s not always the time to tell your entire life story.”\textsuperscript{cclxxxii}
The use and efficacy of psychodynamic therapy in the treatment of mild to moderate postpartum psychiatric illness has been the focus of research studies. These studies hope to gain knowledge about which forms of treatment might prove most helpful in relieving symptoms of postpartum depression.

Cooper, Murray, Wilson, and Romaniuk conducted a study that is cited most frequently in the literature on treatment for postpartum depression. In this randomized, controlled trial, 193 women with postpartum depression were assigned to one of four treatment groups, including a group that utilized psychodynamic therapy. The women were assessed after the treatment phase at four-and-a-half months, and later at nine, 18, and 60 months postpartum.

The results of the study reveal that psychodynamic therapy had a significant impact on maternal mood at four-and-a-half months postpartum. Also, only the psychodynamic treatment produced a reduction in depression. The study also shows that by nine-months postpartum, the benefit of treatment was no longer evident and the treatment did not diminish consequent episodes of PPD. Cooper mentions that the results of his trial were disappointing and that more research is needed to clarify what, if any, psychological treatments work to reduce the symptoms of postpartum depression.

It is important to mention another form of therapy that has been studied in relation to PPD. Interpersonal psychotherapy (IPT), although not the same as psychodynamic therapy, shares similarities worth noting. IPT, like psychodynamic therapy, focuses on the here-and-now issues a client brings forth and, according to Cindy Dennis, is a time-limited therapeutic intervention. As stated by Dennis, IPT looks at the connection
between the onset of the depression and interpersonal problems. Dennis further states, the therapist investigates the client’s social history, noting significant relationships, patterns, and expectations the client holds. A link between the current interpersonal situation and the past is then established as the therapist outlines a treatment strategy.

Interpersonal psychotherapy has been included as a treatment model in trials determining the efficacy of therapeutic interventions for postpartum psychiatric illness. Michael O’Hara, Scott Stuart, Laura Gorman and Amy Wenzel conducted a randomized controlled trial consisting of 120 women diagnosed with PPD. The women received 12 weekly individual counseling sessions. The results of the study showed that 43.8 percent of women in the counseling group, versus 13.7 percent controls had significantly recovered after three months. O’Hara et al concluded that IPT is a good treatment for postpartum depression and provides women with an alternative to medication.

Although there is some evidence to support recommending brief psychodynamic and interpersonal therapy for postpartum depression, according to Dennis there is a great need for better-designed trials with large sample sizes. Dennis also recommends long-term follow-up to determine the treatment’s efficacy over time.

The psychodynamic perspective, in contrast with the biological and cognitive-behavioral models, is not limited to a discussion of studies focused on what forms of therapy might prove promising in alleviating the symptomatology of PPPD. Another facet of the psychodynamic viewpoint encompasses the definition and interpretation of the role of motherhood and the importance this role carries in shaping personality. An
exploration of psychoanalytic theories has relevance to a discussion on postpartum depression. These theories have contributed to the modern discourse on motherhood and have influenced how women internalize this role.

Sigmund Freud, the father of psychoanalytic theory, speculated on the impact the mother possessed on the child. Psychoanalysts Erik Erikson and John Bowlby added their own theories of development, which included the significance of mother-infant relations in forming and shaping human capacities. It is not the intention nor scope of this study to include an exhaustive report on the works of Freud, Erikson, or Bowlby; however, brief mention will be made on each man’s contribution to the psychoanalytic exploration of the central importance of the mother figure.

According to Robert Karen, the importance of the mother-infant bond was never fully developed by Freud. However, as recounted by Calvin Hall and Gardner Lindzey, in Freud’s theory on the stages of development, he acknowledged that the first few years of life are vital to the formation of personality. In describing the oral stage of development, Freud recognized that the baby is almost completely dependent upon its mother for survival and that dependency needs are set during this time. As paraphrased by Hall and Lindzey, Freud theorized that these feelings of dependency remained throughout life, in spite of later ego growth, and were inclined to arise whenever the person felt anxious or insecure.

Himmut Rana maintains Freud placed a great deal of importance on the early experiences in childhood and believed that who we are as adults is determined by these childhood events. In 1938, just prior to his death, Freud described the importance of the early relationship to the mother as “…unique, without parallel, laid down unalterably
for a whole lifetime, as the first and strongest love-object and as the prototype of all other love relations…”  

Although, according to Karen, the “tie to the mother” is not directly stated in much of Freud’s writings, it seems Freud, late in his life, was able to name the mother as the central figure in the child’s world.

In the twenty years following Freud’s death, psychoanalysts were exploring the relationship between mother (or maternal figure) and child and, in the words of Judith Warner, were popularizing the idea that whatever the mother did or did not do in relationship to her infant would have great consequence to that child’s psychological growth. As indicated by Karen,

By the 1950s, most analysts were at least informally agreed that the relationship with mother is of critical psychological importance, that the child’s first relationships are key foundations of his personality, and that his tie to his mother is, by the end of the first year, very strong.

Erik Erikson, who considered himself a Freudian psychoanalyst, pioneered a psychosocial theory of human development that has at its foundation the idea that an infant’s encounters with trustworthy maternal persons lays the groundwork for a human’s sense of self. Erikson’s theory is constructed in different stages. Each stage holds a basic ego quality and ego strength or virtue, as well as the ritualization that emerges as one moves through that particular stage of development. By ritualization, Erikson refers to a “…playful and yet culturally patterned way of doing or experiencing something in the daily interplay of individuals.”

In infancy, the ego quality worked out is basic trust versus basic mistrust. Trust is internalized when the maternal figure responds consistently to the infant’s needs. Out of this trust, the virtue Erikson calls hope emerges. Of hope he writes, “Hope is both the earliest and the most indispensable virtue inherent in the state of
being alive.”  The ritualization that occurs in infancy Erikson refers to as the numinous. Erikson defines numinous as the infant’s sense of the sacred presence of its mother, “…her looking, holding, touching, smiling, feeding, naming, and otherwise ‘recognizing’ him.” This recognition of the infant by its mother forms the basis of the infant’s very right to be; without it, the growing human feels estranged and abandoned.

In discussing the importance of the mother figure, Erikson writes:

To the human infant, his mother is nature. She must be that original verification, which, later, will come from other and wider segments of reality. All the self-verifications, therefore, begin in that inner light of the mother-child-world, which Madonna images have conveyed as so exclusive and so secure: and, indeed, such light must continue to shine through the chaos of many crises, maturational and accidental.

But Erikson also cautioned about the propensity, in his day, to overextend the reach an individual mother has on shaping personality. He felt that this narrow approach unnecessarily burdened the mother-child relationship with the overarching “…responsibility for man’s sanity and maturation.” Erikson affirmed that his developmental theory included the influences on an individual across the life span, rather than deriving “…the meaning of development primarily from a reconstruction of the infant’s beginnings.”

In contrast, John Bowlby, according to Karen, believed that the mother-infant relationship determines a person’s future security and well-being. Warner accredits Bowlby as the mastermind behind attachment theory, the idea of how an infant forms a bond with its mother. Warner emphasizes the impact of Bowlby’s theory by calling it “…the most important ideas to date on the nature of mother-child bonding.”
Bowlby was one of the pioneers in stressing not just an infant’s physiological attachment to the mother, but also the psychological need for attachment. He writes,

Children raised…without the consistent attention of mothering persons suffered major and irreversible psychological setbacks in later life. Mother love in infancy and childhood is as important for mental health as are vitamins and proteins for physical health.

Bowlby espoused that healthy attachment to the mother is not only essential for survival of the organism, but defines a person’s self worth, a belief in the good will of others, self competence, and provides the blueprint for all future relationships.

According to both Karen and Warner, Bowlby’s attachment theory helped perpetuate the notion of a mother’s all-encompassing power in shaping her child. Warner contends that attachment theory instilled a new fear in mothers: not only was she responsible for the physical comforts and needs of her child, but also for how well she attuned to the infant’s psychological needs. Every problem, every foible in your personality, Warner laments, could now be traced back to your mother.

From the vantage point of the psychoanalytic tradition many theories of human development, including Freud’s classical psychoanalytic theory, Erikson’s psychosocial theory of development and Bowlby’s attachment theory, have sought to understand the significance a mother has on determining her child’s personality. These psychoanalytic pioneers advanced the notion that the mother, or maternal figure, has a profound and wide-reaching effect on a child’s psychological growth and progress. The lasting consequence of their developmental theories, as maintained by Warner, is that women began looking at motherhood as an anxiety-producing, high-stakes proposition, which
could possibly lead to devastating outcomes for her child if she failed to be mother

enough. ccccxxxviii

In the cognitive-behavioral section, a mother’s negative thought process was seen
to have consequences in intensifying and prolonging symptoms of postpartum
depression. The psychodynamic perspective seems to support this notion by presenting
the theories that perpetuated the idea of a mother’s central importance to the
psychological health of her child, thus embedding a far-reaching sense of responsibility
to be a good mother. Warner argues that anything short of perfection is seen as
failure. ccccxxxix Perhaps future researchers of postpartum psychiatric disorders will ponder
the significance of the belief in the mother’s central importance, the influence she bears
on her children’s well being, and the pressures felt by this impending task.

Sociocultural Perspectives on Postpartum Psychiatric Disorders

Postpartum psychiatric illness from the sociocultural perspective involves an
examination of a society’s beliefs, customs, and social behaviors and a consideration of
how these systems support or neglect the needs of a birthing mother. In this section,
cultural definitions and expectations of motherhood will be discussed, as well as the
implications these beliefs have on new mothers. The exploration of customs will include
a look into birth practices and rituals and whether these practices have some bearing on
promoting or preventing postpartum illness. Social behavior will be reviewed by delving
into the actions and conduct of the people and institutions that interact with the
postpartum mother and how these interactions affect her both positively and adversely.
Public policy also will be considered in terms of the social assistance a new mother receives.

According to Ruth De Kanter, the cultural beliefs we hold about motherhood are fashioned from images in books, magazines, movies, television, and advertising. De Kanter adds, These external images become internalized ideas about mothering, De Kanter adds. De Kanter, as well as Bennett, Dunnewold and Sanford, and Raskin and Kleiman, have summarized the central themes extracted from this ideology of motherhood. They state that American cultural beliefs romanticize motherhood, advancing unrealistic expectations and assumptions that knowing how to mother is an inborn trait. In addition, they contend that existing beliefs about motherhood perpetuate the notion of a super-human mom who can do no wrong.

Naomi Wolf agrees with the assertion that American women are given an unrealistic image of motherhood as natural and effortless. She insists that American women are unprepared for the real experience of motherhood, which she alleges is a “…work of stoicism, discipline, patience, and will…” born of great effort on the new mother’s part, rather than a natural by-product of biology. Believing the culture’s idealized representations of motherhood, she contends, suspends the new mother in a state of self-blame, silence, and disappointment.

A 1986 study by D. D. Affonso and T. G. Arizmendi supports Wolf’s claim. Their research trial, in which 80 postpartum women were interviewed and given both the Beck Depression Inventory and the Pitt Questionnaire (a measure of postpartum depression), concluded that a woman was more likely to experience postpartum
depression if they had unrealistic expectations for themselves as mothers and felt incompetent as a mother.  

Another study by R. Warner, L. Appleby, A. Whitton, and B. Faragher using the Maternal Attitudes Questionnaire (MAQ), measured the thoughts of a sample of 483 women at six to eight weeks postpartum. The researchers concluded that the postpartum depression group had similar responses regarding role changes, expectations of motherhood, and expectations of the self as a mother and contrasted significantly with the answers of their non-depressed counterparts. The aforementioned studies confirm what postpartum depression experts declare: how competent a woman feels as a mother can influence whether she becomes depressed.

This feeling of competency in the role of motherhood can be significantly enhanced or diminished by the customs or rituals performed by the culture in which she lives, explains Laurence Kruckman. Kruckman contends that the statistically higher numbers for postpartum depression in the United States compared to that of non-western cultures, results from the lack of peri- and postnatal rituals. He argues that postpartum rituals may reduce or prevent PPD by providing structure to postpartum events, social recognition to a role transition, and meaningful support to the new mother.

Kruckman illustrates the value of ritual by contrasting American births and postpartum recoveries to those of non-western societies where little evidence of postpartum psychiatric illness exists. Wolf, Catherine Cartwright Jones, and Robbie Davis-Floyd also draw the distinction between an American birth and postpartum experience to that of non-western cultures that have retained traditional customs.
Wolf exposes weaknesses in the modern birth industry, including a high technological intrusion in which the birthing woman becomes a footnote in her own birth experience. Atul Gawande also questions modern obstetrical practices where “…the mother’s pain and blood loss and length of recovery seem to count for little.”

The postpartum period is also questioned in terms of structured support for the new mother. Kruckman points out that western societies ruled by modern medical concepts consider the postpartum period to last only as long as a woman is hospitalized. With this postpartum period, Kruckman argues, the need to extend social support and policy to provide assistance and recognition for the new mother beyond hospitalization becomes obsolete.

In other, non-western cultures, Kruckman maintains that birth and the postpartum period are treated as “…a traumatic life crisis event.” Kruckman examined cultures in which postpartum depression was not in evidence and hypothesized that these cultures had constructed rituals to provide for this vulnerable time, allowing the new mother rest and protection, as well as recognition of her new status. Wolf concurs with Kruckman’s analysis, adding, “…[T]here are good reasons for other cultures to treat new mothers as if they are in a heightened, vulnerable state. They are.”

In many non-western cultures, according to Wolf, women experience what is known as the lying in period, a length of time in which the new mother rests and is nurtured by family and other women in the community. Kruckman notes that the rest period ends with the new mother being cleansed and purified and her changed status from maiden to mother is celebrated within her community. Kruckman and colleague Gwen Stern state that further research is needed to examine the high percentage
of postpartum depression in the United States compared with non-western settings where rituals to support the postpartum mother are practiced. Postpartum rituals provide structures that mandate certain social behaviors. The ritual in place informs various community members of expected actions and conduct. As Kruckman and Wolf point out, these actions assist the new mother as she recovers from the birth experience and transitions into motherhood, and accomplish what D. Rafael has termed *mothering the new mother*. Kruckman, providing several examples of social support built into ritual, contends that cultures retaining this support system through ritual have little or no incidence of postpartum depression.

In contrast with this nurturing support is the expectation held in the United States, according to Wolf, for new mothers to go it alone. Elizabeth Davis argues that the postpartum mother in America, who is often left alone to heal herself and nurture her baby, epitomizes the cultural denial of the monumental task of mothering. Harriet Rosenberg agrees that the mother’s work in American society is often a 24-hour-a-day responsibility with little relief or support from others. Rosenberg connects this lack of support with the high incidence of PPD in the United States.

Several studies have suggested a link between a lack of social support and postpartum depression. These studies focus on how much and what kind of assistance a new mother receives from their partners, relatives, friends, and institutions. A study by Carolyn Cutrona illustrated that the type of social support a new mother receives has an influence on postpartum depression. In Cutrona’s study of 71 first-time mothers, the two areas of social support that were most predictive of postpartum depression included the support network of people with whom the mother
shared interests and concerns and the people the mother could count on for help. The study concluded that a new mother’s support from others provided rest, opportunity to grow into her new role, and practical assistance enhancing her own mothering skills.

Kendall-Tackett and Kantor insist that a “…woman’s level of social support is perhaps the single most important variable to consider in the study of postpartum depression.” Two recent studies focused on social support as a predictor for postpartum depression. Forman Nielsen et al designed a community-based study involving 5,252 women who attended an antenatal clinic. The women completed a series of questionnaires including questions pertaining to social support. At four-months postpartum, women who were believed to have postpartum depression (based on The Edinburgh Postnatal Depression Scale) also reported a lack of social support. The researchers concluded that assessing a woman’s social support network might identify women at risk for developing PPD.

A second study by T. S. Brugha et al also evaluated the role of social support in predicting postpartum depression. The study reviewed questionnaires and assessment scores of 507 pregnant women. The research showed that postpartum depression could be predicted by how the pregnant woman perceived deficits in her social support. The researchers concluded that interventions should be designed to shore up a pregnant woman’s social support network as a possible preventive measure to developing PPD.

A woman’s social support network may include her husband or partner, relatives or friends who offer the postpartum mother validation, encouragement, help with the
workload, and other forms of support and assistance. It might also include institutions or policy that allow for the continuation of the care-giving process well beyond birth. As Wolf asserts, the data supports that women cope much better with intensive postpartum assistance. 

Wolf argues that America is the only industrialized country without “…national maternity benefits, paid leave, or a coherent day care policy.” Wolf outlines what postpartum mothers need from their institutions of government. Her list includes real family leave and flextime, health care benefits for all mothers-to-be and new moms, on-site day care, an overhaul of the birthing industry, and tax incentives/deductions to encourage parents to take time off to raise their babies. Warner shares a similar vision, stating mothers require “…institutions that can help us take care of our children so that we don’t have to do everything on our own.”

Although no policies have been passed recently to support the aforementioned visions of Wolf and Warner in regard to postpartum psychiatric disorders, two pieces of legislature are of significance. The first, known as Public Law 2006 c12, took effect in October 2006 in the state of New Jersey. The law, the first of its kind, requires physicians in New Jersey to educate pregnant women about postpartum depression and screen new mothers for PPD. Advocates of New Jersey’s new law see it as a positive step in supporting new mothers, their infants, and families. Proponents of the law, including Lauren Streicher, fear that it sets a precedent, forcing physicians to screen for a particular disease.

The second significant piece of legislation to support mothers suffering from postpartum depression was passed on October 15, 2007, by the United States House of
Representatives by a vote of 382 to three. The bill, H. R. 20: The Melanie Stokes Postpartum Depression Research and Care Act, was introduced in 2001 by Congressman Bobby Rush. The bill will help fund research and public-awareness campaigns in connection to postpartum depression, as well as finance grants for screening, treatment, health care and support services for women with PPD. H. R. 20 has been sent to the Senate and awaits approval.

The passing of H. R. 20 and New Jersey’s implementing of mandatory postpartum depression screening might reflect the public’s emerging image of motherhood in the 21st century. Perhaps the beliefs around motherhood are inching toward the reality lived by postpartum mothers, a reality according to Wolf that includes realizing that mothers are made, not born, a mother requires meaningful rituals to address the profound physical and psychological transformations she experiences, and that postpartum mothers need not only social support from partners, family, and friends, but also from the institutions designed to protect them.

**Imaginal Approaches to Postpartum Psychiatric Disorders**

In reviewing imaginal approaches to psychopathology, a journey to the outer edges—and the archetypal realms—becomes crucial in the study of postpartum psychiatric illness to consider the importance of mythic and universal themes. In this section, the term *imaginal approach*, especially as it pertains to care of the soul and the soul’s relation to psychological symptoms, will be defined. The concept of pathologizing as voice of the soul is defined and considered, as well as the concepts of adaptive identity, imaginal structures, multiplicity, ritual, and ritualized pathologizing. The
development of the archetypes will be traced as a means of understanding the soul’s language. The mother archetype will be envisaged through the concept of the feminine principle and the Great Mother Goddess myth.

An imaginal approach to psychology is one that reclaims soul as psychology’s fundamental concern. For thousands of years mankind has attempted to define soul. James Hillman provides a list of words associated with the concept of soul, including mind, spirit, heart, essence, and purpose. Hillman refers to soul as “…that unknown component which makes meaning possible…. the deepening of events into experience…. the imaginative possibility in our natures…” Hillman insists that soul is synonymous with imagination. Taking some of these definitions of soul into account, this study considers an imaginal approach to psychology to have at its core an interest in the imagination’s (or soul’s) expression, the soul’s capacity for experience, and the meaning we make of these soul experiences. With respect to postpartum psychiatric illness, an imaginal approach might remain curious to viewing PPD as the voice of soul.

Freud, C. G. Jung, Hillman, and Thomas Moore all believe that one of the ways the soul presents itself is through pathology, or as Freud referred to it, the symptom. Hillman states that pathologizing “…returns us to soul, and to lose the symptom means to lose this …way of soul.” He describes pathologizing as the psyche’s ability to create disease, chaos, suffering, and abnormality in any facet of human thought or behavior.

According to Hillman, pathology is the voice of soul cracking through the normative identity. By normative identity, Hillman refers to the ideal and statistical norm of man, which is at odds with his vision of personality as many-sided or multiplicitous; this multiplicity of self is a reflection of the psyche’s polytheistic
He suggests that psychology’s concern be redirected from curing pathology to serving it; serving soul is accomplished by listening to what pathology is saying about soul and what soul is speaking by means of pathology. In relationship to postpartum illness, serving soul would be accomplished through listening to postpartum depression as having wisdom and insight into an individual, cultural, or archetypal situation.

Aftab Omer elaborates on three concepts used in an imaginal approach: adaptive identity, imaginal structures, and ritualized pathologizing. These imaginal concepts bear resemblance to and fine tune Hillman’s ideas on normative identity, multiplicity, and pathology.

Omer states that those of us who function well in society, as measured by having a job, relationships, or the ability to get through the tasks of day-to-day living, have adapted to the culture we live in. Culture can include the culture of family, of place, of society or necessity, and these cultures are infused with what Omer calls “a web of habits.” From birth we craft our personality in order to survive within these cultural webs. Omer calls these patterns of personality the adaptive identity.

According to Omer, a complex of imaginal structures forms adaptive identity. Imaginal structures, Omer contends, are constructed out of internalized cultural forces, personal stories, and archetypal influences that each person experiences. Imaginal structures are one way the soul’s voice crystallizes and takes shape.

Omer points out that the adaptive identity, with its complex of imaginal structures, works well enough in our day-to-day living, but not as well in the face of pathology. A principle that Omer espouses is that pathologizing is the soul’s attempt to “sprout through the dead concrete” of our adaptive identity. Both Hillman and
Omer see pathology as a good sign, as soul’s efforts to return multiplicity to the embedded nature of the adaptive identity.\textsuperscript{cdxviii} According to Omer, pathologizing is the soul’s means of correcting, healing, and rebalancing our personal stories, cultural pressures, and archetypal influences.\textsuperscript{cdxix} An imaginal approach to postpartum psychiatric illness might consider PPD as the soul’s way of cracking through the adaptive identity.

Omer cautions that before the pathologized symptoms overwhelm any relationship we have with our environment, each other, our family, or community, it is essential to find a way to ritualize its expression.\textsuperscript{cdxx} Omer equates the word ritual with structure and suggests that when ritual is implemented, it allows other structures, like adaptive identity, to give way.\textsuperscript{cdxxi} The ritual containment sanctions the restorative and rebalancing dimensions of pathologizing.\textsuperscript{cdxxii} Omer suggests that ritualized pathologizing can be seen as a catalyst for restoring our inherent integrity.\textsuperscript{cdxxiii} It is within this ritual container that the multiplicity of soul, beyond the constraints of the entrenched adaptive identity, can be seen and held. The imaginal structures can come out of hiding and be heard.\textsuperscript{cdxxiv}

The purpose of this larger structure is to provide a container that has the capacity to hold the powerful imagery, emotion, and content held within the various parts of the self. In indigenous culture, this ritualized pathologizing is a part of everyday life, and, according to Malidoma Somé, its purpose is to restore balance to the individual and the community.\textsuperscript{cdxxv}

Somé insists indigenous culture spends more time in this kind of ritual-making than outside of this realm due to their close relationship with nature; but modern people, who are detached from the natural world, must practice ritual and live inside ritual space
in order to “…first awaken that natural self and then maintain it.” The repeated practice of ritual begins to release the parts of the self that have been unconscious and dormant. Somé explains the role of ritual in awakening these dormant and unexpressed parts of an individual:

Ritual is aimed directly at the individual’s psyche; it is a language of invocation, inviting the inner self to come out. For the inner self to show itself in the individual, it must be invoked over and over and over until it does.

According to Somé, ritual takes us to an unfamiliar place where we lose our ordinary sense of orientation and familiarity. The more we practice ritual, the more trusting we become of its ability to accommodate the unfamiliar. Somé points out that we bring into ritual a trust that we will become aware of what needs our attention and the forces necessary to heal will emerge. Within the ritual container, all manner of pathology is seen and served.

Hillman asks us to imagine this pathology, not only as the voice of the soul but also as an enactment of myth. He contends that pathology as myth lends an archetypal backdrop to our own history. For Hillman, myths are not merely lifeless stories from long ago, but they live through us and are told through our life story. To understand the individual, according to Hillman, we must befriend the symptom; in turn, the symptom represents a vaster story, a myth constructed from archetypal material.

Two concepts have been introduced that bear further definition: archetype and myth. C. G. Jung writes that archetypes are the “…forms or river-beds along which the current of psychic life has always flowed.” Jung proposes that archetypes have subsisted perhaps since the existence of mankind and depicts them as the contents of the
collective unconscious—the part of the unconscious that is inherited and common to all mankind.\textsuperscript{cdxxxvi}

Erich Neumann traces the origin and transformation of archetypes through the evolution of consciousness from primitive to modern man.\textsuperscript{cdxxxvii} Neumann contends that for primitive mankind, the archetypes were steeped in a primordial stew where masculine and feminine, good and evil, consciousness and the unconscious were all combined.\textsuperscript{cdxxxviii} Neumann states as consciousness became more differentiated, the archetypes developed into more structured forms and began projecting the meaning man made of them.\textsuperscript{cdxxxix} Neumann tracks the conversion of the all-encompassing, primordial archetype into the archetypal feminine, which in turn, through the years, becomes the Great Mother.\textsuperscript{cdxli} To Neumann, the Great Mother still contains the polarities found in the original, primordial archetype, realized as the Good Mother and the Terrible Mother.\textsuperscript{cdxlii} From this point, asserts Neumann, the attributes of the Great Mother become fragments held in a single feminine aspect or figure, such as the Gorgon (Terrible Mother) or the Virgin Mary (Good Mother).\textsuperscript{cdxlii} Translated into modern iconology, Mother Theresa embodies the Good Mother, whereas Britney Spears personifies the Terrible Mother.

Neumann illustrates how archetypes developed from all-encompassing ideas to compartmentalized and polarized figures.\textsuperscript{cdxliii} Instead of having a feminine figure, like Kali, who embodies both the destroyer and the life-giver, the newer incarnations of the archetypal feminine are all good or all bad, as in the Virgin Mary or the wicked stepmother; in other terms, supermom or rotten mother. The relevance of these ideas, as
Neumann asserts, is that archetypes affect us in myriad ways; they determine human behavior and emotions and are therefore relevant to modern psychology.\textsuperscript{cdxlv}

As previously stated, Jung and Hillman imply that the archetypes are seen through the lens of myth.\textsuperscript{cdxlvi} Jung states that archetypes are represented in universal images that find expression through myth.\textsuperscript{cdxlvii} Carl Kerényi advocates the importance of myths by insinuating they create the foundation of the world, since everything rests on myth.\textsuperscript{cdxviii} Kerényi suggests myths are the beginnings to which the individual must return in order to attain wholeness.\textsuperscript{cdxlix} Kerényi would suggest that we find ourselves by returning to the primordial stew, and the way into that mix is through myth.\textsuperscript{cdlix} As well, Hillman suggests that it is psychology’s task to explore the archetype ensconced in the symptom, and one way archetypes are made manifest is through the figurative language of myth.\textsuperscript{cdli}

The notion of the primordial myth is important to the study of postpartum depression as we seek to understand this symptom through exploring the myths and archetypes relevant to motherhood. Following a particular myth through its various incarnations provides a reflection of the attitudes brought to bear on a particular theme. The history of the Great Mother myth and its accompanying concept of the feminine principle are illustrative of Neumann’s idea that as consciousness becomes more differentiated, the archetypes, and in turn the myths that house them, begin reflecting this differentiation.\textsuperscript{cdlii}

Anne Baring and Jules Cashford present the concept of the feminine principle as synonymous with the goddess of mythological history.\textsuperscript{cdlii} Baring and Cashford explain that the feminine principle embodies a perception of the world as a natural, living, and sacred whole, in which mankind, the earth, and all life are interconnected.\textsuperscript{cdliii} Elinor
Gadon describes the feminine principle similarly as earth-centered, holistic, and presiding within each human. Gadon portrays the feminine principle as encompassing an approach to life as a sacred fabric in which, “…all were responsible to each other…and the ongoing rhythms of life, death, and rebirth—humankind…animals and plants, rocks and rivers, the planet earth and its atmosphere.”

For Baring and Cashford, as well as Gadon, the feminine principle is embodied in the goddess religions. Gadon writes that the goddess religions were found in Europe and the Near East from the Paleolithic to Late Classical Age. As explained by Gadon, the goddess religions had as their root the idea of the sacred feminine. The goddess was worshipped and ritualized as the Great Mother of all things who could give and take life. The goddess was said to embody the cycle of birth, death, and rebirth that was omnipresent in all things. Of utmost importance was the connection between the goddess and the natural world.

As indicated by Baring and Cashford, the symbol of the Great Mother Goddess is perhaps the oldest incarnation of the goddess religions. Like the feminine principle, the Great Mother Goddess is seen as a symbol of the unity of all life. The goddess expressed the moral vision of the age in which she appeared. Baring and Cashford trace the origins of the Great Mother Goddess from Paleolithic to modern times. In Paleolithic, Neolithic, and Bronze Age Crete, they state,

…the great mother goddess alone gives birth to the world out of herself, so that all creatures…are her children, part of her divine substance. Everything is living, animated— with soul—and sacred… humanity and nature share a common identity.

In the Bronze Age of Sumeria, Babylonia, Egypt, and Greece, the Great Mother Goddess loses her status of lone creator and is joined with a male god to give birth to the
According to Baring and Cashford, this new phase introduces the idea of separateness and duality. Eventually, the late Bronze Age and early Iron Age saw the disappearance of the Mother Goddess altogether as she was replaced by the monotheistic god figure.

Baring and Cashford suggest that the disappearance of the Great Mother Goddess for the last 4,000 years mirrors mankind’s increasing separation from the feminine principle in which the world and all its features are considered one whole. This separation, they argue, leads to dissociation not only from nature, but also from one’s self as interconnected with the natural world. The shift in perspective produces oppositions, like spirit outside of nature, mind over matter, reason versus instinct, and good over evil.

Baring and Cashford claim that the feminine principle does not disappear from mankind’s collective psyche merely because the Great Mother Goddess is no longer actively worshipped. They suggest we carry within us a legacy of belief—20,000 years’ worth—of nature as “…a sacred, living unity, in which the human race is experienced as one whole and consciousness belongs to all life whatever form it takes.”

According to Naomi Ruth Lewinsky, we are living in a modern era where the archetypal feminine has gone into the shadows. Lewinsky decries that the mother’s experience, perspective, and power are unrecognized by modern culture. Lewinsky proposes that modern women are experiencing a new version of the myth and states,

Daughters suffer the loss of mothers to a cultural underworld in which maternal maturity and wisdom are imprisoned, unseen and unheard by the culture at large.
With the great mother archetype being relegated to the one goddess still routinely worshipped in modern culture, The Virgin Mary, who is pure, self-sacrificing and asexual, Lewinsky argues that modern woman is “…left only with feelings of shame and inferiority for the blood, sweat, desire, and fury of our female experience.”

Jung suggests that therapy’s aim is to dream the myth onward. Neumann illustrates how the primordial archetypes are dreamed forward as man’s consciousness becomes more discriminate. As Neumann explains, “…the Feminine more and more loses her original archetypal character as goddess and seems to become concept and allegory.”

Hillman adapts Jung’s phrase and suggests psychology needs as its aim to pathologize the myth onward. Remembering that Hillman believes pathology to be the path that leads further into the depths of the soul, we look to the pathology of the personal, the cultural, and the archetypal to inform us of what Hillman refers to as the “…failed aspects of life.”

Baring and Cashford, along with Lewinsky and Gadon, might explain the failed aspects of life in terms of the diminishing importance and disappearance of the myth of the Great Mother Goddess. The pathology present in the disappearance of the goddess, according to Baring and Cashford, is the loss of connection to the wholeness of our being.

A dialogue seems to be missing from the current research on postpartum psychiatric illness. That dialogue might speak to the connection between the loss of the potency of the goddess/feminine archetype and a woman’s ability to view herself in motherhood as encompassing the myriad incarnations of the Great Mother. In pathologizing the myth onward, an imaginal approach to postpartum psychiatric illness
might ask what is at work in the depths of the soul through this particular symptom of postpartum depression. An imaginal approach to the study of postpartum psychiatric disorders might offer the inquiry into what this pathology is saying about the individual, the culture, and the archetypes of soul and what the soul is saying by means of postpartum depression.

cdlxxxiv

Conclusion

Through the literature review of postpartum psychiatric disorders, this study has followed how biology, cognitive-behavioral practice, psychodynamic practice and theory, society and imaginal psychology have attempted to define, categorize, and treat postpartum psychiatric illnesses; and, in perhaps a broader context, this study has sought many lenses in which to view motherhood. Regarding postpartum psychiatric disorders as a symptom or pathology related to motherhood, we could summarize each section of the literature review through this point of view.

The biological perspective perceives postpartum psychiatric disorders as a pathology of the body. This approach speculates that something is wrong with the body and searches for answers and possible cures within biology. Researchers examine the role played by hormones, glands, neurotransmitters, and systems within the body to understand the pathology that presents itself as postpartum psychiatric illness. Within this perspective, treatment options for PPPD mirror the idea that postpartum psychiatric illness is an affliction within the body and treats the body through psychopharmacology, hormone replacement, or electroconvulsive therapy.
Within the cognitive-behavioral perspective, the proponents focus not as much on the possible causes of PPPD, as on the negative thought processes of the mother and probable treatment plans once a diagnosis of PPPD is confirmed. Viewed from the cognitive-behavioral perspective, postpartum psychiatric illness is the mind’s pathology—what you think can hurt you. Practitioners of this approach concentrate on symptom reduction through changing thoughts and behaviors.

The psychodynamic perspective of postpartum psychiatric disorders notes that the pathology resides in the biography. From the personal biography, psychodynamic practitioners look at the connection between the onset of the symptom and interpersonal problems and extrapolate the current interpersonal situation to the past. The goal is to solve the problem by focusing on the major interpersonal issue. Postpartum psychiatric illness has also been viewed as a possible consequence of a shared biography. Psychodynamic theories are seen as perhaps advancing the opinion that mothers are the supreme carriers of their offspring’s mental health. This collective story of a mother’s central importance might add pressure to be perfect and falling short of this perfection might contribute to the occurrence of postpartum psychiatric illness.

The sociocultural perspective looks at postpartum psychiatric illness as culture’s pathology. The literature reviewed in this section examines how a culture’s beliefs, customs, and social behavior influence the well-being of the new mother. Postpartum psychiatric illness is considered a disease of the culture and therefore looks to the culture for prevention and cure.

In the last section, the imaginal approach attempts to observe postpartum psychiatric illness as a pathology of soul. Ancient and collective themes about the
archetypal feminine are gathered as a tool to imagine postpartum psychiatric illness beyond the personal or cultural restraints of the individual. The imaginal approach looks to universal themes to explore what the soul might be asking when postpartum psychiatric illness presents itself. A thorough search of the literature on postpartum psychiatric disorders did not reveal any significant writings or studies addressing this issue from an imaginal platform. Perhaps this clinical case study will provide some connective tissue between imaginal practices and the treatment of postpartum psychiatric illness.
CHAPTER THREE

PROGRESSION OF THE TREATMENT

The Beginning

There are two stories to tell. One begins with the first time I worked with Elizabeth Strong. We met for prenatal counseling before the birth of her child. The second story takes up four months after the last time we met. Elizabeth called to schedule an appointment because she felt like she was falling apart.

My first contact with Elizabeth was by telephone in the summer of 2005. She was six months pregnant and a patient of a nurse midwife. I had worked with several of the midwife’s patients, offering hypnosis to aid in labor and delivery. The midwife referred Elizabeth to me. Many of the referrals I had were young, pregnant women with no active partners or with boyfriends. If these women were in a relationship, it tended to be rocky. Rarely did I work with a married couple. I was expecting Elizabeth to be another single, young woman.

Elizabeth sounded very poised and well spoken on the phone. She was interested in hypnosis and conveyed a deep trust in her midwife. She mentioned that she was married, which pleasantly surprised me. My bias was that married, pregnant women would somehow have less conflict in their life, a support system in place, and that working with them would be easier.

Elizabeth disclosed that her brother had molested her as a child and that recently, her mother’s boyfriend had been sexually inappropriate with her. She was feeling
confused about both of these events and wondered if they somehow might find their way into her relationship with her own child. She mentioned that she was working with a body worker, and her conversation trailed off into talk of auras and energy. I admit I found myself tuning her voice out at this point, eager to make an appointment and end our phone conversation.

Usually, I like to schedule my appointments with pregnant women when they are at least seven months pregnant, so we waited until early November to meet. When I opened the door into the waiting room, I was struck by how young looking the woman was who sat waiting for me. She wore maternity overalls, and her long hair was pulled back in a pigtail. She was very tall and quite big—not just pregnant big, but possessed of large hands, feet, and big bones. I immediately felt at ease with her.

During our initial encounter, I spent half of our time going over the business end of our arrangement, orienting Elizabeth to who I was, how I worked, and how our time together might unfold. She, too, had paperwork for me from the midwife, papers required by Medi-Cal patients. Elizabeth appeared interested throughout our exchanges, no signs of boredom or fogginess that I have experienced with other clients at this phase of things. I gave her the choice of either going over her family history or getting right into experiencing hypnosis. She was eager to get right into the hypnosis.

The second story began about four months after the birth of Elizabeth’s child. Elizabeth contacted me saying she was in need of help. She described herself as having huge anxiety, discomfort, and dread. I was enthusiastic about meeting her again, as our previous time together was enjoyable and fruitful.
When Elizabeth arrived this time, she looked gaunt, tired, and sad. We sat down for an hour and a half. It felt like we never came up for air. She spoke of her overwhelming anxiety and feeling like everything was crashing down on her. She said if not for her baby, she would have killed herself. She reported that the crushing weight of emotions she felt would come and go. She would experience a day of feeling okay, and then she would go down under again. She felt like a failure as a mother. She cried, “I’m not supposed to be here! This isn’t right!” Her distress was palpable.

Elizabeth reassured me that she had no intention or plan to kill herself. She brought her baby in with her, and it was obvious that she was an attentive, loving mother by the tender way she held and spoke to the baby. She always interrupted whatever we were doing to attend to the baby’s needs. I knew she was not a bad mother, contrary to how she felt. I also assessed she would not kill herself and leave her baby. We agreed to continue seeing each other.

**Treatment Planning**

In keeping with the two stories, Elizabeth and I had different goals for the two, distinct periods of time we worked together. The first time we worked together, the treatment plan was clear and concise. For eight to twelve hours we would follow a set of pre-designed hypnosis scripts that focused on bonding, labor, and delivery.

When I work with pregnant women, I give them a choice of several areas in which we can focus. The bonding scripts help a woman become more aware and attuned to the growing life within her body. There are opportunities to leave things behind that
may stand in the way of bonding with the baby. Another script is aimed at connecting the woman to the Great Mother—whatever that image might be for her—for help and guidance.

Other scripts are designed to help control one’s awareness of discomfort or pain. A client can become skilled at making areas of her body numb, hot, or cold. She can learn how to generate naturally occurring endorphins to minimize pain or to create internal switches that she can turn up or down to manage her level of discomfort. Another technique is to pair triggers with responses, such as equating full exhalation with deep relaxation. There are also scripts to enable a better night’s sleep or more general ones to promote overall relaxation.

Our plan was to get through as many scripts as time would allow. I would make a tape of the hypnosis portion of our sessions for Elizabeth to take home and listen. We spent approximately 12 hours together. When we parted company, I expected to hear from Elizabeth after the birth of her baby, but only to tell me the details of her labor and delivery and to share in the excitement and joy over motherhood and the new baby.

The second time Elizabeth and I met professionally, our work together lacked the clear prescription that outlined our first meeting. Elizabeth presented with a variety of concerns, such as her symptoms of depression, her lost faith in the durability of her marriage, the abandonment she felt at the hands of her family, and her, at times, crippling self-doubt about her ability to mother her child.

The treatment plan I carried in my heart would probably not impress any government-run agency in need of precise language, timelines, and behavioral outcomes. Elizabeth and I would continue to build a safe and trusting environment together, a place
where she could unpack her psychic belongings. We would become acquainted with each story, each character until we recognized their origins and repetition, their patterns and predictability, their mystery and power. I would also be paying attention to the practical side of day-to-day living and try to provide answers to the immediate problems: Where does Elizabeth feel supported? How can she get more sleep? Where can she work and bring the baby along?

What she asked of me remained unspoken, but I could speculate her needs. She wanted to be held, not necessarily physically, but in a way that soothed a person’s need to be regarded, to be worthy, and to be respected as they are. She wanted to tell her story, to hear herself speak it, and wonder aloud at the repercussions of each unfolding. At times, she needed sensible advice and useful solutions to concrete situations. She seemed to desire someone waiting for her on the other side of some ritualistic ring of fire. She needed a guide, but not just anyone. She wanted a mother.

The Therapy Journey

The first time I met Elizabeth, she was 23 years old and seven months pregnant. She was lounging on the oversized couch in the office waiting room. Her long, straight hair was pulled back in a ponytail, accentuating her youthful appearance. She rose slowly, steadying her balance around the girth of her belly. She had a ready smile, held out her hand to greet me, and commented on how relaxing the music was. Her fingers were long and elegant, which simultaneously suited her genteel manner and seemed out of proportion with her young years and the blush of her cheeks.
When I work with clients, I have unlit candles and Tibetan chimes on a footrest that is situated between my chair and the couch where the client sits. My intention is to begin each session in a few moments of silence and then to light the candles as a way of ritualizing the therapy hour. The ritual is meant to contain whatever might unfold during the hour and to remind me that the therapeutic process is bigger than my fragile and imperfect ego. My hope is that something larger than the client or myself will be helping us hold this journey. Most often, I am nervous to introduce this ritual beginning. With Elizabeth, my apprehension fell away.

That first evening together, I used a hypnosis script (Appendix 5) that I customarily use with each pregnant, first-time client. The script pairs the number one with the suggestion to deeply relax. I could see that Elizabeth was responding to hypnosis based on her breath deepening, her body slackening, and her face becoming smooth. At the end of the script, I allow for a few moments in which the client is instructed to be aware of anything—a thought, image, feeling, sensation—which presents itself.

After coming out of hypnosis, Elizabeth was eager to share her experience. She relayed that she experienced a tipping feeling that made her feel out of control. This led her to the realization of her need to be in control. She felt disoriented when she perceived herself as powerless. I asked her if this feeling reminded her of an earlier time. She spoke of when she was eight, a memory of climbing on her dad’s lap. She said that when she expressed her feelings or needs, he pushed her away. She relayed that this eight-year old needed to “…get it all right or there would be no love.” Elizabeth said that this gave her a “sick, scary feeling in my belly.” I wondered aloud
if there was anything that eight-year-old aspect needed, but Elizabeth said she was not ready to look at that yet. If there was anything that eight-year-old aspect needed, but Elizabeth said she was not ready to look at that yet.

She left the office feeling spacey, which is how most everyone leaves after a session of hypnosis. It is similar to walking out into the night air after witnessing a powerful film or having to return to your responsibilities after a deeply satisfying massage. She expressed her desire to return next week and to mull over the experience she just had.

We met the following week. Our time was spent constructing a genogram of her family. According to Michael Nichols and Richard Schwartz, a genogram is a diagram of a family, listing family members and their relationships to one another. It chronicles such details as ages, dates of significant events, and geographical locations of family members. Usually, I hone in on the dysfunctions of character, like alcoholism, drugs, abuses, or mental illnesses; but, I let the client tell whatever story erupts from the unearthing of these ancestral vaults. Typically, I do not construct a genogram with my pregnant clients. I am not sure what motivated me to do so this time.

In constructing the genogram, I learned that alcohol abuse existed on both sides of her family, dating back to Elizabeth’s grandparents. Her father’s father was an alcoholic and away from the family a lot. Her mother’s father was obese, unfaithful to his wife, and an alcoholic who sexually abused all but one of his eight children. Her maternal grandmother was also an alcoholic, and Elizabeth suspected that she was bi-polar. She remembered her grandmother drinking coffee all day long. The only living grandparent was her mother’s mom, whom she rarely saw.
Elizabeth’s father had two half-brothers who were now dead. They, too, were alcoholics and died young of cancer. Her father drank, but Elizabeth was hesitant to refer to him as an alcoholic. He was previously married and had two sons. He cheated on his wife with Elizabeth’s mother. She also was cheating on her husband of five years. Eventually, her father divorced his wife, her mother divorced her husband, and they married.

Elizabeth’s mother grew up with seven adopted brothers and sisters. She was the eldest and her parent’s only biological child. Her father repeatedly raped her and her siblings for years. The youngest child told a high school counselor about being raped by her father. An investigation ensued, and although the father was found guilty, he was never in prison. He served community time, working after hours for children’s programs. Elizabeth explained that her grandfather was a teacher, a religious man, and well received in the community. Because of his good standing, she felt the authorities were soft when dealing his punishment. Her grandmother never acknowledged his sexual misconduct, and they remained married until he died of a heart attack.

Elizabeth’s parents had three children together, all girls. Elizabeth is the middle child. She described her father as sexually inappropriate. When I asked how, she said he kept pictures of naked women out in the open, including pictures of her mother in suggestive poses.

After composing the genogram together, Elizabeth remarked at how she had never looked at her family this closely. When I asked her if she could recognize any recurring themes in her family, she made comments about the alcoholism, the absentee father, the infidelity, the sexual abuse and inappropriateness, and the checked-out
mother. She was not yet connecting any of this to her own circumstances; she seemed to be simmering in this stew, however, perhaps leery of being burned by it all if she went in any deeper.

The next time I saw Elizabeth, she wanted to talk about the eight-year-old aspect of herself that came up in our first session. She had spent some time thinking about this eight-year-old within her and came up with the thought that this part was afraid of ridicule. We decided to work with this part in hypnosis. While in hypnosis, she seemed to connect deeply to the eight-year-old. She said she was aware that the girl needed friends, something genuine. I asked if there was anyone or anything hiding out behind this idea, and she answered that the girl became uncomfortable around the discomfort of others. She stated that the eight-year-old was “…caught up in others’ comfort.” She wondered aloud why this part would not speak up for itself and value its own needs. I then asked what this part needed from Elizabeth. She answered, “Play.”

We then moved into a hypnosis script for bonding (Appendix 6). In this script, the client is introduced to the idea of a Great Earth Mother, an infinite source of energy that provides all that they need. Elizabeth particularly enjoyed this script. She was able to visualize the Great Earth Mother who said to her, “There are no limits. Problems don’t really exist…they’re gone.” Elizabeth left this appointment with a look of contentment and serenity on her face.

During this session, I explained to Elizabeth how Freud envisioned the conscious and unconscious as an iceberg. The tip that we see out of the water is like the conscious mind—available and finite. The unconscious was like the massive ice floe
under the waters, vast and hidden. The next time I saw Elizabeth, she said that lately she had been more aware of the floe beneath the surface. She spoke about her unconscious mind as an inner voice that she was learning to hear.

The hypnosis script that we followed this meeting was about accessing guidance during delivery (Appendix 7). This script is a good companion piece to the bonding script, as both utilize the imagery of a Great Mother. In the guidance script, clients are directed to go inward to contact the Great Mother deep within them. They have the opportunity to spend some time with the Great Mother to tell her of any concerns they have or to ask her questions.

Elizabeth described seeing her Great Mother. She wore a green, flowing dress and had long hair braided with ribbons. Elizabeth saw herself in this scene as a four-year-old, pissed off girl. The Great Mother said to her, “Come here, my child.” When the four-year-old slipped into the Great Mother’s lap, Elizabeth said she knew the girl was full of good intentions, but was confused. Elizabeth stated that the girl “…easily slips into the love…” offered by the Great Mother and “…feels like she’d just been dipped in the river.” Elizabeth said the four-year-old just wanted to be held and to forget the pressures of the world she was holding. Elizabeth described the girl as “…coming into the Great Mother with gratitude.”

Elizabeth was aware of a gentle wind blowing along a field of verdant grass in which she and the Great Mother were resting. Elizabeth was also aware of a man’s presence; it was Jerry. Later, Elizabeth told me that Jerry was a figure who helped her at the scene of a head-on collision she was in when she was 15. She was not sure if Jerry was real or imaginal, but the memory of him was indelibly etched in her.
Great Mother looked at the four-year-old and said, “This is your father.”

The girl climbed out of the Great Mother’s lap and with Jerry and the Great Mother watching her, she began to perform back flips and summersaults in the soft grass. Down below she saw a farm and striking rock formations. She felt like all of this was her true home.

At our next appointment a week later, Elizabeth and I were joined by her husband. When I greeted them, they were sitting in the outer room on the couch. Elizabeth was leafing through an old *Real Simple* magazine, and her husband had his head cocked back against the couch cushion. He looked like he had been sleeping. I recall being surprised by his appearance. He was older than I had imagined, with thinning and receding hair. He was tall, slightly overweight, with big, calloused and dirty hands that suggested a life of labor. He wore blue coveralls, even though he had not been to work that day. He seemed nervous and uncomfortable, and I thought to myself that he must be skeptical of the hypnosis work that Elizabeth and I had been undertaking.

After the standard introductions, our focus was on using a script for pain control in preparation for delivery (Appendix 8). Elizabeth lay with her head on one end of the couch. She curled her legs up rather than letting them fall over her husband’s lap. He sat at the other end of the couch. It did not take long for him to fall asleep and begin snoring. The volume of this did not appear to bother Elizabeth’s experience; her face remained unfurrowed and peaceful.

The pain control script suggests that the client assign a guardian of wellbeing who will assist them in monitoring their awareness of pain, amongst other tasks. When Elizabeth came out of trance, she relayed that her guardian of wellbeing was a person
dressed up in a bunny costume. She was disappointed in this image and expressed her embarrassment that she was unable to conjure up a more meaningful guardian. Her husband remained asleep on the couch.

The following week, Elizabeth brought in a tattered and chewed copy of the board book, *Runaway Bunny*. She said it was her favorite book when she was little, and that, to this day, she kept this copy in her car. It occurred to her that her guardian of wellbeing was somehow related to the mother bunny in the book. Throughout the book, the baby bunny tries to run away from its mother and hide by turning himself into various objects, such as a sailboat, a rock on a mountaintop, or a crocus flower. The mother tells him that she will come after him, becoming the wind to sail him home, a mountain climber, or gardener. She always catches up with him, and he decides he might as well stay home and be her little bunny. I was quite familiar with the story, having read it many times to my son. Elizabeth decided that her guardian of wellbeing was fitting after all.

Her husband sat at the other end of the couch while we discussed this, mostly silent, sometimes yawning, sometimes shaking his head as if to decry, “What the hell are you talking about?” At least that is what I imagined he was thinking. That night we followed a script called Orchestrating the Brain (Appendix 9). The script helps the client become familiar with the different brainwaves and their functions. The main reason I use this script with pregnant women is to help them sleep. It teaches a client how to activate delta waves, the brainwaves associated with slumber.

Again, Elizabeth’s husband fell fast asleep, his snoring occasionally punctuated by a loud snort. I felt certain this would interfere with Elizabeth’s experience, but she
showed no signs of disturbance. She slowly came out of hypnosis, her blue eyes mostly black from enlarged pupils. She was drowsy, stretching and looking dreamy. Her voice was low and languid as she spoke of how still the baby had been during hypnosis. Her husband leaned over and shook her pregnant belly while saying, “Wake up in there!” in a loud voice. He laughed. Elizabeth excused herself to use the bathroom.

While she was gone, her husband wanted to talk about Elizabeth’s “obsession” with the baby. He reported that he did not share Elizabeth’s views of homebirth, breastfeeding, or talking with the baby. He said there was more than one way to raise a child. I remember the impression his words, mannerisms, and countenance made. I felt ill at ease with him, especially after witnessing him shake Elizabeth’s abdomen. I had been forming an unflattering opinion of him, but I tried to remain flexible and open.

At our next meeting, Elizabeth and I were alone. I inquired about any impact she felt over her husband’s shaking of her belly. She reported that she had not noticed. I began to wonder if I was looking for reasons to distrust her husband or find fault in his behaviors. Elizabeth began recounting the incident and found it interesting and a little disturbing that she had no reaction to her husband’s jostling. She remembered it hurt her because of her full bladder. I believe at this point, Elizabeth needed to see her husband as good enough to get her through the next month of giving birth and caring for their baby. Still, I saw a look in her face, the way her mouth curled and her eyes cast downward, that seemed to belie her obliviousness.

I was to see Elizabeth once more before the birth of her baby. A service I offered to my pregnant clients was to prepare and facilitate a rite of passage ritual as a way to initiate a woman into her upcoming status of motherhood. Elizabeth had been excited to
participate in the ritual. She was instructed to invite women who exemplified the qualities of mothering that Elizabeth admired and with whom she could acquire valuable knowledge. Besides Elizabeth and myself, only three other women attended. I was sad that Elizabeth could not gather more women around her for support and encouragement. Where were the grandmothers, aunts, cousins, and mentors? One woman was a New Age body worker, childless, who spent the evening talking in time-worn clichés. Another was her mom’s friend whom Elizabeth had known since childhood, but to whom she was no longer close. The third woman was Elizabeth’s mother. To me, the evening felt awkward and forced. The group seemed to share their stories with formality, caution, and an increasing sense of personal neediness. I suppose I had hoped for something profound, but I tried to comfort myself by thinking that the evening held importance perhaps beyond my knowing. Elizabeth and I never spoke of this ritual or its impact again.

I visited Elizabeth’s home once, two weeks after the baby was born. Usually I see pregnant clients once or twice after the birth of their baby. I am always curious to see the newborns and hear the account of each mother’s birth experience. Elizabeth’s car was broken, and I had errands to run in her area. I arranged to see her and the baby at her home. The house she shared with her husband (which was owned by her mother-in-law) was on the corner of a busy street. Broken down cars littered the yard and the house was in need of attention—peeling paint, loose floorboards, missing molding around the windows. Inside mirrored the outside appearance. The one bathroom was torn apart, an unfinished remodel that her husband abandoned midstream. The furniture was old and tattered and each area of the house was disheveled and in need of care. I noticed that Elizabeth’s personality was nowhere reflected in the surroundings. It was as if she came
for a visit to her uncle’s old bachelor pad. The large television held court in a living room decorated with mirrors, beer logos etched on their glass.

Elizabeth was concerned because the baby had lost too much weight since birth. She was having trouble breast-feeding. Elizabeth was committed to breast-feeding her baby, and the baby’s inability to latch was causing her visible distress. She was receiving help from her midwife and a doctor, and was looking forward to an appointment with La Leche League that afternoon. Elizabeth’s mother was there, folding baby clothes. Her mother was pleasant, although I did not witness her hold or coo at the baby while I was there. Elizabeth’s husband walked in. He did not acknowledge anyone’s presence in the room. He turned on the TV and disappeared into a back room. Elizabeth looked pinched, worn out, and frazzled.

I had heard her birth story over the phone, from her mother who called me after the baby was born, from Elizabeth about a week later, and also from the midwife. The detail that stayed with me was that Elizabeth’s husband drank alcohol throughout the whole ordeal. Elizabeth confessed that she felt very little support from him that day or in the days that followed. When she discussed her feelings about her husband, her voice quivered; there was an air of panic underneath her resolve to make all of this work.

The next time I spoke with Elizabeth, it had been over two months since the birth of her baby. She was pleased to report that breast-feeding was going well. It turned out that her baby had thrush, a yeast of the mouth, which made it difficult for her to suck. With that cleared up, the baby was thriving. Due to the positive experience Elizabeth had with La Leche League, she began training to become a peer counselor. She was an
advocate of breast-feeding and wanted to help other women persevere through any initial difficulties.

That was the upbeat portion of our phone conversation. Elizabeth also related that she was feeling overwhelmed. She was sad about her living conditions. She felt that her family had abandoned her after a brief show of support shortly after the baby’s birth. She was very concerned about her husband’s drinking. Their parenting styles were quite different, and Elizabeth was questioning the solvency of their marriage. We agreed to meet again, but we were unable to settle on an appointment date due to Elizabeth’s car situation, juggling her life with a newborn, and my limited office hours.

Almost two more months passed until I met with Elizabeth for a therapy session. When I greeted Elizabeth in the waiting room, I was struck by how much weight she had lost. This may have concerned me, but I remembered my own rapid weight loss after my son was born, how many calories were burned by breast-feeding alone, and the inconsistency of a new mom’s eating habits. Elizabeth had cut her long hair into a short, stylish bob that flattered her features. She was nursing her baby on the couch, her full breast exposed. She exhibited a total lack of self-consciousness.

As the baby napped, Elizabeth talked rapidly, like someone on borrowed time. She spoke of her “…huge anxiety, discomfort and dread…” that she tried to convince herself was due to hormones. She felt like everything was crashing down on her. She described the first few days of motherhood as idyllic, but by day three, “…the illusion burst.” She felt like a failure as a mother and feared that people would find this out. She possessed a pervading sense that this was not supposed to be her life,
that something was terribly wrong. She expressed that these feelings would come and go. She would have a day of feeling fine and then she would go “…down under again.” She confessed that had she felt like this before becoming a mother, she would have killed herself. We talked about her suicidal fantasies, and I ascertained that she posed no risk of harming herself. She had no plan. She had no real wish to die. She was committed to and deeply bonded with her baby. She wanted help.

Elizabeth asked me if I had read the book *The Four Agreements* by Don Miguel Ruiz. I had not. She said that after reading this book, she realized that she had made an unspoken agreement to be like her mother. She felt that her mother was operating under the notion that she was unworthy of anything good. Oftentimes, when Elizabeth was young, her mother would say aloud, “I’m a quivering puddle, a pile of crap!” Elizabeth expressed that she found herself repeating this myth of worthlessness over and over in her own life.

Her thoughts and feelings advanced like dots on a page; she was beginning to acquire the skill to connect them to form a cohesive image. She talked about her mother making a silent agreement with her father: she was worthless, so he could use her. She felt her father only valued her mother as a sex object, someone to perform for him. She said she watched her mother settle for whatever she could get and then go through the motions of sacrificing herself to others. I asked if this felt familiar to Elizabeth, this settling. She did not hesitate and answered, “I am always taking what I can get, when I can get it. I’m bad; I will ruin anything good! I survive on scraps because that’s all I deserve.” She went on to say that she had a habit of not seeking anything better for herself.
surviving on “…whatever I could get my hands on.” She began to cry, and then fell silent. When she resumed, she talked about her relationship with her husband. When she met him, she believed he would be her way out, someone who would take care of her, and understand her. He was older, by 18 years, and would provide some kind of security.

She spoke of her old impulse to take whatever she could to survive and cling to it. She believed that her husband played into this “…myth of scarcity.” Although she knew deep down that her husband was an alcoholic who barely eked out a living, she felt she could claim him as hers. This claim had the effect of temporarily dulling the feeling that there was never enough.

Before we parted company, I gave Elizabeth a copy of Brooke Shields’ book *Down Came the Rain*. A friend of mine had recently given it to me. I read about a third of the book before passing it along to Elizabeth. Because Shields chronicles her experience of postpartum depression in the book, I thought Elizabeth might benefit from reading it. I had no conscious awareness of postpartum depression or even that Elizabeth might be suffering from this, but I managed to pick up on something Elizabeth was experiencing. I encouraged her to sit with the myth of scarcity, to be curious about it and see where it might lead.

Before our next session, I began researching postpartum depression. I honestly knew very little about this topic and still had no conscious idea as to why I was looking in this direction. I suppose I was searching for a map, some theory or construct to guide me through Elizabeth’s symptoms. When I feel like I am not doing enough, I tend to look for a map. I stumbled upon an article written by Laurence Kruckman about the importance of
ritual in preventing postpartum depression.\textsuperscript{dxxxix} I recalled the ritual I facilitated for Elizabeth a month before her baby was born, remembering my disappointment. I began feeling that it would take a lot more than my awkward, tepid attempt at ritual to help hold a woman as she transitioned from maiden to mother.

At our next session, we revisited the myth of scarcity. Elizabeth had thought about her father’s birth in 1938.\textsuperscript{dxc} He was six weeks early and weighed only three pounds. His survival was a bit of a miracle in those days. He had survived with so little. His father left the family when Elizabeth’s father was two. His mother had told him his father was dead.

She told me about her mother’s father being repeatedly beaten by his alcoholic father.\textsuperscript{dxci} How in turn, her mother’s father beat and raped her mother.\textsuperscript{dxcii} Elizabeth remembered her mother telling her about being raped.\textsuperscript{dxciii} She said to Elizabeth, “I’m going to be more emotional and have trouble because I was raped at your age.”\textsuperscript{dxciv}

Elizabeth was four. When she was older, her mother told her how she used to sleep in a woodpile to protect herself from her father.\textsuperscript{dxcv} She would make a barricade of stuffed animals and toys around her bed so that when her father came to abuse her in the night, he might trip over her snare, making enough noise to spoil his plans.\textsuperscript{dxcv} Elizabeth expressed her anger towards her mother for not protecting her from her stepbrother, her father, or her mother’s last boyfriend.\textsuperscript{dxcvi} Elizabeth fumed, “She seems so paralyzed all the time! I’m pissed at her inability to cope, for staying in an unhealthy marriage, her inauthenticity…for the past.”\textsuperscript{dxcvii}

Elizabeth remembered feeling like she was alone in the world, that somehow she knew she could not count on her parents.\textsuperscript{dxcix} We examined the possibility of this being...
handed down to her by her mother and father, a myth that she was carrying forward into the world. When I asked her how she was carrying it forward, she had many examples. She reiterated that she viewed life as survival. She felt she had done very few things for herself because her needs were not as important as her mother or father’s needs and now, her husband’s needs as well. She remembered feeling invisible in her family and secretly wanting something horrible to happen in order to garner some attention. She underscored that her underachieving—flunking out of college, working menial jobs—was tied into the scarcity myth. Elizabeth stated, “You cannot have it all, so just take what you can get.” She voiced her concerns about how buying into this myth related to her choice of men, especially her husband. Because she did not feel entitled to much, the men she chose did not offer much in return.

Life with her husband was getting worse. He continued to drink every day. His business was not doing well. He spent minimal time interacting with their baby, and when he did, Elizabeth found his behavior to be rough and careless. He would invite his drinking buddies back home where they would stay up late smoking pot, drinking, using foul language, and creating an atmosphere where Elizabeth felt scared and trapped. Elizabeth informed me that he had a revoked driver’s license for three previous DUIs (Driving Under the Influence). He continued to drink and drive. She confessed that she almost called the police to follow him home from the bar. Her fantasy was that he would be thrown in jail, and she would have one less thing to consider. Elizabeth was beginning to feel like she deserved—and needed—more.

I ran into Elizabeth in my hometown one weekend. I was with my husband and son, enjoying the day listening to street musicians and sharing an ice cream cone.
Elizabeth approached me, and we chatted briefly. She was with her baby and her husband. When I saw her again in my office, she said that my family was her role model; to Elizabeth, we were the picture of what she longed for. She was realizing that her marriage was unable to sustain her. She expressed how she would never have the marriage and family she desired with her husband.

Elizabeth spoke about another myth she had been living by: don’t be honest with yourself. I asked her what she meant by this. She explained that she made a habit of denying huge parts of her life, both past and present. When I asked her what purpose the denial might be serving, she answered, “I numb out because the pain associated with the reality is unbearable.” She feared other people’s judgments of her if they knew the truth.

I wondered what truths she was referring to. She admitted that she, too, had been arrested for a DUI the previous year. Her license was suspended. She was put on probation. She had outstanding debts relating to this incident that prevented her from renewing her license. So, she, like her husband, was driving illegally. She began to cry. She expressed her shame and felt guilty over her harsh judgment of her husband for his similar indiscretions. There was something in this confession that felt like a significant turning point for Elizabeth, as if she might metamorphose from victim of circumstance to master of destiny. She was bringing more of her story into the room.

At our next session, Elizabeth was contemplating a separation from her husband. She feared that leaving would be perpetuating a pattern she witnessed in her family. That pattern was one of fleeing. She related how her father had spent his life fleeing one situation after another. She began to list all the ways her father obsessed
over something and then left it behind—his first wife, his first kids, his second wife, his second kids, thinking he had ADD and going on Ritalin, then diagnosing the kids and giving them Ritalin too, the car accident, his health, bicycles, his youngest daughter’s problems, his jobs, his new wife, and now his participation in and devotion to the Landmark Forum, a self-help institution.

She recalled her mother leaving the family once after an angry outburst. When her mother came back, she told Elizabeth that she would not tolerate anger; when adults got angry, they beat someone up. When Elizabeth tried to express her emotions, she recognized that her mother often shamed her, which in turn shut her down emotionally. Her emotional life fled.

She recalled a recent heart-to-heart talk with her sister. Her sister’s response was to pull the hood of her sweatshirt over her head and shout, “I don’t want you to see me this way!” and then ran away. She thought about many conversations that were aborted whenever things got messy. She felt that her family made decisions quickly and that these decisions lacked reflection or evaluation. She looked up at me, as if punctuating her last point, and said, “I have moved 22 times since high school!” Considering she was only 23 years old, that was a lot of fleeing.

I asked Elizabeth to use some art materials to draw a picture of her relationship to the fleeing. She drew a foot in a trap. I suggested that Elizabeth have a dialogue with the image. The technique is to have the client speak from the perspective of the image. For instance, I asked Elizabeth what part of the drawing she would like to embody, and she answered, “the foot.” I began by asking the foot who it was. Elizabeth would in turn answer as the foot. Elizabeth expressed that the foot felt trapped, trapped by the
She said, “My mom got trapped. She used to be earthy. She gardened and baked.” Elizabeth felt that now she was trapped by some silent pact to become the mother that was modeled to her, a mother who stayed on the surface of her life, who observed other people and did what they wanted of her, who stayed once removed from her own self, who gave herself away sexually, who hid behind a happy-go-lucky façade when the walls came tumbling down. She looked up from the drawing with widened eyes and exclaimed, “I think I’m depressed over having to deal with all this shit when all I want to do is sit with my baby and blow bubbles all day!”

Although Elizabeth and I had been working together again for about a month, we rarely discussed postpartum depression. Instead, we remained focused on her symptoms and the images she brought into the room. However, I kept researching postpartum depression on the Internet and found the Edinburgh Postnatal Depression Scale (EPDS) (Appendix 10). I had a growing curiosity about this disorder and wondered how Elizabeth’s symptoms fit into this diagnosis. I decided to revisit more specifically the territory of postpartum depression.

At our next meeting, I asked Elizabeth if she would be interested in taking the questionnaire. She was very eager and willing. A score of 10 or higher on the EPDS indicates the likelihood of a postpartum depressive illness. Elizabeth scored 23.

When speaking about postpartum depression, Elizabeth said that the people around her did not want to talk about it. Her family would change the subject or assume she was in dire need of extreme intervention to prevent her from killing herself. She felt, aside from our time together, there was no place where she could express her true feelings without being shamed, over-exposed, or in jeopardy of being
grossly misunderstood. So, she remained silent. She related that people’s response to postpartum depression was like “…Capitalists pitting employees against each other so no one notices what’s happening at the top.” I asked her to elaborate on this idea, and she stated that she felt like everyone around her was squabbling over what to do about her depression, while no one was asking or listening to her.

Elizabeth was quiet for a few minutes and silently began crying. She then stated, “It seems like my mom had postpartum depression.” She told me that her mom became pregnant with her just four months after the birth of her sister. Her mom admitted to crying for three days after finding out she was pregnant again. Elizabeth confessed that she was holding onto her mother’s response as “…some kind of personal injury.” We looked at the larger story, her mother in an unhappy marriage, a newborn baby with another on the way. Elizabeth related that she and her mom were living the same struggle. We looked at some of the parallels: both Elizabeth and her mom marrying men over 10 years older, pregnant before marriage and in their early 20’s, sexually inappropriate fathers, sexually abused as young girls, a sense of betrayal and abandonment by their mothers. She felt empathy for her mother’s situation and less hurt by her mother’s anguish over discovering she was pregnant with Elizabeth.

A week later, Elizabeth started the next session by saying, “What if everything that has happened in my marriage was in part because of my depression?” She explained that she had cried a lot the night before. She called an old boyfriend to collect some memory of her self. She woke up feeling melancholic.

The two areas I latched onto this day were the melancholy and taking the blame for a failing marriage. I asked Elizabeth where the melancholy lived in her body.
took a deep breath, closed her eyes, and pointed to her chest. Her bottom lip began to quiver. Staying with this, I asked Elizabeth what was in that place, in her chest. She answered quietly, “My dad.” As I continued talking with the melancholy housed in her heart, Elizabeth’s words ran like a wild river. She spoke of her dad’s upper class parents and how being raised in an elite environment encouraged her father to seek a higher status in the world. She felt her father carried an aristocratic air, but had nothing to show for it. Looking back, she realized that her father needed his children to live what she referred to as a “…higher level of life,” one that he was unable to achieve for himself.

The melancholy began to transmute into anger. “I always felt like dad was the boss,” Elizabeth said. She recounted how eagerly she wished to be close with him, becoming involved with his interests, like model airplanes and playing Mah Jong. She felt he did not notice her or her efforts at pleasing him, and when he did, he pushed her away. Elizabeth cried out, “I spent so much time getting him to like me that I missed out on who I really was!” She related how she could hear her father saying, “Calm down, Liz,” as if her emoting would force him to look at the truth of his life. She felt her father rarely talked about anything of import or relevance. She thought she developed a knack for second guessing people and situations by keeping a watchful eye on her father.

When her older brother, the one who molested her, came back to live with the family when Elizabeth was still quite young, she sensed that she could no longer trust her father, perhaps anyone. To feel safe, she felt like she needed her family to think that she was on their side. She said she learned to stifle her interior experiences and nod
her head. This is when she became increasingly uncomfortable with and distrusting of her father.

I wondered how this all might relate to Elizabeth’s original statement insinuating that she was to blame for the instability of her marriage. I asked her how she behaved like her parents’ daughter in the relationship with her husband. After some explaining, Elizabeth caught on and stated that, like her child self did in relation to the family, she “…stepped out of myself.” She said she made a practice of observing her husband and then doing whatever he wanted or needed her to do. That was the only way she could maintain a sense of trusting him. She told me she “…gave him lots of sex, became his designated driver, and turned into Miss Happy-Go-Lucky all laid back with no worries.” She described fitting herself into the pre-existing form of her husband’s life. She had no expectations of his curiosity about her or her life. She did not bring her friends over. She expunged her needs, her identity, in service to his. As long as she remained caught up in this web, she remained comfortable. But now, the web was unraveling.

Because of the intense nature of this last session, we agreed to meet a few days later. A pattern I witnessed with Elizabeth was her need for a victim-persecutor dichotomy. Sometimes she embodied the victim role, powerless in the face of a greater force working against her. At other times, she became the persecutor, ruining the lives of others through her mere existence. If she was the victim, someone else had to be the villain and vice versa. Growing up, there had been very little gray area between this polarity. Someone in the family seemed willing to be one or the other; it appeared there
were no rescuers. I thought Elizabeth and I could work on this polarity at our next session.

In the days ahead, Elizabeth made the conscious decision to leave her husband. Besides all the subtexts of her husband’s story—the alcoholism, the marijuana use, staying out all night with drinking buddies, the revoked license, the instability, the growing indifference to his child—Elizabeth felt that she could no longer trust him. As she was becoming familiar with her own needs, she began insisting on her safety, well-being, and for her life to begin reflecting the values she was unearthing from under the deep layers of her conditioned responses. Two events occurred that would cement her feelings with action. They both involved protecting her child.

Elizabeth recounted the events at our next meeting together. She left her house in the evening to buy some diapers. Her husband would watch the baby, and he encouraged her to take her time. She was away for about an hour. When she returned, unfamiliar cars lined the driveway. She felt the hairs on her body stand up as she bounded for the front door. Opening it, she saw a roomful of men drinking, smoking pot and cigarettes, while some were gathered around the kitchen counter where her husband was changing the baby’s diaper. He had his back to Elizabeth. She heard him say, “Look at her little pussy!” Not wanting to frighten the baby, she calmly approached the counter, picked up the baby, and said she would finish the diaper in the bedroom. No one left. As she barricaded herself in the back room, she heard laughter and beer bottles clinking. She felt ensnared.

The second incident happened a few days after the first. Her husband returned home from work after stopping off first to have a few drinks at the bar. Elizabeth
was fixing dinner. The baby was on the counter in an infant seat. The baby cried, and
Elizabeth asked her husband to comfort the child while she continued to prepare dinner.
Elizabeth’s husband walked over to the counter and with his hand, covered the baby’s
mouth and nose. The muffled noise caused Elizabeth to turn around. She grabbed her
husband’s hand, soothed the baby, and freed her from the seat. Elizabeth was shaking.
She described having a memory in that instant of her father holding his hand over her
mouth and yelling, “Shut up! Shut *up!*”

When Elizabeth later confronted her husband about the inappropriateness of these
two events, she told me he felt she was overreacting. She relayed that at first, she
did not know what was real: her husband’s insistence of innocence or the feeling she had
in her gut that her life had taken a very wrong turn. She said she managed to have a
productive conversation with her husband, in which she laid out her demands for raising
their child in the ways she saw fit. One of those demands, she said, was that the
drinking had to stop. He countered by insisting he did not have a drinking
problem. In that moment, she said, she knew her life would remain beyond her
control if she stayed.

The next session was spent on practical matters, like where she could stay when
she left her husband, what could she do for money, and shoring up her support system.
She followed through on all the possibilities we outlined, such as checking on the
assistance offered through Social Services, calling on family and friends, finding legal
aid, and joining Al-Anon. There was good news and bad in all of these places. And in the
middle of all this turmoil swirled Elizabeth’s postpartum depression. She asked me if I
thought medication might help her. A social worker had suggested this course of
action. We talked about what she might hope to gain from medication, and I encouraged her to take advantage of her Medi-Cal insurance offering to pay for a psychiatrist or psychologist.

In all of this upheaval—adjusting to motherhood, the dissolution of a marriage, the symptoms of postpartum depression, confronting the difficult stories that compose a life—Elizabeth was feeling stronger. Despite the bedlam, she seemed more intact. Her choices felt intensioned. She looked beautiful. Her sense of humor was evident. She increasingly looked at a complex situation from many angles.

After four sessions with a psychologist, Elizabeth told me she decided not to pursue medications. One reason for her decision was that she was breast-feeding and did not want to take the risk of any side effects to the baby. Another reason, she explained, was that she sensed that despite the look of things on paper, she was doing and feeling better.

“My mom will not let me move in!” Elizabeth complained as she sat in my office a week later. She cried and wondered how a mother, living alone in a big house, could refuse to shelter her own daughter. We examined the reasons her mother had for refusing Elizabeth’s request. Although I did not agree with her mother’s decision, I focused on other solutions. Elizabeth admitted to calling her father in Montana and asking if she could live with him and his wife. She said her father had called back to say she could live with him. Elizabeth was seriously considering his offer.

With all that I knew about Elizabeth’s relationship with her father, this option felt odd. I was reminded of the myth of fleeing that we had explored. We looked at the pros and cons of her father’s proposal. As Elizabeth talked, she began divulging some of the
He told Elizabeth that none of this would change with her and her child’s arrival and even encouraged her to go naked as well and join he and his wife on their vacations. She confessed that he made an inappropriate comment about her breasts the last time she saw him. Elizabeth also related that if she moved in with her father, he wanted her to attend the college where his wife taught, to manage her money, and he insisted that she join the Landmark Forum program.

I wanted to know what aspects of Elizabeth’s self felt it would be a good idea to move in with her father and how this might relate to the fleeing myth, the myth of scarcity, or of not being honest with herself. She quickly admitted she was operating from a much younger aspect of herself, a child who wanted her dad to make everything all right. She knew she was running away from dealing with her crumbling marriage, forging some kind of satisfying relationship with her mother, and ultimately from taking responsibility for herself and stepping into her life. She decided not to move in with her father.

At our next session, Elizabeth informed me that she told her husband she wanted a separation; he did not argue. She said he agreed, begrudgingly, to pay for a couple months rent when she found a place to live. She joined a church that some friends of hers attended, and within a week, a member of the congregation gave Elizabeth an old car. She found a small apartment within 10 minutes of both her husband and her mother’s houses. She decided to return to school in the fall. She was cleaning houses part-time to
supplement the money she would receive from her husband for childcare and from the social service agency. Life was a struggle, but Elizabeth was taking care of herself.

In the following weeks, we continued to work on Elizabeth’s symptoms of postpartum depression, exploring the personal, cultural, and archetypal levels in which they were housed. Elizabeth recognized that her family bought into the cultural myth of pulling oneself up by the bootstraps and going it alone. We discussed how America was founded on the idea of rugged individualism and how this ideal permeates an individual life. She equated this idea to her feelings of isolation and inability to sustain a feeling of interconnectedness in relationships. I normalized these feelings by assuring Elizabeth that the issues with which she grappled were common to all humans: isolation, despair, uncertainty.

Elizabeth shared that she spent a lot of energy trying to hide “…everything from everyone.” We explored shame and its connection to hiding any weakness or vulnerability from view. Elizabeth expressed that she would feel a sudden terror at times that people would find out. That’s all she said, so I asked her, “Find out what?” She answered, “Me. They would find me.” She said she harbored serious paranoia over others’ judgments of her. I asked about her own self-judgment. She began to cry. I mentioned how she was so hard on herself. She whispered, “Thank you.”

Elizabeth had been, according to her account, completely unaware of her self-criticism. Now, she was noticing how often she beat herself down. We explored how staying on the surface of things might be a defense against being seen by another; being seen meant being judged. The worst judge of all, Elizabeth noted, was herself. She added, “I learned to skim the surface of life. If you stay on the surface, you can back...
peddle if someone notices you." She conveyed how she learned this style from her parents. She recognized now that they learned it from their parents, too. Her capacity for compassion had grown.

She sat up, leaned forward, and exclaimed, “No wonder it was so hard for me to become a mother! I was still dancing on the surface of it. I didn’t learn how to stay with anything for too long. There’s terror in seeing that a child is forever!”

As Elizabeth returned to school, reestablished her massage practice, and began life as a single mother, we spent less time together. We would schedule an appointment once a month, then two months would go by. A year after her child was born, the symptoms of postpartum depression receded. She and her husband divorced amicably. She continues to work on her relationships with her mother, father, and sisters. For Mother’s Day, I sent her a card. I wanted her to know that she is seen; that she is a great mother.

Legal and Ethical Issues

While working with Elizabeth, I felt apprehensive only once over a legal issue. When Elizabeth decided to leave her husband and seek divorce, I was concerned with the legal implications that might arise from a divorce and custody settlement. My fear was that Elizabeth’s husband might use some of the material from therapy against her. Elizabeth had been very open about her postpartum depression, along with other issues she was exploring in therapy. My hope was that her husband would not use her disclosures as ammunition.
I was unsure about Elizabeth’s right to confidentiality if a court case ensued. I had questions about my role in the divorce and custody case if I were asked to participate. I researched these concerns in the reference guidebook, *California Laws for Psychotherapists*, and felt confident that: 1) Elizabeth would hold the privilege for our time together, and 2) I would not be asked to appear in court or mediation. When I double-checked my findings with my supervisor, she agreed.

Fortunately, Elizabeth and her husband separated amicably and have since signed divorce papers. Elizabeth sought free legal counsel to educate herself on her rights and how best to go about separation and divorce. She and her husband navigated this process together without mediators or lawyers. I was not involved in any of the legal proceedings.

**Outcomes**

When Elizabeth first appeared in my office, she was a child. Even though she was seven months pregnant and married, her clothes and demeanor revealed her youth. She had a grace and confidence about her, but she was also shy and insecure. I remember thinking to myself after our first visit that she seemed to be floating, like her feet were not firmly planted on the ground or her spirit did not completely inhabit her body. A year later, Elizabeth appeared more grounded.

A huge transition that I noticed during our time together was that Elizabeth went from being a maiden to a mother. When we first began working together, Elizabeth was self-doubting and easily blown about by the opinions of others. She would give up the authorship of her life to anyone who offered her a suggestion. I remember once how she began quoting the Bead Lady, a bead shop owner in town. She co-opted the Bead Lady’s
words as her new philosophy. It reminded me of a scene in a Monty Python movie where the villagers are eager to follow a prophet, anyone who might show them the way. Each week, Elizabeth seemed to be trying out the latest advice from her mother, sisters, father, and friends. None of it fit her very well.

Although she is still impressionable, I saw her developing her own sense of the world and her place within it. She was making good decisions for herself and her baby. She left a bad marriage when financially it would have been easier to stay. After leaving her husband, she found a nice place to live, she sought out jobs that would allow her to bring her baby along, and she slowly began paying off her old debts. She started attending Al-Anon for support and clarity. She went to church, and when the church she attended seemed ill-fitting and restrictive, she started searching for one that met her needs. She joined the mom-and-tots group at the local Waldorf School and began forming new and supportive friendships. She had business cards made and reestablished her massage practice. And last fall, she returned to college.

In addition to all of this, Elizabeth stepped into her life as a mother. She is a phenomenal mother. I ran into her once at a local coffee shop when her child was beginning to toddle. An older woman remarked how special her baby seemed; the woman used the word “secure.” I have spent many hours with Elizabeth’s baby in my office. Her child is friendly, open, curious, and happy. Elizabeth treats her with respect, showers her with affection, and creates a safe atmosphere for her. Elizabeth made all of the baby’s food, using fresh, organic ingredients. Her commitment to providing for her child has been unwavering.
As Elizabeth became more confident, our relationship shifted. She always participated indefatigably in our sessions, but she looked to me less and less for approval or direction. Towards the end of our professional alliance, she would come into the office with a dream from the night before or a conversation with someone that left her wondering. Instead of waiting for me to guide her somewhere, she steered both of us in the direction she wanted to go.

I witnessed Elizabeth loosening her identification with both the victim and persecutor roles. She had been quick to anger, blaming her mother, her father, or her husband for the circumstances of her life. She also frequently victimized herself, berating herself for her thoughts, feelings, and actions. As our work progressed, she began appreciating herself more and noticing the good in others. She took more responsibility for herself. I remember she told me that after hanging up the phone with her husband, she yelled, “My life is your fault!” She sat down and followed that train of thought, wondering where it might originate or lead. She discovered that blaming others led her to feeling she had no control over her life. Instead of blaming, she said she was striving to remain present in her relationships. She expressed her desire for human connection.

One of the last times Elizabeth and I saw each other, she told me she had a new myth to share. She smiled and said, “I have let down the myth of scarcity and picked up the myth of abundance.” She felt that—for the first time—she could have what she wanted.
CHAPTER 4

LEARNINGS

Key Concepts and Major Principles

Several theoretical backdrops helped to shape the therapeutic environment that Elizabeth Strong and I created. These orientations provide a frame in which to view life experiences and lend a theoretical context for the work we engage in. Although I recognize that the sources influencing my work as a therapist are numerous and far-reaching, for the purpose of this particular case study I will focus on four classifications in which to house the key concepts and major principles. The five orientations include Goddess Literature, Jungian Theory, Archetypal Psychology, and Imaginal Transformational Theory.

Under the classification of Goddess Literature, the key concept of the feminine principle will be defined and discussed. Jungian Theory lends definition to the concepts of archetype and myth, while Archetypal Psychology explains the concepts of pathology and multiplicity. Finally, the concepts of imaginal structures and ritualized pathologizing will be addressed from the perspective of Imaginal Transformational Theory.

The category referred to as Goddess Literature includes scholars from varying areas of study, such as archaeology, anthropology, religious studies, psychology, and history. From these diverse backgrounds, some key concepts emerge. Consideration is
given here to the interconnected concepts of the feminine principle and the Great Mother Goddess and the principles attached to these key concepts.

Anne Baring and Jules Cashford present the concept of the feminine principle as indistinguishable from the Great Mother Goddess of mythological history. Baring and Cashford explain that the feminine principle represents a vision of the world as a natural, living, and sacred whole, in which mankind, the earth, and all life are interrelated. The feminine principle is a collection of these archetypal characteristics that are crucial to psychological expression.

For Baring and Cashford, the feminine principle is alive in the goddess religions. They suggest that the symbol of the Great Mother Goddess is perhaps the oldest incarnation of the goddess religions. Like the feminine principle, the Great Mother Goddess is seen as a symbol of the accord between all living and inanimate things. Baring and Cashford express that the goddess reflects the moral imagination of the ages.

Baring and Cashford present the principle that the disappearance of the great mother goddess for the last 4,000 years mirrors mankind’s increasing separation from the feminine principle. This separation, they argue, produces dissociation from nature and self. This shift in perspective has produced polarities that at one time would have been contained within the individual and held by the feminine principle. Another principle Baring and Cashford put forth is that even though the Great Mother Goddess is no longer revered, the feminine principle does not disappear from mankind’s collective psyche. In this section, the Jungian concept of the archetypes, with
additional attention paid to the mother archetype, is defined. The concept of myth will also be explored, and the principles attached to these concepts considered.

C. G. Jung’s description of the archetypes in their inchoate form within the collective unconscious bears resemblance to the concept of the feminine principle. Jung describes archetypes as having “…no inside and no outside, no above and no below, no here and no there, no mine and no thine, no good and no bad…. There I am utterly one with the world.” The concept of the archetypes is a difficult one to describe, as even Jung, who is looked upon as an authority on the subject, admits. He provides a succinct working definition when he writes that the archetypes represent “…definite forms in the psyche which seem to be present always and everywhere.” Jung calls the archetype a psychic organ residing in every human, as present in us as a heart or brain. The archetypes as forms—be they symbols, dream content, or myth—give us a glimpse into the vast realm of our unconscious mind.

Jung proposes that it is the task of psychology to address the archetype expressing itself through the individual. This principle’s purpose is two-fold, according to Jung. On the one hand, psychology must support the exploration of archetypal material so that the connection with our “original condition” remains intact. By original condition, Jung means the inherited and universal contents of the collective unconscious. The second purpose is to understand what the archetype is revealing about an individual’s present condition. Jung states that the function of the archetype is to “…compensate or correct, in a meaningful manner, the inevitable one-sidedness and extravagances of the conscious mind.”
From Jung’s concept of the archetype emerges the principle that the archetypes are living psychic forces that behave like any other neglected organ of the body. They show their neglect through sickness—in Jung’s terms, through neurosis and psychosis. The archetypes, as they show themselves in symptoms, provide a litmus test of how the psyche is experiencing the physical facts or events of a life. Jung postulates that the archetypes or contents of the psyche arise when we are in an altered state of consciousness. He suggests that when consciousness is usurped by a greater state of intensity, unconscious material can stream out into the field of conscious awareness.

Jung suggests that the unconscious or archetypal material presents itself in metaphors, namely through myth. He describes myth as “…original revelations of the preconscious psyche…” that are experienced rather than invented. According to Jung, myth reveals the secrets of the soul in images. Jung develops the principle that through myth—the language of the primordial, psychic inheritance of mankind—we make meaning of our own life.

In Archetypal Psychology, Jung’s use of the word neurosis is replaced with pathology and the unconscious is the realm of soul. The following paragraphs consider the concept of pathologizing and the principle that our pathology is the soul’s way of getting our attention. Another concept, multiplicity, will be defined, especially as this term relates to soul, the individual, and how Archetypal Psychology views pathology.

James Hillman states that pathologizing is “…the psyche’s autonomous ability to create illness, morbidity, disorder, abnormality, and suffering…” in any facet of behavior. Pathology, according to Hillman, is the myth of our life presenting
Hillman suggests that through pathology our soul is trying to get our attention about something. He asks that we experience the pathology rather than classify or explain it away. The pathology is living us in some way, showing us some truth about our experience, and Hillman advises to pay attention to the stories it tells. He implies that, “We are those stories, and we illustrate them with our lives.”

Hillman puts forth another principle about pathologizing: the soul is not merely escaping reality through pathology, but searching for a new reality in which the pathologizing makes sense. Soul is asking us to reconfigure a new truth out of the stories told by our pathologies. Hillman encourages us to trust our pathologizing not only as informants of personal experience, but also as “…echoes of conditions in the world soul.”

Hillman’s concept of multiplicity is similar to the feminine principle in that it suggests that the many reside within the one. Individuals, cultures, even the archetypes are multi-valenced. Out of this concept comes the principle that the soul possesses a polytheistic nature. Hillman insists that we view pathology from this perspective and recognize that through multiplicity we become aware of distinct parts within us, thus rescuing the diversity of the psyche from control by any single point of view.

Within the context of Imaginal Transformational Theory, Aftab Omer introduces the concepts of imaginal structures and ritualized pathologizing. These concepts are defined below and the major principles attached to them are considered.

Omer defines imaginal structures as “…assemblies of sensory, affective, and cognitive aspects of experience constellation into images; they both mediate and
Imaginal structures, Omer states, are constructed out of internalized cultural forces, personal stories, and archetypal influences that each person experiences. Imaginal structures can be seen as the distinct parts of the multiplicitous self.

A governing principle attached to the concept of imaginal structures is that although the structures feel like the self, they are not. As paraphrased by Claire James, imaginal structures are aspects of the self that form meaning around experience. Another principle related to the idea that imaginal structures are adaptations to the self, is that in order for change to occur in individuals, it is imperative that the individuals disidentify themselves with the imaginal structure. This requires a certain amount of reflection and the ability to discern an imaginal structure from the authentic self.

Another key concept from Imaginal Transformation Theory is Omer’s idea of ritualized pathologizing. Ritualized pathologizing is bringing one’s imaginal structures into the room within a larger structure in place. This larger structure is ritual. A principle related to this concept is that ritual provides a form that allows other structures, like imaginal structures, a forum in which to be revealed as distinct from the self. Ritualized pathologizing sanctions the restoration of the pathology to soul, returning the distinct parts to the multiplicity of the soul’s expression.

The key concepts and major principles presented in this section, although unique in their particular fields of study, intersect and share similar qualities. Distinguishing the various concepts and principles offered by Goddess Literature, Jungian Theory, Archetypal Psychology, and Imaginal Transformation Theory assists in lending meaning to the therapeutic process with Elizabeth. Although unique to their perspective fields of
study, they share the notion that psyche is a multiplicitous living presence within us whose voice bears heeding. This principle has guided the therapeutic process as Elizabeth and I reflected upon the varied facets of her life.

**What Happened**

The following section addresses the content of the therapeutic process shared by Elizabeth and myself. Therapy, for me, is like a whirlpool where images, experiences, and emotions surface in a circular motion. The material is presented in a way that mirrors this spiraling or unfolding inherent in the therapeutic process. Therefore, it does not follow a linear pattern, but a thematic one. In this section, the therapeutic process is reflected upon through some of the key concepts and major principles that informed our work together.

The following paragraphs address the concepts of the feminine principle and the Great Mother Goddess. Presented here are examples from my work with Elizabeth of some major principles associated with these concepts. The three principles illustrated include the following: modern man is living in a moral age characterized by our separation from nature; this separation has led to an inability to reconcile polarities; and, the Great Mother Goddess has survived within our psyches despite having disappeared from the world’s major religions.

When Elizabeth first contacted me, she was struggling with her desire to have a natural, home birth and the conflicting message that birth belongs in the hospital. Part of her trusted her body’s ability to lead the process of giving birth, but another part of her judged this idea as irresponsible. She knew that birth was a natural event, done the world
over millions of times by thousands of species each day. However, her doctor, husband, family and friends told her she would be better served in a hospital with medical intervention. This point of view supported the part of her that felt irresponsible and reckless for having a home birth. She had a difficult time containing these two realities within her. They tore at each other, leaving Elizabeth worn out and confused.

Elizabeth strained to make connections between what the culture was dictating and what she felt deep in her bones. The idea of interconnectedness, a place within her that could hold many versions at once, was foreign to her. This theme would rear itself many times in our work together as Elizabeth fought the internal polarities vying for prominence. The principle of the Great Mother Goddess as symbol of unity helped Elizabeth listen to and hold the varying experiences within her.

Early in our work together, during a hypnosis session, Elizabeth met a Great Mother Goddess who was clothed in greenery, walking amongst nature, and taking a profound interest in Elizabeth. She described feeling “at one” with the goddess, with herself, nature, and the baby inside of her. She seemed to have within her the collective myth of the Great Mother Goddess. As Baring and Cashford might assert, Elizabeth was recovering the Great Mother Goddess through these images.

At times, Elizabeth saw me as a Great Mother Goddess. She worshipped me as some divine model of motherhood, a model that provided something to aspire towards, but also fueled her persecutory voices that told her she could not measure up. I shared stories from my experiences of being a mother that included success and failure, security and doubt, vulnerability and courage. Elizabeth, at first, expressed disbelief at my
fallibility—my humanness—but as we continued to work on this transference issue, she found comfort in truly knowing that her experiences were shared.

Our work together seemed to be held by the concept of the feminine principle: an awareness of life as a sacred whole. The principle of unity and fragmentation weaved its way into the context of the individual sessions. The idea of the Great Mother Goddess’ capacity for containing all life in mutual relationship and sensing her aliveness within our collective psyches served to remind Elizabeth and myself of the sacredness of each interior participant traveling the territory of this therapeutic experience.

The concepts of archetype and myth also guided my work with Elizabeth. How they were manifested in therapy is discussed here. The principles attached to these concepts, namely that unconscious matter can pour forth when the conscious mind is distracted, unconscious material originates from the psyche in the form of archetypes—and that archetypes find representation in myth—are explored.

One principle at play was Jung’s idea that unconscious material streams from the psyche when the conscious mind’s vigilance is subdued. When we began our work together, Elizabeth’s situation—pregnant, giving birth, tending a newborn, isolation—gave rise to the state her consciousness was in, what Jung describes as a state of reduced intensity. The overwhelm of her situation, the otherworldly quality of pregnancy, birth, and motherhood, and the lack of meaningful support she was offered provided the leaks by which the unconscious material could stream forth.

Our work together was supported by the principle that unconscious material originates from the contents of the psyche in the form of archetypes. To express one example, Elizabeth’s life situations (pregnancy, becoming a mother) corresponded to the
mother archetype, and that archetype became activated on both the level of the collective unconscious and personal consciousness.\textsuperscript{dclxviii}

The universal motifs of the mother archetype were expressed through Elizabeth as she conveyed her experience of unconditional love, transformation, intuition, and nurturing as they lived within her.\textsuperscript{dclxix} She also spoke of the darker qualities attributed to the mother archetype, like depression, the unknown, chaos, and the abyss.\textsuperscript{dclxx} In the personal realm, Elizabeth brought stories about her mother, grandmothers, and mother-in-law, whom Jung refers to as the “first in importance” as an aspect of the mother archetype’s many manifestations.\textsuperscript{dclxxi}

The archetypes find representation in the figurative language of myth. At the level of myth, Elizabeth and I searched for the themes that were informing her current psychological state. We explored the myths she carried within her—archaic and modern—pertaining to the mother, relationships, abundance, and scarcity. In this way, we were experiencing her neuroses at the level of the universal motifs commonly shared by all and the personal conscious unique to her story.

A personal motif we explored pertained to the powerless mother. Elizabeth and I traced this myth back to the stories of her grandmother who, according to Elizabeth, sat idly as her grandfather raped and abused Elizabeth’s mother and seven adopted siblings.\textsuperscript{dclxxii} The grandmother also stayed married to the grandfather despite his having several extra-marital affairs. Elizabeth described her grandmother’s alcoholism, severe caffeine addiction, and depression as ways her grandmother could “numb out” from her situation.\textsuperscript{dclxxiii}
Elizabeth’s mother had an affair with a married man whom she later married after being publicly humiliated. Her mother’s shame of being found out as “the other woman” and being pregnant led to her decision to marry Elizabeth’s father. Her father was also sexually inappropriate with his children and lost a job due to suspected relations with a minor. One of his children from his first marriage molested Elizabeth and her sister. Throughout these ordeals, her mother remained passive. Like her mother before her, Elizabeth’s mother drank, used caffeine, and was depressed. Elizabeth describes her mother as being emotionally checked out and unable to assert herself.

Elizabeth also became pregnant under undesirable conditions after a one-night stand with a man she had met while drinking heavily at a bar. She married him because that is what she thought you were supposed to do, not because she loved him or felt they would have a healthy relationship. Despite her husband’s alcoholism and inappropriate behaviors, Elizabeth felt she had no choice but to stay with him. After the birth of their child, she began abusing caffeine, smoking marijuana, and became terribly depressed.

Her seeking help was a step out of the myth of the powerless mother that was recapitulated throughout her family. Elizabeth began to make meaning of her life through the conscious discovery of this myth. Our work with archetype and myth allowed her to recognize what myths were forming her and how they revealed the longings of her soul.

In working with Elizabeth, the concepts of pathologizing and multiplicity were fundamental. The following section will illustrate the principle that soul searches for a new reality through pathologizing. In keeping with Hillman’s thought, if the symptom of postpartum depression is Elizabeth’s soul searching for a new reality, then part of our
responsibility was to uncover what PPD was saying about Elizabeth’s personal story and the culture in which she lives.

Perhaps her soul, through PPD, was searching for a new reality in which her experiences of overwhelm, being a terrible mother, losing control, feeling as if she were tumbling into a great abyss, might make sense. With her pathologizing as our guide, we searched her personal and cultural landscape to find where the split was between the reality of the everyday world and the reality her pathologies were seeking.

Exploring Elizabeth’s multiplicitous psyche provided ample opportunity to reflect upon the reality she found herself in and the reality her soul craved. Elizabeth shared her experience of not knowing how to be a mother, the free-falling feeling of having no support, and the overwhelming and daunting responsibility in caring for a baby. The reality she found herself in was that no one had prepared her for motherhood; she had little support from her husband or family and did not know how to find it in the community. She felt utterly confused as to whether she was doing right by her baby.

The reality that her confusion, overwhelm, and shame—as voices of the soul—were longing for was one in which she was initiated into motherhood by loving, wise mothers, with her new status recognized by a supportive community who shared in the tasks of raising a child. She desired family, a solid marriage, and a tribe around her who mirrored her values. She wanted someone to tell her that her experiences had meaning and were acceptable. Her pathologizing showed her, not that she was defective, but that the reality she found herself in was flawed.

Elizabeth had a tremendous amount of resistance to this last idea. One of her guiding myths was that she was unworthy. This translates into her distrusting her notions
about what she needs or the possibility of those desires being met out in the world. Because of her lack of self worth, she hid in underachievement. In Elizabeth’s words, “For three years I retreated into my [receptionist] job at Motherlode Storage. I went into the woods on my lunch break and tuned out of reality.”

Her stories of retreat and unworthiness dominated her self-description. I would learn much later about her accomplishments, like performing in local theater, a year’s stay in Sweden, and graduating from therapeutic massage school by age 19. I remember her saying to me that she never noticed how hard she was on herself until I brought this to her attention. Elizabeth became increasingly able to make connections between her internal sense of unworthiness and the messages she received long ago. Her resistance remains, but her ability to see her worthiness has gained a good measure of ground.

The concepts of ritualized pathologizing and imaginal structures were vital in the work with Elizabeth. The following principles were reflected in the therapeutic context: ritualizing sanctions the healing dimension of pathology and allows other structures a forum in which to be heard; imaginal structures are not the self but a mediating lens that gives meaning to our experience and; one’s disidentification with an imaginal structure is essential for change.

The ritual container Elizabeth and I built was simple yet powerful. We started each session with the chiming of bells, silence, and lighting a candle to whatever had been evoked in the silence. Beginning each session this way became a holy practice that provided grounding and breadth to whatever material came forth. If ritual is, to quote...
Omer, “the river we can have our scrapes in,” then this ritual practice was the sacred river where we brought our wounds to be healed.

Building and sustaining this ritual seemed to enable Elizabeth to bring the varied imaginal structures within her into the room. Often in the silence, a thought, memory, or image would emerge and be identified with an imaginal structure that Elizabeth would embody. For instance, the imaginal structure of the helpless child, which formed years ago in response to her parents’ suggestion of her incompetence, would be activated as Elizabeth collapsed into her pathology around being an inept mother. After listening to that voice’s despair, hopelessness, and self-flagellations, we considered what might be possible if Elizabeth embraced a bigger picture of herself, one encompassing her resourcefulness and competency.

Omer states that change in behavior cannot be made without first transforming imaginal structures. In Elizabeth’s case, an imaginal structure was formed around the idea of her incompetence. After naming this structure and becoming familiar with its origins and points of view, our work was to distinguish the mediating lens she identified with from a more expansive vision of self. Elizabeth’s acknowledgement of her accomplishments was one way she exposed the limiting nature of the imaginal structure, thus gaining more spacious ground in which to imagine her self as capable.

Part of the resistance in transforming an imaginal structure is then bearing the responsibility of change. If Elizabeth no longer looked at her life through the lens of incompetence, she might be expected to return to college, to pay off her debt, to step fully into a new, broader definition of self. At times, Elizabeth vacillated between this broader definition and the comfort of the familiar confines of long ago. She decided the
discomfort she felt over the daunting task of becoming more fully herself outweighed the
anguish and despair she felt within the web of her old habits.

Imaginal Structures

How I Was Affected

Part of my professional practice is devoted to offering therapy for pregnant
women. The work I do with these women follows a basic pattern. I invite them to tell me
their life story. I want to know their attitude about being pregnant and the prospect of
motherhood. I inquire about their relationships and the support they have. We talk about
bonding. Then we move into practicing hypnosis to address bonding, labor, birth, and
pain management. Most of these women, including Elizabeth, are Medi-Cal clients, and
as such, I get paid very little, if at all, for my time. And yet, I am compelled to offer this
service as if it were a calling I could not ignore.

How I was affected by working with Elizabeth is similar to how I am affected by
all these pregnant clients, except with Elizabeth, I had the good fortune of continuing our
work and the privilege of seeing what happens after the baby is born. Our extended work
together allowed me to sit within this calling of mine long enough to grapple with how I
am influenced by these pregnant clients and what it is within me that compels me to work
with this population. To illustrate how I was affected by the work with Elizabeth, three
themes are traced in this section: 1) Where is the Great Mother?; 2) Sorrow and anger; and, 3) There is no easy fix.

In consideration of the first theme, Where is the Great Mother, it seemed that both Elizabeth and I were asking this question. The more I learned about her own mother and grandmothers, the more I wanted some beneficent mother figure to step in and embrace Elizabeth. I was pleased when she received the image of a Great Mother figure during a hypnosis session. Although she utilized this internal figure many times, I wanted more for her. I wanted for the hour or so that she was with me to be that Great Mother figure.

My desire to embody the Great Mother figure was born from the ways Elizabeth’s story moved me. I wanted to be her good mother to make up for her own mother’s emotional distance and tempered support. I wanted her to know that she was not alone in this world or with her experiences. I wanted to provide the support she lacked from other family members, her marriage, and the culture at large. While she was with me, I wanted to create a utopian world, where all that was lacking out there in the real world was held and made up for.

Elizabeth’s stories not only evoked the Great Mother in me, but also feelings of sorrow and anger. I could relate to her feeling like a motherless, lost child as these reactions mirrored some of my own postures. I felt sad that Elizabeth was so alone and overwhelmed. I grieved the absence of female role models, and that the women she turned to for guidance—her mother, her mother-in-law, her grandmother, her childless sisters—abandoned and misinformed her in her hour of need. I was sorry that Elizabeth
lived in an environment that provided no rite of passage for her when she voiced that she desperately needed one.

And all of those things angered me as well. I was mad that modern culture had lost the rituals and rites that might have helped Elizabeth navigate this stage of her life. I was angry that the significant women in Elizabeth’s life could not meet her needs. I was aggravated by her father’s inability to protect Elizabeth both in childhood and in her adult life. I also was disappointed in myself, that despite my efforts, I could not change the facts and make Elizabeth’s suffering go away.

I soon realized there was no easy fix. I suspected there was no single approach that contained the answers to some of the problems she brought forth. In turning to the authorities on postpartum depression, I knew that simply using a cognitive-behavioral approach or pharmacology would not suffice in easing the complexity of her story. Recognizing there was no simple solution, I became aware of my idealistic responses to Elizabeth’s suffering, such as wanting to end the difficulty for her, to abate her pain, as if my desire alone could make it so. I felt assured that I was helping Elizabeth, but I also knew the work we engaged in was a life-long process.

**My Imaginal Structures**

During the course of therapy with Elizabeth, many of my imaginal structures became activated. Imaginal structures can be viewed as the many ways identity has constellated in relation to significant experiences. They are regarded as the varying lenses in which we view life situations. I reference my imaginal structures by descriptive monikers and am aware of several working within me. Some of them are the *Know-it-all,*
the Judge, the *Savior of the World*, the Motherless or Lost Child, and the Good Therapist. This section references an imaginal structure related to the three themes mentioned in the previous paragraphs and places it within the context of the therapeutic process.

Related to the Great Mother concept is one clearly defined imaginal structure within me, which I refer to as the Good Therapist. The Good Therapist is much more helpful and skilled than any other therapist. The Good Therapist wants to provide the best counseling experience for her clients. She uses every technique at her disposal—and she has many—to conquer illness, vanquish suffering, and eradicate the general messiness and uncertainty of human interactions. She possesses the healing salve to cure all psychic wounds and is quick to jump in and apply it.

If you scratch beneath the surface of the Good Therapist’s front, she is afraid of not knowing what to do. When Elizabeth said she thought she had postpartum depression, the Good Therapist quickly armed herself with articles and books on the subject and a copy of Brooke Shields’ *Down Came The Rain* for Elizabeth. She administered the Edinburgh Postnatal Depression Scale to Elizabeth. She worried that she was not doing enough, that she might miss something and her incompetence might be detected by someone who knows better, someone licensed, someone more professional, someone who can define the pathway of a neurotransmitter as easily as giving directions to their house. How good would the Good Therapist be then?

The more embedded version of the Good Therapist is quite old, and I have carried her within me under various pseudonyms since childhood. From an early age, I have used my intellect to counter-balance my dreamy nature and the cute factor of my outward appearance. I felt I had to prove my worth through finely honed intelligence. This
afforded me many merits along the way, like winning the first grade honor pin awarded to the smartest child in the class and being chosen 8th grade class valedictorian. I graduated from college with two bachelor’s degrees and went on to acquire two teaching credentials. Then I got my master’s and am now pursuing a doctorate degree.

All of these accomplishments are wonderful things and have led to newer and more expanded ways of seeing myself and the world. However, when that older, more encapsulated version of the imaginal structure is activated, I feel that I must accomplish twice as much to be taken half as seriously. I feel tongue-tied and twisted in the face of someone whom this structure perceives as smarter than I. When seeing through this lens, I feel small, and this smallness is automatically driven out by a dismissive quality.

When Elizabeth asked my advice about seeing a psychologist whom a perinatal coordinator suggested, the smallness crept in. The internal voices said to me, “You’re not a psychologist,” “You don’t know how to do a psychological evaluation,” “You’re missing things that a real psychologist would find,” and “You aren’t up on new meds or what the professionals know.” The shrunken me relies on the dismissive one to back her up and pounce. I wanted to say to Elizabeth that I had heard this particular psychologist was okay, but not very deep, that she would give pat answers and pills. Although I did not voice this, it was evident in what I did not say, in my body language, the upturn of my nose, and the vibe in the room.

The Good Therapist basks in Elizabeth’s compliments and adoration of her. They fuel her propensity towards over-explaining and the urge to tell yet another story or give one more example. She is bolstered by Elizabeth’s growth and undermined by setbacks. When the younger incarnations of the Good Therapist show up, I rush to fix things and
settle the unsettled. Rather than drop into Elizabeth’s experience, such as shame, the Good Therapist in me over-encourages Elizabeth’s pride.

When I am able to disidentify myself with the older imaginal structure, realizing that it is okay to have no answer, that this does not cancel out my intelligence, its embeddedness gives way to an expanded, more inclusive view of Elizabeth’s situation and myself. I am able to research and prepare for our sessions without my reputation being at stake. I am less compelled to win over her admiration to make up for feeling small. Sitting with silent pauses and allowing the process to unfold lends a spaciousness in which both Elizabeth’s experience and my understanding have room to grow. The parts of my identity held bound within this imaginal structure are freed and more of my authentic nature is available to us both.

The Client’s Imaginal Structures

During the course of our work together, Elizabeth brought in several of her imaginal structures. An element of my work with Elizabeth was to uncover her various imaginal structures and to distinguish them clearly from the expansive nature of the self. Part of my task as therapist is to assist Elizabeth in recognizing that the fullness of her being is not limited to these imaginal structures by which she has viewed herself and the world. As these structures come into view, it is imperative to recognize them as both a constructive and limiting adaptation inevitably and understandably assembled from responses to an individual’s life stories.

As an example of Elizabeth’s imaginal structures, I will use an excerpt from a session in which two figures became visible. One figure Elizabeth referred to as The
Victim; the other one she named The One Up Here. They became evident as Elizabeth was grappling with something a friend told her. The friend said in response to Elizabeth’s feeling sad and overwhelmed, “You choose to be happy. You have that power within you. Just decide to be happy.”

Some parts of Elizabeth took this friend’s advice and ran with it. One part thought in response, “I am the source of my unhappiness. Suffering is all in your head. Be happy, now.” When that proved ineffectual, another part responded, “I cannot do it. It is too much. There is something wrong with me.” The first voice is from The One Up Here; the latter is The Victim.

This is not the first time these imaginal structures have been evident. By this time, Elizabeth had grown her capacity to recognize them and reflect upon their motivations and characteristics. She stated, “When the victim gets activated, I blame everyone else for my situation, and I have no control over my life. I feel like I’m not good enough.”

About The One Up Here she explained, “When I’m feeling bad about myself, that other one says, ‘Why can’t you rise above?’”

I explained that these two structures seemed to be on opposite sides of a continuum and quoted Omer that, “we must surf the polarities to find the virtue in the middle.” I drew a horizontal line with The Victim on one end and The One Up Here on the other. Somewhere in the middle I wrote, “authentic self.” Elizabeth was quick to correct my drawing and made a vertical line with The One Up Here at the top and The Victim at the bottom. I thought this was a fine example of her innate understanding of these structures.
I invited Elizabeth to embody these figures. We used a structure known as *The Guest House*, whereby you enter a circle as an imaginal structure. As *The Victim*, she entered the circle and immediately sat down with hunched posture. *The Victim* said:

I have no control over myself. I don’t get it. Why is everybody poking at me, pointing their fingers? It doesn’t make sense. Can’t they see I have a child to take care of? It’s so confusing. I’m sad.”

A completely different look came over Elizabeth’s face as she abruptly stood up, brushed herself off and announced, “And then I get mad.” Noticing the change, I asked who she was. She had not intellectually felt the difference between these figures, but was then able to name this as *The One Up Here*. From this perspective she pointed her finger to the ground as if addressing *The Victim* and angrily stated,

Who are you? Why aren’t you better? Can’t you look at everything around the world and see that it’s all bullshit? Did you really think that people would help you? How come you can’t rise above? Why are you choosing all of this? You wouldn’t find me down there!

At this point, I was writing down what this figure was saying. The imaginal structure used this as a way to put me down. I found myself getting uncomfortable and fidgety in its presence. I decided to voice this, trying to be matter-of-fact. *The One Up Here* responded, “That’s what I do. I’m above everyone. My job is to make everyone uncomfortable.” At this, Elizabeth sat back down in a slump. Again, her countenance shifted; she looked sad and small.

I asked this figure what her name was, and she replied, “Lizzie Liz.” I then asked how old she was and Lizzie Liz continued as she curled herself into a ball,

I am six or seven months old. Everything is scary. Chaos. Yelling. Fighting. I don’t understand it. Why do people want to fight all the time? I’m afraid I’m not good enough. There’s no pattern; it’s shaky. No rhythm, like a heart that goes [the figure moves its hand in a slow, fast,
slow motion]. Sometimes it’s here. Sometimes it’s there. What if I don’t belong here? Elizabeth was ready to end this form and asked to stop *The Guest House*. She shared her experiences with me. As *The Victim* she felt powerless, crushed, and wanted to escape. The only way *The Victim* knew how to escape was through death. As *The One Up Here*, Elizabeth felt “above it all” and noticed how this figure blamed everyone and everything for her circumstance. *The One Up Here* makes people uncomfortable and the by-product of this is alienation.

Elizabeth reported that she felt a great deal of shame as both *The Victim* and *The One Up Here*. I asked her to sit with the shame and follow its lead. She began to cry and expressed that underneath the shame was grief. Immediately the shame reappeared and she stated, “I feel the shame when I get close to the grief. I’m not supposed to feel or cause emotion. The little girl feels ashamed of her feelings.”

I invited Elizabeth to stay with the feelings. She described feeling shame and then grief again. She cried. Her grief led her to an awareness of sorrow she felt for Lizzie Liz. She compared Lizzie Liz to her daughter and was able to see how awful and confusing her own childhood had been at times. Elizabeth had articulated this before, but the difference this time was that she knew the experience now in her bones and not just her head. She was beginning to disidentify with *The Victim* and *The One Up Here*, enabling her to access long denied feelings.

Her grief gave way to compassion, not only for Lizzie Liz, *The Victim, The One Up Here*, and herself, but also towards her brother who had molested her. She stayed here for a while, comparing her childhood to her brother’s similar experience. She cried for those two children. Her compassion and understanding rippled out to her mother and
father, struggling to do better than their parents had. Her body lost its usual inward turn, as she sat erect and open, free from the frozen images that had found form within her so long ago.

New Learnings About My Imaginal Structures

One of the great gifts of being in relationship with people is the opportunity to track the thoughts, feelings, and sensations evoked through our association with them. In a therapy context, this might be referred to as countertransference. This section discusses the insights I gained regarding my imaginal structures as I tracked the thoughts, feelings, and sensations that surfaced throughout the therapeutic relationship with Elizabeth. The following paragraphs are organized into several discoveries about these structures that have come into focus as a result of this relationship.

One general comment about my imaginal structures is that they have the unyielding capacity to knock me off my ground when they suspect that I am abandoning my authentic self. They seem to be waiting in some invisible wing, like an understudy waiting for the star to take ill. When I become confused, dissociated, or scared (to name but a few sensations), an imaginal structure is ready to step in with its own limited but pointed interpretation. My authentic self has gone unconscious while the imaginal structure rewrites the script to suit its capacity.

An example of this process became evident as I contemplated a ritual I facilitated for Elizabeth as an initiation rite into the passage of motherhood. Even though I knew days before the planned ritual that going forward with it might be a bad idea, I could not stop it. Then, the night of the ritual, it became clear within minutes that the intention I
had, one of support, of elders sharing what they know, of holding Elizabeth throughout the initiatory process of becoming a mother—all of this was quite different from what was unfolding. The authentic me disappeared and the imaginal structure took the stage. The structure would stay the course, not wanting to be perceived as unsure or noncommittal.

Connected to this structure that does not back down is the one who judges when faced with competition. Elizabeth’s family (mother, father, sister, and brother) is very involved in a self-awareness program called the Landmark Forum. When Elizabeth brought up the topic, she was interested in participating in the program and thought it might have much to offer. Immediately I felt a narrowing of myself take place and an aloof, condescending figure come to the forefront. “Well, if you go in for those sorts of things…” was the tone of my responses. This figure did not want Elizabeth to find comfort, information, or enlightenment from a source it deemed inferior or suspect. It also did not want to share a spotlight with another player.

I have learned, however, that my imaginal structures are more than just myopic, limited, formulaic, demanding taskmasters. What I have learned about my imaginal structures is that if I turn towards the passionate nature of my soul, they are willing to see things a different way and support the bigger picture of myself. When they are acknowledged and respected by me, they are prepared to take chances. Because I perceived Elizabeth as non-threatening and respectful of me, my older, more embedded structures loosened their grip. Elizabeth’s faith in the process in which we engaged and her trust in me emboldened me to bring more of myself into each session. I could actually feel those older structures rooting for a more comprehensive me.
Through this case study, the relationship with my imaginal structures has shifted. Rather than seeing them as pathologies needing eradication, I have come to respect them as a wise council created from my life story, the cultural climate that surrounds me, and the universal motifs of human existence. When I possess the capacity to engage with and build awareness of the imaginal structures shaping my experience, it enables a broader view of the client and myself. Our multiplicitous nature can display its pageantry without my feeling threatened. And in this embracing of my imaginal structures, I have come to understand that they crave unity; they yearn to belong.

**Primary Myth**

This section provides a mythic backdrop by which Elizabeth’s personal journey can be reflected. Myths, according to Jung, are the psychic life of humans and therefore reveal the nature of our soul. If, as Jung suggests, we make meaning of our own life through myth, then it is essential to know the myth behind our particular pathology. The pathology Elizabeth brought into the therapy room was her expression of postpartum depression. The following paragraphs attempt to illustrate a parallel between the arc of the diminishing influence of the myth of the Great Mother Goddess and the revelation of the nature of Elizabeth’s soul through the presenting symptom of postpartum depression.

According to Baring and Cashford, in the beginning, God was a woman. For 20,000 years of human existence, the Great Mother Goddess alone gives birth to the world. Out of her, all beings and all nature are made and therefore, are divine. Humans and nature share a common, sacred identity. Soul imbues all experience
with the awareness of the interconnectedness of all things, and all things are in unity, held
by the Great Mother Goddess.\textsuperscript{dcccvi}

In this epoch the archetypal feminine, as represented in the Great Mother
Goddess, includes a myth of giving birth to the world. Birth is the first cosmic feat, and it
is perceived as a sacred act. Because everything in existence—you, me, trees, bugs,
water, rocks, animals—is of the Great Mother Goddess, we are all equal, valuable, sacred
matter. Man does not rule over nature. Woman is not less than man. Feelings are not
separate from thought.

In the next era, Baring and Cashford assert, the Great Mother Goddess and the
god give birth to the world.\textsuperscript{dcccvii} The focus of the myth shifts from sacred birth and unity
to introducing the concept of duality.\textsuperscript{dccviii} In the next stage the myth is transformed
again, with the god brutally destroying the Great Mother Goddess and creating the world
from pieces of her dead body.\textsuperscript{dccix} From this late Bronze and early Iron Age myth,
Baring and Cashford claim that the shift occurs from unity with nature to man over
nature.\textsuperscript{dccx}

Finally, and where the myth stands today, the Great Mother Goddess disappears
from the myth altogether.\textsuperscript{dccxi} God alone creates the world; birth as a sacred, natural
event is lost, creator is apart from creation, and man is made in god’s image and therefore
superior to animal, plant, and mineral.\textsuperscript{dccxii} According to Baring and Cashford, the long
process of replacing the myth of the Great Mother Goddess with the myth of the god
mirrors man’s steady alienation from the natural world.\textsuperscript{dccxiii}

With the marginalization, degradation, and disappearance of the Great Mother
Goddess myth, so go the time-honored concepts attributed to her. Fast forward to the 21st
century where unity has been replaced with division, man’s conquering of nature has led to the possibility of global extinction, and the feminine principle as holding vessel for all experience is exchanged for a few powerful men devoted to their individual gods and causes, creating polarities at every altar. We are dissociated from the sacred feminine and the birthing logos that have been unseated by a dishonoring of difference and a suspicion of nature and soul. It is within this overarching cultural context that Elizabeth brought her personal myth, rife with polarities and warring factions, and a strong assertion from soul that something was amiss in the modern myth.

Even though the myth of the Great Mother Goddess has been disregarded for centuries, Baring and Cashford propose that it lives on in the collective psyche. Perhaps the myth of the Great Mother Goddess is itself, like Elizabeth, undergoing a postpartum depression and some women, especially those within cultures of modernity, are echoing this psychic phenomenon. Maybe the soul, through postpartum depression, is attempting to get our attention and seeks a new reality where PPD makes sense.

The myth of the Great Mother Goddess is possibly what postpartum depression is trying to bring to our attention. Postpartum depression as voice of the soul is calling, “Look over here to the necessity of multiplicity; to treating birth as a sacred logos; to the valuation of all life, including women and mothers as sacred rather than evil, sick, or invisible; to finding soul again in nature and in everything we do; and to caring for the world and all its inhabitants as though we are a sacred whole rather than its rulers.” In the words of Hillman, “…the soul’s want is the soul’s lack.”

We have neglected the soul’s want in our rejection of the Great Mother Goddess; yet, she lives in us as a psychopomp—the teacher and guide of the soul. Historically, the
rituals of the Great Mother Goddess were the most powerful in the world. The Greek rituals of the Thesmophoria and the Eleusinian Mysteries were sacred rites that provided a psychological cornerstone of understanding for what it is to be human. Through the Great Mother Goddess, mankind was restored to nature. Perhaps through postpartum depression, the Great Mother Goddess myth is attempting, through pathology, to reenter human consciousness and repair this rupture.

**Personal And Professional Development**

It is difficult to distinguish between the personal and professional growth I experienced in working with Elizabeth—as one develops, so goes the other. The capacities gained or strengthened as a result of our therapeutic relationship have affected my whole being, and therefore will be addressed accordingly. This section addresses the promotion of trust in the soul’s process, psychological faith, empathy, and mutuality that was encouraged by my work with Elizabeth.

Working with Elizabeth has grown my soul. To be honest, I did not want to use Elizabeth as a case study because I had no conscious desire to explore the topic of postpartum depression. I had barely heard of PPD. I knew I had not experienced it after the birth of my baby. I dismissed the topic as irrelevant, uninteresting, disconnected from my sense of what kind of case I was looking for, and it certainly held no glamour for me. I had forgotten that the soul chooses which images we inhabit, and for some reason, mine kept insisting on following Elizabeth and her postpartum depression wherever it led.

Surrendering to the topic’s insistence fostered my psychological faith. I learned to trust that soul has reasons beyond what my ego, will, or conscious mind can muster. After
surrendering to this call, I began realizing how the invisible threads of my life had guided me to this point: being educated at the Institute of Imaginal Studies, my life intersecting with Lorna Cutler who taught me about bonding, choosing a midwife and homebirth for my pregnancy, driving three hours to Sonoma while seven-months pregnant to work with Lorna’s peer in preparation of my own birth, giving birth later in my life after a certain amount of initiatory experiences, and then working with the local midwife’s clients on bonding and birth. My psychological faith directed my understanding. I had gained so much knowledge about what was on the pregnant side of birth, and then soul escorted me to the other side, to the side of motherhood.

Elizabeth delivered a particular story of motherhood that broadened my empathy for her situation, for mine, and the countless other mothers living in an age dissociated from the myth of the Great Mother. My compassion for and understanding of the imaginal structures that formed around this dissociation deepened. Viewing these structures through Elizabeth’s experiences afforded me the necessary distance to recognize them in myself. I could see that the younger, more embedded structures were drowning in the responsibility of motherhood and ached for a Great Mother figure to lift them up. They possessed no models for mothering; no one initiated them. These structures were unable to assist in the grown-up work of motherhood. Although I did not share Elizabeth’s lack of social support and overwhelming situations, I empathized with the loss and yearning.

This collaborative work Elizabeth and I engaged in expanded my awareness of the mutuality of therapy. Working with Elizabeth in empowering and caring ways helped catalyze her own empowerment and healing, which in turn empowered and healed
In my helping Elizabeth gain new understanding of her experiences, I gained new understanding of mine. The mutuality of our work assisted in encouraging my presence. I witnessed what Omer describes, “When I am me, you are you. Then more of me and more of you show up.”

Applying An Imaginal Approach To Psychotherapy

The extended work with Elizabeth and the subsequent intensive examination of this work has left me with a number of conclusions about using an imaginal approach in the psychotherapeutic process. The following section addresses the potency, limitlessness, and connective qualities inherent in an imaginal approach. How an imaginal approach to psychotherapy mirrors the logos of the Great Mother Myth is also considered.

An imaginal approach adopts the tenet that the primary concern of psychology is reclaiming soul. Inherent in this belief is that the therapist practicing from this orientation is caring for the soul of another. The crucial distinction here is caring, not curing. The therapist might hope to cure or alleviate suffering, but a governing principle is to see the client as a process unfolding, not an illness to cure. Given that much of the therapeutic community is ensconced in the medical paradigm of absolutes and cures, there is great risk and vulnerability in care of the soul.

The potency of an imaginal approach is worth the risk. The move away from defining therapy as the eradication of a client’s symptoms towards characterizing
psychotherapy as serving the soul—and therefore the symptom—proves a powerful paradigmatic shift. With Elizabeth I have witnessed how, as Hillman states, “staying in the mess” eventually liberates the multiplicity intrinsic to our nature and to soul. In valuing the many voices of the soul, Elizabeth’s ability to live within the complexity of her life with courage, compassion, accountability, and grace was strengthened.

Just as soul is a many-valanced entity, the imaginal approach to caring for soul mirrors soul’s limitless nature. An imaginal approach to therapy is founded on the shoulders of shamans, storytellers, scientists, and artists. This approach appreciates and incorporates the wisdom, depth, and breadth of many orientations, including spiritual traditions, somatic practices, creative arts, mythology, indigenous wisdom, literary and poetic imagination, deep ecology, and social critique.

In working with Elizabeth, I used bits and pieces from each of these practices. I was grateful to have so much ground on which to stand at any given moment in the therapy. Whenever I found myself feeling inadequate and unable to rise to the challenges that Elizabeth’s story presented, I began noticing how I was limiting myself not only through old imaginal structures, but also by the facts and skills they carried. A less unified me might turn to a more limited approach. I might reach for the medical model or hold a cognitive-behavioral approach as the one, true god. The restrictive nature of working from this purified perspective left both Elizabeth and myself unable to bridge the story to the technique.

An imaginal approach to the therapy provided the connective tissue, bridging such seemingly disparate paradigms as medicine and indigenous practice. I was able to work with Elizabeth from an orientation of inclusion. An imaginal approach is both horizontal...
and vertical, reaching down into the primordial stew and up to the heavens while acknowledging the theoretical steps taken throughout this human unfolding. It takes into account the client’s personal story, the cultural context of the story, and the archetypal implications at work within this narrative. Working with Elizabeth from an imaginal approach broadened her experience of herself and provided her with the connective tissue to contextualize her story within the more spacious container of soul.

The polytheistic nature of soul is represented in an imaginal approach, which in turn echoes the logos of the Great Mother Goddess myth. They all hold within them the principles of multiplicity as the nature of soul, that wholeness is strengthened in honoring uniqueness and variety, and that there exists a sacred interconnectedness between all things. The potency, limitlessness, and connective qualities of an imaginal approach are also the fundaments of the Great Mother Goddess. An imaginal approach to psychotherapy helps restore the concept of the Great Mother Goddess to our modern times.
CHAPTER 5

REFLECTIONS

Personal Development And Transformation

When I became pregnant at age 40, I knew I needed support beyond my own resources to mother a child. I contacted a midwife. I attended hours of therapy to confront anything in me that might inhibit my bonding with this baby. I created a ritual for myself, gathering many mothers, including my own, to impart their wisdom and to usher me from single being to bearing the responsibility for another’s life. At that time I felt I had no mothering instinct and was not comforted by assurances that this instinct would kick in after I saw my baby. Instinctively, I knew this was an initiatory experience, and I was unsure of who I would be on the other side of it. I became a more spacious human, a more curious and friendly one, with heightened sensitivity and awareness of self and other, and my respect for the plurality of our nature grew as I witnessed my son’s multiplicitous expressions and my myriad responses to him.

This Clinical Case Study echoes my initiation into motherhood. My midwife was a fellow cohort member, Claire James. The therapy I sought was in the writing group I attended with two students from the Institute of Imaginal Studies. My initiators were the wise elders—Jung, Hillman, Omer, and many others—whose theoretical constructs contained me as I journeyed into the unknown. Oftentimes, I was on the outer edge of my mental capacity and would refer back to trusting that this initiation held great promise; it became natural to not know where I was going.
Like my initiation into motherhood, the Clinical Case Study has initiated me into another field of maturity. The two kinds of intelligence that Rumi speaks of—the one acquired and the other one inside you—were called upon to flex and dig and soar each time I turned my attention to this process.\textsuperscript{decxxi} The Clinical Case Study initiation has broken me open. I am reminded of the grand, Morpho butterfly in Monte Verde, Costa Rica I watched crack out of its cocoon, wings folded, unsteady, getting its bearings, feeling the air, sensing its surroundings, and then raising its luminous azure wings aloft.

Just as my experiences at the Institute of Imaginal Studies informed the way I buried my brother and father, the way I married my husband, and the way I birthed my son, so too is the Clinical Case Study facilitating a deeper understanding of the interconnectedness of all things and the crucial necessity to honor our multiplicity and dissolve the wall of otherness that creates division. This initiation has strengthened my desire to move into community activism, not as a student or daughter or child, but as an initiated elder, as a mother. The Clinical Case Study experience enlarged my faith that something vast and more substantial than my ego, or even a belief in any god, is at work in us all. This vastness is soul, and it asks to be heard. As a result of this initiatory process, I feel a bit more fluent in its language.

**Impact of the Learnings on My Understanding of the Topic**

Initially, my understanding of postpartum psychiatric disorders was minimal. I had heard of postpartum psychosis from sensationalized news reports and headlines involving women killing their infants. I was aware of celebrities speaking about their
experience of postpartum depression. I had heard the terms but never fully reflected on the meaning and experiences behind the labels.

When Elizabeth Strong called me and said she thought she might have postpartum depression, I honestly had little idea of what that meant. The DSM proved unsatisfactory in providing answers. Someone had given me Shields’ book about her experience with PPD, so I read some of it before passing it along to Elizabeth. I went on-line and found out about the Edinburgh Postnatal Depression Scale and saw an article about the state of New Jersey passing a mandatory pre- and postnatal screening test. I ordered a few more books on postpartum depression and thus began the research that would become this Clinical Case Study.

My learning curve was steep. I knew next to nothing about the physical adaptations a woman’s body goes through after childbirth. Like so many women, I was well informed about pregnancy and could use its terminology—lochia, vernex, alpha-fetal protein—with ease. But after birth I stopped reading the books about me and turned my attention to the baby. And that is indicative of the modern mothering experience; we get lost somewhere after the baby is born. I knew nothing about hormonal crashes, thyroid functioning, cortisol levels, or genetic predispositions. I had never heard of postpartum anxiety disorder, postpartum mania, or postpartum post-traumatic stress. I had no understanding of the differences between baby blues, postpartum depression, and postpartum psychosis.

As the research drew me further into this topic, I kept feeling that the books I was reading were missing something. Although I learned a tremendous amount from the experts and scholars who have spent their careers devoted to postpartum psychiatric
disorders, it was not until I stumbled upon Laurence Kruckman that I felt something stir within me. His anthropological view of postpartum depression as an illness of culture resonated with the growing inclination in me that PPD was not just a disease of the body or mind. I was beginning to grasp that PPD was an illness housed in a personal body, mind, and story, but also inhabited a space within the culture.

This led me to the realization that has since guided this endeavor: postpartum depression has personal, cultural, and archetypal dimensions. There exists a generous amount of literature devoted to the personal aspects of PPD. When you enlarge the search to include the cultural considerations, there are fewer scholars studying the implication of culture specifically to postpartum depression. Moving out into the archetypal realms, I found no one viewing PPD through this lens.

I felt like a pioneer venturing out on a cosmic limb, extrapolating the concepts within Goddess study and Jungian, Archetypal, and Imaginal Transformation Theory to fit this specific research. The question that kept arising was, If postpartum depression is a voice of the soul, then what is it saying specific to motherhood? My initial understanding of PPD as some vague psychiatric diagnosis metamorphosed into an imaginal inquiry to answer that question. This inquiry has ended where it began, with my and other mothers’ experience of overwhelm, of being underappreciated, of birth and motherhood being treated callously by others, and the frustration and isolation these experiences bred. What has been gained is the awareness that perhaps these feelings inherent in the modern mothering experience is the Great Mother Goddess expressing herself as a collective re-visioning of motherhood as sacred.
Mythic Implications of the New Learnings

If, as Hillman contends, the gods “force themselves symptomatically into awareness,” then the pertinent question in relation to postpartum depression is, What god desires to be seen? Answering this question has become a sacred duty. At times, I have felt like a mere mortal who has been visited by a goddess who demands I build a sacred temple in her honor on the ground of this Clinical Case Study.

The goddess who has been ignored and thus demands to be seen is the Great Mother Goddess. The archetypal manifestation of the Great Mother Goddess through the symptom of postpartum depression can be seen as a compensatory reaction to the modern experience of motherhood. Perhaps the parallel can be drawn that as the myth of the Great Mother Goddess and the feminine principles inherent in her myth began to disappear from culture, postpartum depression began to emanate out of this absence. As the myths and rituals pertaining to mother as sacred being began diminishing, the first known reports of postpartum psychiatric disorders were recorded.

As mankind moved from the Great Mother Goddess myth to a masculine monotheistic model, the devaluation of womankind was mirrored by the disappearance of the feminine initiatory rites. In the Great Mother mythos, mankind and nature are interconnected and all things have sacred value as part of the goddess creator. The masculine model advances that nature is to be conquered and subdued. If woman is linked to nature and nature is to be subdued, then a woman’s worth is lessened. The imaginal abandonment of the Great Mother myth coincides with a literal abandonment of the mother. The rejection of the mother as an empowered entity perhaps has led to the disempowerment of motherhood. And this loss of personal worth is passed on.
This idea is also found in the de-evolution of the diagnosis of postpartum psychiatric disorders. As mankind sought ways to tame and classify nature, the respect for a unique postpartum consideration began disappearing from the scientific language and was gone by the end of the 19th century. Possibly this disappearance echoes the devaluation of the feminine principle, of motherhood, and of birth. If postpartum depression is seen as a cultural necessity with purposes and values, then perhaps this symptom has become so prevalent in Western culture as a way of critiquing the culture it inhabits. Maybe the archetypal imprint of the Great Mother Goddess seen through the pathos of PPD is the mother longing to be revered and deemed worthy of care.

This century has seen new laws being passed to screen for PPD, which belie the seriousness of this time in a woman’s life. Studies have shown that grandparents, fathers, even adoptive and foster parents suffer from postpartum-like depressions. Perhaps this supports the idea that the Great Mother archetype belongs to the whole human race and enters wherever there is a need. Maybe the loss of the Great Mother Goddess myth has brought us to this moment in Western history where the top two contenders for the presidential nomination are a woman and an African American man who espouses the feminine principle in his talk of unity. And perhaps the very planet we live on, with her melting caps and disappearing life, is the archetype’s voice longing to be heard.

**Significance Of The Learnings**

The learnings gained as a result of this Clinical Case Study have the possibility of contributing to a redefinition of postpartum depression, motherhood, and the feminine principle as bearing tremendous value to our modern times. This section proposes three
areas where the Clinical Case Study might enhance our understanding of postpartum depression. First, postpartum depression is viewed as both an historical and social critique of a culture’s handling of motherhood. Secondly, modern cultures need to embrace a reinstatement of the initiatory rites of passage belonging to motherhood. And lastly, postpartum depression is not just a disease of the body or mind, but also an experience of soul.

Much of the literature concerning postpartum psychiatric illness is limited to examining it as a disorder of the individual. As such, the majority of the literature is devoted to medical studies to discern the biological causes of PPD. Scholars writing about the spectrum of postpartum psychiatric illness also mention with great frequency the individual woman’s psychiatric history, thought processes, and social support she receives from her family and friends. However, very few writers address postpartum depression as a mandate for social change.

This study has emphasized the possibility that postpartum depression serves as an assessment by which to measure a society’s ability to do right by its mothers. This point of view shifts the focus from the individual to the onus being on us all. American medical society treats pregnant women within a disease model. Modern birth practices take away the birth privilege from the mother and give the control to the hospitals. After the birth, women are largely left to their own devices, sometimes lucky enough to have a husband, mother, or in-law participating in household responsibilities. In my case, and in the lives of the many women I have spoken with and have read about, a clinical diagnosis of postpartum depression may or may not have been warranted, but we all felt depressed. Something was missing from our experience that left us feeling alone, misunderstood,
and overwhelmed. It has been the contention of this Clinical Case Study that this depression is directly related to the loss of reverence for the feminine.

In modern society, this loss can be seen in the disappearance of an initiatory or ritual experience for motherhood. Several writers from an anthropological orientation address the correlation between the occurrence of postpartum depression and the dissolution of ritual experiences. This study has attempted to make the case that postpartum depression is in part a product of the loss of rituals enacted to prepare a woman for motherhood, to take care of her after the birth of the baby, and to welcome her back into the community with her changed status of mother. In addition, this study proposes that the loss of these rituals is contemporaneous with the devaluation of the feminine.

The crux of this study has been to elucidate the connection between postpartum depression and the soul’s expression through pathology. PPD is a disorder that is understood through evaluating the effects the body, mind, or society has on an individual’s experience. This study has looked at body, mind, and society, but now asks the question: What is soul saying about the experience of motherhood through the symptom of postpartum depression? It is the contention of this study that postpartum depression is a meaningful expression of the soul’s desires and acts as an internal compass to track the personal, cultural, and archetypal influences on its landscape.

The Application Of Imaginal Psychology To Psychotherapy

The learnings that have grown out of this study possess the potential to amend the psychotherapeutic landscape through the application of Imaginal Psychology. An
imaginal approach does not exclude other theoretical constructs; rather, it augments other approaches by way of its inclusionary and multiplicitous nature. Specifically, Imaginal Psychology restores soul to the practice of psychotherapy.

Hillman asks that we re-vision psychotherapy in accordance with the root words of its name, *psyche* and *therapy*. Taken together, these words mean “to serve soul.” The shift from curing, eradicating, or alleviating a client of their symptom to caring and serving is radical. When I worked for county mental health, the way we were subsidized for clients was through their progress based on curing, eradicating, and at the very least, alleviating their symptoms. No matter how good you made things look in the chart notes, these same clients resurfaced again and again.

The learnings that have emerged through this study suggest that serving soul enlarges the scope of psychotherapy. Success is not measured by how quickly you can rid the client of their symptom, but by how faithfully you remain attuned to the symptom itself. In Elizabeth’s case, the use of Imaginal Psychology provided a structure by which postpartum depression could be viewed as an endowment rather than a disease. This is not to suggest that postpartum depression is a lovely gift, but Imaginal Psychology asks the practitioner to look at the symptom as the voice of the soul. We want to serve the symptom by unearthing the treasures it has hidden beneath the layers of confusion, turmoil, and unrest.

The learnings suggest that psychotherapy must flex beyond the treatment of body and mind, to consider a symptom by means of not only the influence of the personal, but also the cultural and archetypal perspectives. Using an imaginal approach has many implications to the practice of psychotherapy. The learnings suggest the importance of
restoring reverence to the feminine principle, of building a ritual context for the therapeutic relationship, of recognizing the multiplicitous nature of the self, and of viewing pathology as the soul’s way of getting our attention.

In our western culture, the concepts of soul, ritual, or the feminine principle are foreigners and therefore suspect. An imaginal approach to psychology has the responsibility of teaching this foreign, if not long forgotten, language to the clientele traveling amid the psychotherapeutic terrain. It takes an initiated practitioner of this approach to then initiate others into its territory. Because an imaginal approach does not rely solely on teaching or dispensing information, it requires a willingness and capacity to explore regions beyond what Omer refers to as the web of habits. And for this region, there is no map. A practitioner cannot pull a book down from the shelf, like the DSM or a cognitive-behavioral workbook, and follow an outlined guide for the presenting symptom. That may serve the therapist’s sense of direction but not necessarily the soul’s journey.

Perhaps the same impetus that drove Omer and others to create the Institute of Imaginal Studies compels practitioners like myself to reach towards Imaginal Psychology in therapeutic practice. Imaginal Psychology is both groundbreaking and ancient in its orientation. It is an open field where the many incarnations of self can roam—and where the many voices of the soul are heard.

**Bridging Imaginal Psychology**

In my practice, I try to begin each session with silence and the lighting of candles. At first, I can sense that many of my clients are unfamiliar with this kind of ritual
making. Some appear uncomfortable. Other clients snicker or wonder if they are doing it right. But it does not take long before they expect this ritual beginning and even ask for it when I forget. It seems that there is something in us that is drawn to infusing our life with soul.

This inherent longing perhaps is why it does not take much to bridge Imaginal Psychology to mainstream settings and the work with clients. I have witnessed clients’ willingness to participate in an imaginal approach to therapy despite the suspicion when words like ritual or soul are mentioned. At first, a client sometimes adopts the cultural stance against multiplicity or soul, equating these concepts with things they deem silly, like daily horoscopes or New Age ideology. This stance is usually a temporary attempt at staying in familiar territory. Most clients begin quickly discerning the difference between silliness and soulfulness.

When I talk to clients about caring for their symptom rather than erasing it, their curiosity is palpable. Of course they come to therapy to get better, but something wise in them senses that getting better may have a different meaning than merely being rid of their symptom. Before long, the client is engaged in befriending what at first seemed to be their nemesis. They are capable of comprehending the concepts of imaginal structures, adaptive identity, and ritualized pathologizing and are willing to explore themselves in an imaginal way. Whether the work is conducted through engaging an image or embodying an imaginal structure, the clients take to this work and make meaning out of their rich experiences.

I am appreciative of scholars who have been able to translate theory and conceptual language into every day usage. So, a way that I bridge Imaginal Psychology to
the mainstream is that I avoid using terms specific to this approach. Even words like *ritual* or *soul* can be negatively charged and off-putting to some people. I tend to arrive at these words, let alone the more specific language associated with Imaginal Psychology, in a way befitting to the client or situation. The message remains the same whether I use the word *imaginational structure* or *lens* or *mask*.

The most effective way I know to bring Imaginal Psychology into mainstream settings and to the clients I serve is by representing it with reverence, thoughtfulness, and intelligence. My clients trust what I am delivering because the language I use and the presentation I make are anchored in a tradition of erudition. Imaginal Psychology is founded on deep, intellectual ground that has been first tread by indigenous wisdom, poets, artists, writers, and scholars, such as Rumi, Jung, and Hillman. Imaginal Psychology is not merely a movement trapped in rigid dogma or a consequence of its time. It is part of the myths that ring the world and go back millennia. It is not American or European or Asian; it is universal in the human condition. The references Imaginal Psychology draws upon have breadth and depth, and people get the sense of this wisdom, gentleness, humor, and curiosity.

I bridge Imaginal Psychology into the world through knowing that I am the bearer of this deep and effective work. My clients are feeling me out and sensing whether I am willing to stay in this arena. The confident and habitual way I present this practice, with a boldness of bringing soul into the room, allows their ancient self to meet mine. The moment reaches through all the cool layers between self and soul, and the space between imaginal and mainstream, between foreign and customary, between us and them dissolves.
Areas For Future Research

The majority of the literature addressing postpartum psychiatric disorders is devoted to finding a biological explanation for this phenomenon. The bulk of research in progress is being conducted to pinpoint which organic mechanisms, especially hormonal deficits and imbalances, influence postpartum psychiatric illnesses. Research is also focused on finding efficient drug treatments and ascertaining what psychotherapeutic methods might prove effective. To a smaller degree, research is exploring what role a mother’s social support plays in relation to postpartum psychiatric disorders.

So far, there is no unified theory as to what causes postpartum psychiatric illness. There is no agreement in the medical field, and studies showing favor for one biological explanation over another have been discounted or refuted by other studies. The conclusion is there exists no biological proof that postpartum depression has at its root a biological cause. The search continues, and proponents within the research community are hopeful that future research will provide a biological etiology for PPD.

Research has shown repeatedly that cognitive-behavioral and psychodynamic approaches, although helpful in symptom alleviation in the short-term, have little effect in either the long-term or in regards to prevention for a repeated diagnosis. Medications, too, have been shown to ease symptoms, but were not found to be any more beneficial than the aforementioned therapies. If there is no conclusive biological theory for PPD and cognitive-behavioral, psychodynamic, and psychopharmacological interventions prove ineffectual, then there must be something more at work here—something requiring a different type of microscope or cure.
This Clinical Case Study has exposed some openings for future research. There is tremendous opportunity in reflecting upon postpartum depression as a messenger offering unique insights into the personal, cultural, and archetypal myths surrounding the experience of motherhood.

On a personal level, research into a woman’s experience of motherhood is essential in understanding postpartum depression. My client, Elizabeth, felt that her postpartum depression was partly about her re-experiencing not being mothered. She felt a strong desire to be taken care of and revered in this new role. Her experience was that she felt alone and invisible. Research needs to address the correlation between postpartum depression and this type of biography.

From the cultural perspective, research needs to be conducted using postpartum depression as a cultural critique. If PPD were considered a cultural responsibility, then addressing the issues within the culture that fail to support mothering, such as modern birth practices, maternity leave, childcare policy, and other forms of social support, would be a necessity. The status of women and children would be reconsidered under this type of scrutiny.

An archetypal rendering of postpartum depression is absent from the literature. Future research needs to consider PPD as a messenger of soul. As such, it would be important to design some qualitative research in which mothers were able to embody or express the full experience of not only postpartum depression, but of motherhood as well. From such studies a greater depth of knowledge about all the forces at play in this varied diagnosis would be gleaned.
Lastly, I believe the lack of a DSM classification for postpartum psychiatric disorders needs to be considered. The fact that postpartum psychiatric illnesses are absent from the psychiatric nomenclature speaks to the devaluation of the feminine experience and the whitewashing of the unique personal, cultural, and archetypal event of motherhood. It is sad commentary when the premiere book of psychiatry fails to acknowledge the complexity and distinctiveness that motherhood brings to the psyche of a woman.

APPENDIX
APPENDIX 1

INFORMED CONSENT

To _____________________________:

You are invited to be the subject of, or referred to in, a Clinical Case Study on Postpartum Depression. The study’s purpose is to better understand postpartum depression within the context of a woman’s narrative.

For the protection of your privacy, all of my notes will be kept confidential and your identity will be protected. In the reporting of information in published material, any and all information that could serve to identify you will be altered to ensure your anonymity.

This study is of a research nature and may offer no direct benefit to you. The published findings, however, may be useful to new mothers experiencing postpartum depression and may benefit the understanding of postpartum depression.

The Clinical Case Study does not directly require your involvement. However, it is possible that simply knowing you are the subject of the study could affect you in ways which could potentially distract you from your primary focus in the therapy. If at any time you develop concerns or questions, I will make every effort to discuss these with you.

If you decide to participate in this Clinical Case Study, you may withdraw your consent and discontinue your participation at any time and for any reason. Please note as well that I may need to terminate your being the subject of the study at any point and for any reason; I will inform you of this change, should I need to make it.
If you have any questions or concerns, you may discuss these with me, or you may contact the Clinical Case Study Coordinator at the Institute of Imaginal Studies, 47 Sixth Street, Petaluma, CA, 94952, telephone: (707) 765-1836.

I, __________________________, understand and consent to be the subject of, or to be referred to in, the Clinical Case Study written by Dolora Dossi, on the topic of Postpartum Depression. I understand private and confidential information may be discussed or disclosed in this Clinical Case Study. I have had this study explained to me by Dolora Dossi. Any questions of mine about this Clinical Case Study have been answered, and I have received a copy of this consent form. My participation in this study is entirely voluntary.

I knowingly and voluntarily give my unconditional consent for use of both my clinical case history, as well as for disclosure of all other information about me including, but not limited to, information which may be considered private or confidential. I understand that Dolora Dossi will not disclose my name or the names of any persons involved with me, in this Clinical Case Study.
I hereby unconditionally forever release Dolora Dossi and the Institute of Imaginal Studies (and all of its trustees, officers, employees, agents, faculty, successors, and assigns) from any and all claims, demands, and legal causes of action whether known or unknown, arising out of the mention, use and disclosure of my clinical case history, and all information concerning me including, but not limited to, information which may be considered private and confidential. The Institute of Imaginal Studies assumes no responsibility for any psychological injury that may result from this study.

The terms and provisions of this consent shall be binding upon my heirs, representatives, successors, and assigns. The terms and provisions of this consent shall be construed and interpreted pursuant to the laws of the State of California.

Signed this ________ day of __________, 20__, at ______________, ____________.

Day                              Month             Year                 City                             State

By:  ________________________________________________________

Client’s signature

____________________________________________________________

Print client’s name legibly and clearly on this line
Release of Information for Supervision
Consent to Treatment

I, _____________________________________________________________

Client’s name

with full understanding of my rights, freely consent to psychotherapeutic treatment with

Dolora Dossi, MA.

I understand that Dolora Dossi, MA is an unlicensed practitioner, practicing psychotherapy as a psychological intern and is functioning under the direction and supervision of her supervisor, Dr. Galyn Savage, a licensed clinical psychologist, license number CA PSY 14914.

I understand that, in supervision, my therapist will provide to this supervisor full access to my treatment records, and will discuss any relevant details of my situation with the supervisor that are necessary to assist in ensuring the best possible psychotherapeutic treatment.

_______________________   _________   _______________________   _________
Client’s Printed Name                     Date                        Therapist’s Signature             Date

_______________________   _________   _______________________   _________
Client’s Signature                     Date                        Supervisor’s Signature             Date
Dolora Dossi, MA #PSB 32085  
Galyn Savage, PhD #PSY 14914  
6 South Washington Street  
Sonora, CA  95370  
209-532-0988

Dolora Dossi, the counselor with whom you are being provided services, holds a Master’s Degree in Psychology and is certified in the practice of hypnosis. She has completed her coursework required for a doctorate in clinical psychology and 1500 pre-doctoral hours required for licensure. Dolora is a psychological intern under the supervision of Dr. Galyn Savage.

Focus of Practice  Counseling consists of face-to-face contact between the client(s) and therapist with the focus being to explore the sources of the presenting symptoms.

The intention of counseling is to care for the client(s) through exploration of symptoms and underlying causes of problems, as well as searching for alternatives to habitual responses. There is no guarantee there will be complete resolution within the treatment period, as many problems have developed over a lifetime. At times you may feel conflicted about your therapy, as the process can be uncomfortable and unsettling. There is great benefit in trusting this process and remaining engaged in the therapy.

Confidentiality  Information shared by each client is strictly confidential except when the following legal limitations apply:

1. To ensure the best treatment for you, at times your case may be discussed in supervision with Dr. Galyn Savage.

2. When a client communicates threat of bodily injury to self or others.

3. When there is reasonable suspicion of child abuse or abuse to a dependent adult has occurred or is likely to occur.

4. If you are in therapy or being tested by order of a court of law, the results of the treatment or tests ordered must be revealed to that court.
5. If a court of law issues a legitimate subpoena, it is required to provide the information specifically described in the supine.

6. If you sign a release of information to any person or agency you specify, as an adjunct to treatment, or reveal information in the public domain, or waive your privilege by filing an action against the therapist.

**Fees** Fees will be discussed at the beginning of treatment and periodically thereafter. Please discuss any circumstances that arise during the course of treatment that effect your ability to pay. This office offers a sliding scale fee adjustment.

**Telephone and Emergency Procedures** If you need to contact the therapist between appointments, please leave a telephone message at 209-532-0988. This is a confidential line. Please indicate if you have an emergency. If you need to speak to someone immediately, call the crisis hotline at Tuolumne County Behavioral Health Services at 209-588-5928 or dial 911.

**Cancellations** Your appointment time is reserved for you. In the event you are unable to keep your appointment, please notify the therapist within a 24-hour period or you may be charged for your session.

**Termination** Ideally, termination of treatment is a mutually agreed upon decision between the therapist and client. When considering the termination of treatment, please feel free to discuss this with the therapist.

**Testimonial Admissibility** If you currently are involved in or anticipate future involvement in legal proceedings, there is a possibility that your testimony might not be allowed if hypnosis has been utilized in therapy. The determination of admissibility of testimony is made case by case and varies widely.

I have read the above, understand the content, and agree to the terms and conditions.

__________________________        ___________________
Client Name                                                              Date
Focus of Practice  Although the therapist’s training includes several methods of therapeutic practice, the majority of treatment will be spent using hypnosis. Other therapeutic techniques may be employed during the course of treatment.

Definition of Terms Used in Hypnosis

**Hypnosis** is a highly active, but narrowly focused state that heightens awareness.

**Hypnosis** is not sleep or being unconscious. You are alert and awake. You have full conscious control over this process and will not reveal anything that your conscious mind would not want you to reveal. Hypnotic trance states occur naturally and daily. Hypnosis is self-induced, and you will learn how to go in and out of a hypnotic state.

**Conscious Mind** is usually identified with the ego or persona. It has access to the level of information that we are able to bring into conscious awareness.

**Unconscious Mind** is an active, significant realm. It contains our stored memories and dissociated aspects of self. Some theories claim the unconscious has two components: the personal and the collective. The personal unconscious consists of our unique biography of events and emotions. The collective unconscious contains the events and emotions inherent throughout human history. The unconscious mind contains the unlimited possibilities of our becoming all that we have potential to be.

**Part or Aspect** This term refers to parts or aspects of the self that comprise our identity. These aspects have developed over time through all of our life experiences and story.

**Higher Self** is one term to describe the essence of an unconditional, loving “witness” or “Friend” that we possess within the self. Other terms commonly used are soul, deepest
self, spirit, inner awareness, inner wisdom, or true nature. The Higher Self can be accessed in a number of ways, including prayer, meditation, and hypnosis. The Higher self does not judge and is accepting and welcoming of each aspect of your being.

The above-mentioned material has been read and explained to me. I understand that hypnosis will be utilized during treatment and enter into this therapeutic relationship freely.

___________________________________          _______________________
Client’s Printed Name                      Date

___________________________________
Client’s Signature
APPENDIX 5

HYPNOSIS SCRIPT 1

Lorna E. Cutler, PhD
Please request permission to copy

Eye Fixation With Progressive Relaxation and Counting

Relax, take a deep breath…place your feet on the floor with your legs and arms uncrossed, your hands comfortably on your lap or at your sides…Or if you are lying down, shift your body a moment and find a comfortable spot.

Now find a spot on the ceiling and fix your eyes on it…or imagine that you are looking into a candlelight…reflecting light into your eyes as you reflect upon it. If your eyes stray away, relax and bring them back to the object and continue to gaze steadily…relaxing as you continue to listen to my voice…(pause)…Any sounds you hear are a part of the external world…which will become less and less important…(pause)…as you begin to turn your attention away from the external sounds…towards your inner source of guidance…Going deeper and deeper within…away from the external sounds…as you seek this source within you…(pause)…

Discovering this source will assist you…in learning to trust…your inner guidance…(pause)…Your inner wisdom will alert you to pay attention only to those external sounds…which it wants you to attend to…(pause) Gradually all other external sounds will grow less and less important…(pause)…And no matter how deeply you go,
my voice will go with you…(pause)…Your conscious mind can, if it chooses, even tune out my voice…All that is important…is that your unconscious mind, your inner wisdom…will attend…only to those suggestions …that are beneficial to you…(pause)…as you gradually drift into trance…listening to my voice…tuning out all unnecessary sounds. (pause)…you can enjoy the relaxation…that can begin to deepen now…(pause) And whenever your eyes become heavy…or tired…and you wish to close them…simply do so…

As I count…you will learn…to use the numbers from ten to one…as suggestions to go deeper. As you focus your attention onto your feet now…allowing them to relax…(pause)…not worrying whether they relax or not…(pause)…no efforting…just allowing whatever relaxation begins…to expand and spread…10…from your feet…(pause)…to your ankles…(pause)…to your calves…(pause)…Just allowing the relaxation to deepen…(pause)…and your body to feel heavier…(pause)…relaxation spreading to your knees…(pause)…and your thighs…9…Allowing, without efforting, your muscles to relax more and more…(pause)…And you may wonder…(pause)…if your legs…or your arms…(pause)…will grow heavier first…(pause)…or lighter…(pause)…And your breathing…(pause) which has grown more rhythmical…(pause)…will begin to match your heart rate 8. As you relax, you feel more calm…and more relaxed…(pause)…and your eyes…(pause)…if they are not already closed…(pause)…can do so now…and feel so heavy…(pause)…and tired from staring (pause)…that closing them…(pause)…will be a relief…(pause)…that’s right…7…And your eyes can now relax more fully…(pause)…so that the number one…in the future…will be your cue…(pause)…to relax…and go deeper into
trance...6. Whenever your inner wisdom...(pause)...knows it is safe...and with whom it is safe...(pause)...whether with me...(pause)...or with others your inner wisdom trusts...or in trances you do on your own...(pause)...the number one...(pause) will be your cue...to relax and go deeper...5. Allowing your body to relax...(pause)...more fully...(pause)...each time you go into trance...(pause)...As you discover your internal organs function more easily...(pause)...as your pelvis relaxes...(pause)...you are grateful that your inner wisdom...(pause)...automatically regulates...(pause)...the functioning of each of your organs...4. And your conscious mind...(pause)...can enjoy recognition...that it is appreciated...for all that it does...interacting with the external world...(pause)...and can now relax...to allow the functioning...of your inner wisdom...3. As you relax more fully now...(pause)...drifting deeper into trance...(pause)...by the time I reach one...(pause)...you will be able to enjoy...(pause)...knowing that you have your own way...(pause)...to go into a deeply relaxed state...2. Relaxed states and trance states are much like gentle waves...(pause)...allowing you to drift up and down gently...(pause)...and each time your are lifted up...(pause)...you will again drift down...(pause)...each time a bit deeper...(pause)...more able to trust that you will be supported...(pause)...and protected...(pause)...by your inner wisdom. 1. Relaxing your entire body now...(pause)...relaxing into the supportive guidance of your inner wisdom...(pause)...One is now the cue for you to relax...(pause)...in future trance states...whenever it is safe for you to do so.
Lorna E. Cutler, PhD
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Utilization for Bonding During Pregnancy

Begin by taking a few deep inhalations and exhalations...allowing your breath to float out fully and slowly. As you do so you will begin to feel yourself settle more deeply into your body. Sense your body...give it more attention than you have ever done before.

From a source deep within you, realize the importance of enhancing your relationship with your body for yourself and for the growing life within you. From this inner source you also sense how important it is that your spirit together with your body need to form a loving, cooperative relationship with each other. A loving relationship between your body and spirit may be a new concept for you...and there may by some things that are in the way of this relationship at first.

Ask your Inner Source to assist you through dreams, trance states, and deep meditative states to reconcile any problems between your spirit and body. Knowing that whatever difficulties may be between them, can be resolved over time through these processes, without your conscious mind’s efforts.

Begin now to become more aware of your body. Experience your body as a plant. If you visualize, allow an image to form as well. If you are auditory, you might begin to hear a sound. If you are sensate, you may begin to sense areas of your body that are
cooler or warmer than each other, or cut off from each other, or out of balance. What is most important is that you focus all of your awareness on your body.

Whether you see or hear or sense your body, or do all three…now become the plant. Gradually expanding until you feel your roots sinking deep, deep into the earth. And now become aware that you can draw energy from the earth. Sense the Great Earth Mother’s infinite source of energy deep within her core from which you can draw. Feel her willingness in providing for you. Through her you will receive all that you need. And as you daily renew yourself through her abundance, you can more easily provide for that life beginning to grow within you.

Knowing that the Great Earth Mother is always there for you, continue resting on the Great Earth Mother’s vital warm body. As you do so, you can also sense the Great Father Sun shining upon your face. Deep penetrating warmth comforting you and assisting the abundance to flow through you from Mother Earth. Know that you are not alone in creating this new life. For they are a vital part of its creation.

This new life began through its own creative spark uniting with your egg and the father’s sperm. Even before the cells began to divide and multiply…forming a unique embryo that continues to develop….this new life brought with it its own Soul, its own personality. What is more important is for you to relax and know…that there is nothing you need do. Simply allow your own love to grow…sustained as you are from the abundance of Great Earth Mother and the deep comforting warmth of Father Sun. Simply allow yourself to open to receive their vibrations of harmony and light surrounding you…let their love hold you and the developing child within you.
And with this love, you sense greater awareness of the growing life within you. The relationship between you and this unfolding infant within you began even before you were aware of this growing life, your baby…it already had a deep Soul awareness of you. And even before you could feel it move within you…your baby heard your heartbeat…heard the gurgles of your internal blood flow and organs…heard the rhythmic breathing of your lungs. All sounds are a lullaby to this growing life.

And as you feel this unique personality…your baby…within your womb move…it can hear you sing. Your baby understands what you say to it. It knows when you are happy and when you are sad. Talk to your baby, tell it how much you want it…how you are welcoming it…how you will encourage it to be all of who it truly is…with no unrealistic expectations…so it need not carry the burden of your needs.

Share soothing, tranquil music and nursery stories with your baby often…the more you do so, the more it will recognize and respond to this music and these stories over others after it is born.

You have begun “the dance”…the “reciprocal dance” that will continue between you and your baby long after your child is born. This dance is the mirroring of each other that forms and deepens your relationship.

All that you do, all that you eat and drink, affect this growing life within you. Be conscious of this…and whatever help you need in altering your diet or intake of substances…call upon the abundant help of the Great Earth Mother, and the Father Sun…open to the love emanating through the vibrations of light all around you.

Take three minutes now…all the time you need in the infinite timelessness of the unconscious…to allow anything or any part of you that needs attention to come to your
awareness. Anything or any part of you that in any way may interfere with your love for this growing life…this unique personality…your baby…within your womb. Allow yourself to be open, without being critical of whatever may appear. Know that every part of you, everything you have ever done, or thought, or felt, is already known by the Great Earth Mother and Father Sun, and is accepted and loved. And either release any tension, or guilt, or fear that might be in the way…or integrate all parts of you into your own Soul…for every part of you is wanted and loved.

(After 3 minutes…) Know that if there are other things or parts that also need attention, your Inner Source will continue to work with them…to resolve whatever is required…and to integrate the parts necessary through your dreams and future trance states.
Utilization Accessing Guidance During Delivery

Take a deep breath in…slowly let it out. Especially aware that as you exhale you are relaxing more and sinking more deeply into your body. Your relationship with your body is more important than ever before. Allow yourself to feel in harmony, in cooperation with your body. It has all the awareness…all of the instinctual knowledge of thousands of years in the development and delivery of new life on this planet.

Go inward now to contact the Great Mother deep within you. She will guide you through the following weeks until you give birth to your child. To reach her you will go through seven doors. Know that at each door you will leave something behind…that you can retrieve later if you choose. You might want to leave anxiety or your fears behind…fear increases constriction of muscles and increases your body’s pain. Leave behind any expectations of what you think your baby should be…or look like…Leave behind any remaining grief over loss of any loved one…and loss of anything else…that might get in the way of bonding with your baby. If at any door nothing spontaneously comes to mind…ask your Higher Self to choose something that is important for you to leave that would in any way interfere with delivery or bonding of your baby.
Begin now. Go through the first door…then, leaving something behind (pause) close this first door behind you. Continue inward…until you reach the second door…there again leave something that may interfere in any way (pause)…and then close the door behind you. Down and down until you reach the third door…where you again leave something behind (pause)…and close this door after you. Going on until you reach the fourth door…where you leave something more (pause). Then closing this door…you continue down and down to the fifth door…leaving something here that is no longer needed (pause). Then close this door…going in and in until you reach the sixth door…where you again leave something of the world (pause), close the door…and continue until you reach the last door…the seventh door. At the seventh door, your Higher Self will assist you in leaving one thing more…pay close attention to whatever this is…and let it go…(pause). Then close this door and enter the innermost chamber.

Within this chamber dwells the Great Mother…go to her…she will enfold you in the radiant light of her love. She will guide you through each day and each stage of your developing baby’s growth…and through the birthing process and delivery. You will have three minutes to spend with her right now…and you can return later as often as you wish. Begin by telling her of any concerns that you have…and ask her answers to any questions you may have. Be open to receive her answers. If she does not respond immediately…or if the answers are confusing to you, ask her to bring you more understanding now…or through your dreams. (Pause 3 minutes and then continue.)

Now relax even more fully with her…curl up in her arms…or snuggle at her feet…or wherever you feel most comfortable. She will assist you to retain and add to the following suggestions in any way most beneficial to you.
As the growing life that is your baby has continued to develop within you…you
(and your baby’s dad) have grown closer and closer to this child that (the two of you)
have formed. Sense your baby’s presence within you now…tell your baby that you
welcome it. Tell your baby that you have been preparing for its entry into the world. That
you are looking forward to this event…and are preparing to be as relaxed as possible
throughout your baby’s delivery and birth.

Continuing to feel close and safe with the Great Mother…you find you are more
and more relaxed with each breath you take in and with each breath you release. Sensing
now with each breath that you are breathing in soft, golden, radiant light. Allow this light
to fill your abdomen…to expand throughout your uterus, your cervix, your birth
canal…and to surround your baby with its luminous protection. Feeling this protection
and allowing yourself to relax completely throughout every fiber of your being. Allow
this luminous light and warmth to fill your lips…your mouth…and your jaw to enhance
their complete relaxation. Allow this luminous light and warmth to fill your throat…your
diaphragm…your stomach to enhance their complete relaxation. Allow this luminous
light and warmth to continue to fill your complete abdomen and back…to fill your
uterus…to permeate deeply into every cell of your cervix…your vaginal canal and
vaginal opening…deepening their complete relaxation.

As you let go and allow this luminous golden light to relax you so completely, so
comfortably, you find that you become more in harmony with deep instinctual responses
within you that are a natural process to the baby’s birth. You sense a connection to all the
mothers that have ever given birth before you. You sense their presence within you…and
know that you draw from their wisdom and love. They assist you through your
unconscious mind’s ability to spontaneously relax your entire oral, digestive, reproductive tracts. They help you to realize that the looser your mouth and lips can be…the looser your vaginal canal and vaginal lips will be. Through them and the Great Mother’s assistance, you discover that you find a rhythm of breathing that is best for you…drawing energy in with the luminous golden light on the inhale…and allowing the energy and light to move through your body and around your baby in the most productive way to aid in the process of birth as you exhale. Allowing yourself to trust your inner responses and the guidance of the Great Mother. Trusting your inner knowing over those various and sometimes contradictory things that you were told or read about. Sensing how the entire process becomes more and more spontaneous and automatic for you the more you trust.

As the rushes of energy grow stronger in your pelvis…you will know that you are gradually allowing the opening of your cervix to dilate to allow your baby to move through. You will be aware that the sensations you feel are sensual streamings of energy. The stronger the rushes…the more sensual streaming you will feel…allow this…it is normal and natural…and provides you with awareness of pleasure…as well as pressure. And as the rushes become stronger…you will allow the soft, golden, radiant light to stream throughout your pelvis…penetrating deep into your pelvic bones and your cervix. You will feel the streamings of energy and light…and a deepening numbness to become more and more complete. Numbness spreading along with the streaming light…from your ribs radiating throughout your back…and then downward. Spreading and radiating deeply throughout your abdomen…permeating deep through every cell of your uterus and cervix…throughout your vaginal canal. More and more numbness,…more and more
streaming…and you are only aware of movement, pressure, and pleasure as your baby moves downward towards your birth canal.

You are confident and calm…you know that as the rushes become more intense…you will become more and more aware of the streaming energy and light. Your awareness will be on the streaming and the light…even as the numbness continues to deepen…permeating every cell…you are focused on the light. You know that it is beneficial to stay focused on the light filling you and surrounding your baby…and that you can do so by keeping your eyes open if you wish and in deep connection with the person with whom you feel the most bonded…the most love.

You know that by cuddling and kissing each other that the dilation of your cervix flows most easily…you do so readily and with enthusiasm…and as you do so your lips, your mouth, your throat, your diaphragm, your stomach, your cervix, your vaginal canal and vaginal lips become looser and more relaxed. More able to open and expand effortlessly. You know that by allowing yourself to make deep harmonious sounds along with the streamings and movement of your baby, your cervix will increasingly open. Allowing yourself to respond to the guidance and wisdom of the Great Earth Mother and all the mothers who have given birth before you. You feel their energy strengthen you…and it allows you to stay focused…and fully in harmony with your baby’s progress.

You also know that your unconscious mind is prepared to spontaneously and automatically develop numbness in any part of your body as it is needed through the development of heat or cold. The development of cold will allow immediate reduction of the burn sensations commonly associated with the final stages of delivery. Cold sensations in these areas will enhance your ability to stay focused on feeling the
streamings of energy and the passage of your baby through the birth canal without unnecessary discomfort. The more pressure the more numbness there will be…but you will not have to be aware of them for them to occur. Each time pressure occurs the numbness and cold sensations will maintain for longer intervals…the longer and harder the pressure, the longer and more fully will you experience the streaming. Streaming and numbness will occur more and more automatically.

You probably will want only minimal medication or none at all, since you are so able to trust in your inner guidance…and so deeply able to relax throughout your mind and body. Should you however at any time choose to reduce even the pressure from your awareness by requesting medication, do not feel guilty about asking for whatever you need. If you need anything for any reason…allow yourself to receive whatever it is…whatever you choose that will enable you to provide the happiest experience for yourself and your baby…is what is most important.

What is most important is that soon you will see your baby. You will see your baby’s eyes. You will look deep into your baby’s eyes and experience the love flowing from beyond your baby. Love transcending your baby…flowing through your baby’s heart, through your baby’s eyes into your eyes…and then deep into your heart…transcending you. Love will return through you, transcending you, through your heart, through your eyes into your baby’s eyes, into your baby’s heart, transcending both of you. Bonding both of you forever in such a deep way that you will both know that your love transcends this lifetime…transcends both of you.

Take another three minutes now to allow these experiences to go deep into all levels of your unconscious mind. Spend time with the Great Mother and highest
vibrations of all the mothers before you. Feel their strength and experience flow through you and strengthen you. Knowing that at all levels of your mind, these awarenesses and suggestions are spontaneously available to you whenever you need them. Then when you are ready…begin to bring yourself out of trance…knowing that you can return to spend time with them whenever you choose.
APPENDIX 8

HYPNOSIS SCRIPT 4

Lorna E. Cutler, PhD
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Pain Control in Preparation for Childbirth

Close your eyes, inhale deeply…and then allow your breath to release slowly and fully. As you exhale, begin to associate exhalation with relaxation…so that each time you exhale, you give yourself the suggestion to relax more deeply. As you continue to inhale and exhale deeply and slowly…you will sense your body begin to feel heavier, your heart rate begin to slow down, and a sense of deepening relaxation spread throughout your body. Allow each exhalation to be your cue or anchor that activates your response to relax your body and mind and to drift more and more inward. Turning inward now to ask your Inner Source to assist you in pairing deep, slow exhalation and relaxation with a sense of wellbeing and healing. From this moment on…the anchor that is the cue to which your Inner Source will respond in assisting you to reach levels of wellbeing and healing beyond the functions or capacities of your conscious mind…will be slow, full exhalation and deep relaxation.

All external sounds from the outer world simply take you deeper and deeper inward…Even the most intrusive of sounds simply urges you to go deeper…towards a restful, relaxed inner state. As you drift deeper…your Higher Self will focus on each suggestion…while you allow all other thoughts…all other feelings…to fade far, far away
into the distance. While your Higher Self selects all suggestions useful to you to become indelibly, permanently etched into the many levels of your unconscious mind…available to you whenever you need them.

Continuing to drift more deeply inward…settling into the quietest, most tranquil space deep within. As if in a warm cocoon within which you can breathe easily and without concern. As if floating on the bottom of a deep, deep lake in a bubble of fresh air…while far above…on the surface, there is a wild and noisy storm. No matter what occurs in the external storm, it cannot touch you as you rest safely deep within. As you continue to settle now into a pleasant state of detached comfort, letting this sense of safety and comfort permeate every cell of your body, penetrate every fiber of your being, so that everything you do is done in a calm, relaxed, comfortable, and serene fashion.

Ask your Inner Source now to provide a special Guardian of Wellbeing that will be available to you every moment whenever you move into this state. A Guardian who will spontaneously and automatically respond to all cues and activate all anchors established to facilitate your healing and your wellbeing. Ask your Higher Self if you can become aware of your Guardian of Wellbeing…and wait for a response. You may simply receive a response through an image or you may sense your Guardian. If you do, inquire of your Guardian’s name…(pause)…If you do not receive a clear response, do not be concerned…your own Higher Self will then be your Guardian of Wellbeing and will facilitate all healing and control of pain.

The following suggestions will be the ones that your Inner Source and Guardian of Wellbeing will utilize to facilitate the most positive outcome possible for the upcoming delivery of your baby. As the date for delivery approaches, you will be able to
relax and sleep soundly each night. You will feel relaxed and comfortable…calm, confident, and secure in every way on the day that labor begins. Unless given by your primary caregivers or your Inner Source…all warnings or cautions not founded on fact will be ignored. All levels of your mind will completely reject and ignore any negative, harmful or detrimental thoughts, feelings, ideas, or emotions expressed in your presence…as you prepare for the delivery of your baby.

All obsessive, worrisome, unnecessary thoughts will be resolved through your dreams…series of dreams if needed…so that as the day approaches, you will be calm, centered, and full of confidence. Ensuring that as the time of the delivery of your baby approaches, you will feel safe in every way.

When the actual time of your labor begins, you will experience everything with a deep calm…detached comfort. Deeply confident that through your Inner Source and your Guardian’s guidance…that your body and mind will respond in all of the ways most advantageous to you and your baby’s wellbeing.

You will respond to all positive messages and completely reject and ignore all negative communication except that which is directed toward you by your primary caregivers or your Inner Source. All other negative, harmful, or unpleasant thoughts, feelings, ideas, or emotions expressed in your presence, before, during, and after delivery will be completely ignored.

When labor begins, all of the muscles in your body will flow as effortlessly as possible in the normal process of giving birth to your baby. Your body’s muscles will begin to move in waves…much as ocean waves gently move to a crest, curl, then relax and flow onto the sand. Your Inner Source and Guardian will assist your body and mind
in this natural process…will facilitate each “wave” to move through to completion in bringing about the release of muscular tension and relaxation…without your undue effort. This normal undulating rhythm of movement will gradually and safely urge your baby forth into the world. And as the process continues, your Inner Source and Guardian of Wellbeing will activate a spreading sense of numbness in the areas of your body where there is most stress. The more intense these “waves” or rushes become…the more numbness will develop throughout your abdomen and birth canal, while in no way interfering with the process of birth itself. You and your baby will be full participants without experiencing undue stress.

Your Inner Source and Guardian will activate all cues and anchors to diminish any unnecessary tension in your body…through the relaxation and softening of all unnecessarily tense muscles if they begin to tighten…Your Guardian of Wellbeing will automatically assist all muscles in your body to remain comfortable, resilient, and flexible. They will ensure that your breathing stays calm, deep, and full…your heart beat calm, strong, and regular…throughout your delivery. Any anesthetic you receive will be administered carefully and safely and the delivery performed with competence and skill.

After delivery your Inner Source and Guardian of Wellbeing will facilitate your body and mind to relax in order to easily and comfortably urinate and have bowel movements at the proper time…without nausea or gas. Any sensations you feel are those of the healing process setting everything right…so you need not mind them. The delivery area will remain soft, relaxed and comfortable. Your Inner Source and Guardian will facilitate your body to bring sufficient blood to these areas to supply them with the materials needed for healing…just enough…so that none spills over. The entire healing
process will come to a natural, normal, healthy conclusion smoothly, safely, and rapidly. You will be up and around soon and eager to participate in all of your normal activities.

Ask your Inner Source and Guardian of Wellbeing to assist you with the pain-control cues and anchors that will bring about the facilitation of internally-induced anesthetics. You and your Guardians will be able to use these cues and anchors spontaneously whenever they are needed for the rest of your life…without your conscious mind needing to remember them.

So begin now to sense or visualize a row of lights in your inner mind…with a switch underneath each light. There may be six or more lights and switches…Each switch may have a specific vibration, or sound, or a particular color, or shape, or size. Vibrations associated with these switches often range from the lowest to the highest vibrations that can be felt through your body. The specific vibration, sound, color, shape, and size of each switch indicates their control over specific areas of your body and mind. During delivery when any of these switches change in vibration, in sound, in shape, in color, or flash, or pulse, this is the cue and anchor signals used to alert you and your Guardians to activate these particular switches.

(pause…ask if they sense, feel, hear, or see the switches right now. If no, simply state “when you need them, your Higher Self will provide them…”)

As you experience by sensing, feeling, hearing, or seeing these switches and lights in your mind, be aware that each of these switches either dims your awareness of specific areas of your body…or turns your awareness “off” or “on.” By activating any of these switches, you will be able to diminish or temporarily turn “off” or “on” your
awareness of sensation in these areas of your body. You will have control of the degree of awareness you have anywhere in your body.

You can create numbness wherever you choose…to any degree you choose. Begin to practice now…practice by activating specific switches connected to different parts of your body…one at a time…so that you know you have control. You can choose to connect these switches to parts of your body any way you wish…or change them in the future whenever there is a need. Or you can ask your Inner Source and Guardian to connect them now, and to later reconnect them in the best ways possible for you to sense minimal discomfort…or no discomfort at all.

Now dim or turn off any switch…any switch you choose. Be confident that these changes will occur. (Pause…ask them to turn down or off one of the switches…) Notice sensations subtly begin to diminish…decreasing until they are out of your awareness. If you choose to turn sensations off entirely…you will sense only pressure in those areas of your body. Regulate the switches until you have the degree of numbness that you find advantageous to your comfort. Later, the sensation of numbness will slowly fade away while allowing a return to normal sensation. Even when the numbness is gone, you will have increased comfort and muscle relaxation…And, any time you wish, you can reactivate one or several of the switches again whenever you feel the need.

Remember that during and after your delivery, when you notice specific changes in vibration, sound, color, size, flashing of lights or pulsation…these are the cues and anchors attracting attention to the specific areas that need your attention. Activate those switches directly by turning them off or dimming them…or by calling upon your Inner Source and Guardian if at any time you are unable to focus sufficiently for any
reason…should you need help, your Inner Source and Guardian will activate these switches automatically for you. But for now, if you want to practice turning off any of the switches again…feel free to do so. (Pause and ask if they wish to do so.)

Now that you and your Inner Source and Guardian are working together to regulate your awareness and comfort…you can relax even more completely. It is a fact that it is absolutely impossible to feel any kind of discomfort when your body and mind are deeply and profoundly relaxed…completely flaccid and limp. So now, take a deep breath and slowly let your full breath out and feel every muscle in your body relax inside and out, and go as limp and floppy as an old rag doll. Every time you exhale it will be the cue and anchor to your Inner Source and Guardian to facilitate deep relaxation in your mind and body. Now, as you continue to drift calmly, deeply relaxed in mind and body…you realize that all of these suggestions are now available to your Inner Source permanently…and are automatically available and completely effective whenever you need them for the rest of your life.
APPENDIX 9

HYPNOSIS SCRIPT 5

Lorna E. Cutler, PhD
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Orchestrating the Brain

Turn your attention to the inside of your skull…to the space where your brain is.
Let your eyes look there. Look to the left side, notice the size of your left hemisphere, the cerebral cortex, notice all of the convolutions, how luminous it is. Now look to the right side…notice all of the convolutions and ridges and valleys. You have two hemispheres…really two brains…in the cerebral cortex. Become familiar with the marvelous potential…of these brains…as a part of your mind. Working together…to bring about positive changes…in your life…inwardly and outwardly…always in accord with your deepest self.

Now identify the place where the two hemispheres come together…the bridge that connects them, the corpus collosum. Be aware of the importance of this bridge…the importance of being able to cross over from one hemisphere to the other and back again. Mentally travel across that bridge right now…imagining the information in your two brains moving back and forth. Open any closed doors. Ask your Higher Self to unblock any passageways that are blocked.

Now imagine that you can walk through the labyrinthine convolutions of your own brain. Become real small, and travel through the twisting, turning crevices, the great
pink walls of living brain tissue. Living brain tissue rising high on either side of you. As you breathe, feel your brain breathe. With each breath allow your brain to expand and contract, expand and contract.

Maintain your attention there in your brain. Remember that your brain produces various kinds of wave patterns. Your Inner Source, working with your Mind knows how to orchestrate your brain so that it produces a preponderance of the various wave patterns. Suggest right now that your Inner Source activate your brain so that it will begin to produce the long amplitude waves of alpha. Alpha waves are associated with diffused, serene states and with meditation states. Beginning now to experience the long, slow, amplitude waves of alpha. Peaceful, calm, meditative, prayerful waves of alpha. Long, meditative alpha waves. With your eyes open or closed, your mind producing the long, amplitude waves of alpha. Your Inner Source can spontaneously produce alpha waves any time it chooses…any time it may benefit you to feel calm, tranquil, meditative. All your Inner Source has to do…is to orchestrate your brain…to produce the long, amplitude waves of alpha.

And now it is even easier…to begin to produce the slower waves of theta. Theta waves are even slower waves than alpha. Allowing your Inner Source to begin now…to produce theta waves…Long…slow…waves of theta. Theta waves…produce…creative reverie. Anytime you wish…to be creative…your mind…will begin…to produce…the slow…long…amplitudes…of theta. Creativity…in your work…in solving problems…in play. Creativity…of forming new alternatives…new ideas. The creative waves…of theta. Long…slow…waves of theta…creative reverie. And no matter how deeply you drift with these slow waves of theta, my voice will go with you and your Higher Self will be
completely responsive…to any of these suggestions that are useful…now, or any time in the future.

And as your mind goes right on producing theta waves…I will remind you that…for each of us as children, we developed ways of responding to the situations around us…by developing habits. Some of the old habits or patterns of responding…were…due…to an early need…to protect oneself. Many of the old ways now can be modified to include new ways of responding. Ways that will allow your Inner Source to creatively adapt to present situations instead of old patterns of automatic response. Some of the old ways are still useful, and will be retained…while others you have outgrown. You can develop new ways of responding once the old patterns are replaced by new pathways. Your Inner Source can assist you in becoming aware of old defenses that were important at the time they originated, that have now become habitual, that you no longer need for survival. In fact…they may be interfering with your ability to develop all of your potential. Allow your Inner Source to begin to assist you by developing new patterns. Providing you with options that will run parallel with the old ways. So that there are now choices. Choices from which your Inner Source and every part of you can use to develop new ways of responding. Your Inner Source can work with every part of you, to recognize that there is now access to the cooperative participation of all within you. There are now available all of the experiences of survival from which all parts can draw to create even more ways of responding.

And as you continue to experience the **theta waves**, allow these suggestions to go deep…to allow your Inner Source to continue to work to provide you with new choices. All suggestions permanently accessible…automatically…from this moment on…in
however way useful. Whenever any part of you or your Inner Source recognizes that an old habit or pattern has begun to interfere with a healthier, more open…and more protective…new pattern, your Higher Self can activate your brain to begin to create theta waves…and create new ways to reach your full potential.

From the long slow waves of theta…one can move easily…comfortably…to the slowest, longest waves of all…delta waves. Slow…sleepy…drowsy…waves…of delta. Ask your Inner Source to now begin to produce slow…sleepy…waves…of delta. Delta waves…drowsy…waves…of delta. And no matter how deeply you go…no matter how sleepy you become…even in deep sleep my voice will go with you. Delta waves…sleepy …drowsy…waves. The delicious feeling of drifting off…to sleep…and as you do…you will drift deeply…and safely…through all of the normal stages of sleep…the stages of deep sleep…and REM sleep…alternating normally throughout the sleep period. Pleasant dreams…processing your day comfortably and completely…working on problems…resolving them…all in your dreams. As you go right on producing delta waves…long…slow…slow…waves of delta. So that when you awaken…at the appropriate time…completely relaxed and refreshed…not yet…when it’s time…you will be aware of the wondrous experiences you have begun to explore…through your own mind.
APPENDIX 10

THE EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

Instructions for users:

1. The mother is asked to underline the response which comes closest to how she has been feeling in the previous seven days.

2. All ten items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others.

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

5. The EPDS may be used at six to eight weeks to screen postnatal women. The child health clinic, postnatal check-up or a home visit may provide suitable opportunities for its completion.

Name: _________________________________________

Address: _______________________________________

Baby’s Age: ________

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

1. I have been able to laugh and see the funny side of things.

   As much as I always could
   Not quite so much now
   Definitely not so much now
   Not at all
2. I have looked forward with enjoyment to things.

   As much as I ever did
   Rather less than I used to
   Definitely less than I used to
   Hardly at all

3. * I have blamed myself unnecessarily when things went wrong.

   Yes, most of the time
   Yes, some of the time
   Not very often
   No, never

4. I have been anxious or worried for no good reason.

   No, not at all
   Hardly ever
   Yes, sometimes
   Yes, very often

5. * I have felt scared or panicky for not very good reason.

   Yes, quite a lot
   Yes, sometimes
   No, not much
   No, not at all

6. * Things have been getting on top of me.

   Yes, most of the time I haven’t been able to cope at all
   Yes, sometimes I haven’t been coping as well as usual
   No, most of the time I have coped quite well
   No, I have been coping as well as ever

7. * I have been so unhappy that I have had difficulty sleeping.

   Yes, most of the time
   Yes, sometimes
   Not very often
   No, not at all
8. * I have felt sad or miserable.

   Yes, most of the time
   Yes, quite often
   Not very often
   No, not at all

9. * I have been so unhappy that I have been crying.

   Yes, most of the time
   Yes, quite often
   Only occasionally
   No, never

10. * The thought of harming myself has occurred to me.

    Yes, quite often
    Sometimes
    Hardly ever
    Never
NOTES

Chapter 1

1. Abbe Smith, “Searchers Find Missing Woman’s Body in Creek,” The Union Democrat newspaper (Sonora, CA, November 6, 2006).


10. Kathryn A. Leopold and Lauren B. Zoschnick, “Postpartum Depression,” [journal on-line] The Female Patient (accessed 2 July 2007) available from http://www.obgyn.net/femalepatient/default.asp?page=Leopold; Internet. Here the authors speak to the connection made between childbirth and psychiatric illness as far back as 460 BC when Hippocrates described a puerperal fever. Their point is that even though the awareness of postpartum psychiatric illness dates back centuries, our understanding of this disorder remains incomplete.

11. Ibid., 1.

12. Ibid., 4.


8. Ibid.


22. Ibid.

23. Ibid, 3.


27. Ibid.


30. Elizabeth Strong, personal communication to Dolora Dossi (Sonora, CA, May 2005).


Chapter 2


2. Valerie Thurtle, “Post-Natal Depression: The Relevance of Sociological Approaches,” *Journal of Advanced Nursing*, 22 (1995): 416-424. The term puerperal is used in medicine to mean pertaining to the process of childbirth; lochial discharge is a specific medical term to distinguish a specific vaginal discharge related to the final stages of pregnancy.


7. Ibid.

8. Ibid.

9. Ibid.

10. Ibid.

11. Ibid.

12. Ibid.

13. Ibid.

14. Ibid.

15. Ibid., 8.

16. Ibid.

17. Ibid.


21. Ibid.

22. Hamilton outlines, in the book Postpartum Psychiatric Illness, 16, the three categories that were conceptualized at this time: 1) dementia praecox—later known as schizophrenia; 2) Manic and depressive syndromes; 3) toxic-exhaustive psychoses or organic psychoses. Typical patterns and symptoms were assigned to each grouping and psychiatric illnesses were placed within this category accordingly. Postpartum psychiatric illnesses were tricky because a woman could present with symptoms belonging to one group and later develop symptoms from another. A woman could even exhibit symptoms from all three categories at the same time. Wanting to preserve the integrity of psychiatry as a medical science, Hamilton notes the classifiers were eager to drop the term postpartum and record only those presenting symptoms that fit into the nomenclature.


26. Ibid.

27. Ibid.

28. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4th ed., 387. A specifier, according to the DSM, provides “an opportunity to define a more homogenous subgrouping of individuals with the disorder who share certain features.”

29. Hamilton, Postpartum Psychiatric Illness, xiii. It is important to note Ian Brockington’s pivotal work, Motherhood and Mental Health, published in 1996. This 600-plus-page book is a tremendous resource for not only postpartum illnesses, but for many other subjects related to motherhood, such as fertility, pregnancy, birth, and child-rearing.

30. Ibid.

31. Ibid., xiv.

32. Ibid.

33. Ibid., xiii.

34. Michael W. O’Hara, Postpartum Depression: Causes and Consequences (New York: Springer-Verlag, 1995), 1. O’Hara is not alone in dividing postpartum psychiatric illnesses into three classifications. Several other authorities on the subject of postpartum depression share this view, notably Kathleen Kendall-Tackett in her book Postpartum Depression: A Comprehensive Approach for Nurses.


44. Ibid.


46. Ibid.


49. Andrea Yates and Susan Smith are examples of women who were most likely suffering from a postpartum psychosis during the time they committed their crimes. Both women killed their infants and their other children. Their stories and subsequent trials were much publicized. Yates, whose murder conviction was overturned, remains in a prison psychiatric ward (Associated Press, “Yates’s Attorneys Won’t Seek Release,” CNN.com); Smith received a sentence of life in prison (Cable News Network, Inc., “Year in Review,” CNN.com).


52. Nonacs, “Postpartum Depression.”

53. Ibid.

54. Ibid.


59. Ibid.

60. Ibid.

61. Ibid.


63. Ibid.


66. Dunnewold and Sanford, Postpartum Survival Guide, 59 and Bennett and Indman, Beyond the Blues, 40.


69. Ibid., 8.

70. Ibid.


73. Ibid., 12.

74. Ibid., 13.
75. Ibid.

76. Ibid.


80. Ibid., 7.

81. Ibid.

82. This idea is expressed in numerous publications, including Rosenberg, Greening and Windell’s *Conquering Postpartum Depression*. See especially Chapter 3 “What Is My Risk for Postpartum Depression?,” 29-31. See also Dunnewold and Sanford’s *Postpartum Survival Guide*, Chapter 3 “Am I At Risk?,” 56-64.


86. Kendall-Tackett and Kantor, 19.

87. Ibid.


89. Kendall-Tackett and Kantor, 23.

90. Ibid.


92. Ibid.

93. Ibid.

94. Campbell, 95-98.

95. Campbell, 95.


102. Campbell, 97-8.

103. Leopold and Zoschnick, 5.


105. Ibid.


107. Ibid.


111. Ibid.


113. Ibid.

114. Ibid.

115. Ibid.

116. Ibid.

117. Kruckman and Smith, 14.

118. Ibid.

119. Ibid.

120. Ibid.


125. Filer, 159.


127. Venis and McCloskey, 100.

128. Kruckman and Smith, 14.


131. Ibid.


135. Bennett, *Postpartum Depression For Dummies*, 50.

136. Ibid.

137. Ibid., 51.

138. Ibid., 54.

139. Ibid.


141. Ibid., 37.

142. Bennett, 47.
Venis and McCloskey, 206. The authors discuss current research being sponsored by The National Institute of Mental Health (NIMH), namely studies interested in prevention of and treatment for postpartum depression.


158. Ibid.


160. Ibid.

161. Ibid.


164. Ibid.

165. Ibid.
166. Ibid.
167. Ibid.
168. Ibid.
169. See, for example, Rosenberg, Greening and Windell, *Conquering Postpartum Depression*, 119-20 or Bennett, *Postpartum Depression for Dummies*, 11.
170. Rosenberg, Greening and Windell, 120.
171. Ibid.
173. Ibid.
175. Ibid., 27-9.
176. Ibid.
177. Rosenberg, Greening and Windell, 121.
178. Ibid., 120-1.
179. Ibid., 121.
181. Ibid.
182. Ibid.
183. Ibid.
185. Ibid., 194.
186. Ibid., 193.
187. Ibid.
188. Ibid.
189. Ibid., 194.
190. Ibid.
191. Ibid.
192. Ibid.
193. Ibid.
194. Ibid.
196. Ibid.
197. Ibid., 28-9.
198. Ibid., 29.


201. Ibid.
202. Ibid.
203. Ibid.
204. Ibid.
205. Ibid.
206. Ibid.


208. Ibid.
209. Ibid.


212. Ibid.
213. Ibid.
214. Ibid.

216. Ibid.

217. Ibid.

218. Ibid.

219. Ibid.

220. Ibid.


222. Ibid.

223. Ibid.

224. Ibid.


226. Ibid.

227. Ibid. It is important to note here the other therapies the research cited to be beneficial in treating postpartum depression: group therapy (CBT, educational, and transactional analysis); interpersonal psychotherapy; psychodynamic; and educational counseling.

228. Again, see Cooper *et al*, Appleby *et al*, Misri *et al*, and Milgrom *et al*.

229. See Cooper *et al* and Misri *et al*.

230. Kleiman and Raskin, *This Isn’t What I Expected* and Rosenberg, Greening and Windell, *Conquering Postpartum Depression*.

231. Kleiman and Raskin, 137.


234. Ibid.

235. Ibid.

236. Rosenberg, Greening and Windell, 120.


238. Ibid.

239. Ibid.
Ibid., 10.

See Rosenberg et al, *Conquering Postpartum Depression*, 120; also Kleiman and Raskin, *This Isn't What I Expected*, 137.

Ibid. Also note Bennett, *Postpartum Depression for Dummies*, 117. The author discusses the importance of a short-term, structured therapy focusing on the here-and-now issues of the client.

Bennett, *Postpartum Depression for Dummies*, 116-117.

Ibid.

Kleiman and Raskin, *This Isn't What I Expected*, 137.

Ibid., 140.

Rosenberg, Greening and Windell, *Conquering Postpartum Depression*, 121.

Some of the individual research studies will be highlighted and referenced as they are discussed in this section.

Cooper, Murray, Wilson and Romaniuk, “Controlled Trial of the Short- and Long-Term Effect of Psychological Treatment of Postpartum Depression.”

Ibid.

Ibid.

Ibid. It is important to note that non-directive counseling and cognitive behavioral therapy also had a significant impact on maternal mood at the four-and-a-half month phase of treatment.

Ibid.

Ibid. The conclusion of Cooper et al’s study was that psychodynamic therapy for PPD improved maternal mood in the short term, but appeared to have no benefit beyond a woman’s spontaneous remission of PPD in the long term.

Cooper and Murray, “Author’s Reply,” 461-2.


Ibid.

Ibid.

Ibid.

Ibid.


262. Ibid.
263. Ibid.
264. Ibid.
266. Ibid.
275. Karen, *Becoming Attached*, 91. Karen continues by noting the significance of Freud’s daughter Anna’s work in furthering the concept of the importance of the mother on a child’s psychological development. Karen states that Anna Freud saw the mother as “…the person whose relationship with the child forms the prototype for future relationships; an auxiliary ego, who helps the child cope with difficult situations; and the social legislator who inducts the child into the world of rules and standards….”
276. Judith Warner, *Perfect Madness: Motherhood in the Age of Anxiety* (New York: Riverhead Books, 2005), 73. Warner cites psychoanalyst Helene Deutsch and her notion of ideal motherhood, as well as Edward Strecker’s account of the doting mother whose emotional attachment to her children was producing a nation of mama’s boys. She goes on to mention psychoanalysts Rene Spitz and D. W. Winnicott; the former, alleging that a mother’s personality is a “psychological toxin,” and the latter being responsible for the notion of the “good-enough mother”—a mother at one with her infant. Warner’s case is that the ideas set forth in the 1940s, 50s and 60s put too much pressure and prevalence on the mother as the end-all determinant of how a child turns out in adulthood.
280. Ibid., 91-92.

281. Ibid., 92.


283. Ibid.


285. Ibid., 115.


287. Ibid., 93.

288. Ibid.

289. Ibid.


291. Ibid., 114.

292. Ibid.

293. Ibid.


296. Ibid.


300. Karen, *Becoming Attached*, 103-106 and Warner, *Perfect Madness*, 92-93. Karen attempts to paraphrase Bowlby’s intentions by stating “…[the mother] must never forget that the job cannot be skimped without lasting damage to the child” and quotes him directly as saying, “One cannot ever really give back to the child the love and attention he needed and did not receive when he was small.” Warner speaks to the disservice Bowlby’s attachment theory and the legacy thereof has conferred upon mothers when she writes, “…the potential to do damage, to cause one’s child unbearable and lifelong pain, became part of the very definition of motherhood… The fear of causing children to experience the feelings of abandonment… or any other form of emotional deprivation became the ghostly epidemic haunting motherhood in the post-Bowlby years.”


302. Ibid., 95.
303. Ibid., 99.

304. Ibid.


306. Ibid.

307. De Kanter supplies a list of seven central points comprising what women feel “real mothers” ought to do. Her list includes: “All women want to be mothers; a biological mother always loves her biological children; the biological mother is the best caretaker for her children; mothers know intuitively what their children need; infants need the constant presence of their mothers; love, marriage, and motherhood are naturally linked; motherhood within the heterosexual structure of marriage is the best way to raise children,” 141. Bennett, in Postpartum Depression for Dummies outlines ten common fantasies about motherhood, which include “This Should Be the Happiest Time My Life; I Should Be Able to Do Everything Myself; I Shouldn’t Need Breaks; My Life Won’t Change That Much; My Needs Shouldn’t Matter; Bonding Happens Immediately at Birth; Breastfeeding Is Natural, So It Should Come Easily; Mothering Is Instinctual; I Should Feel Satisfied Being a Stay-at-Home Mom; and My Baby Will Be My Companion,” 331-336. In Postpartum Survival Guide, Dunnewold and Sanford look at the ways motherhood is romanticized in our culture, 258-60. Finally, Kleiman and Raskin, in This Isn’t What I Expected, devote a chapter of their book to the fantasies and expectations of motherhood, 196-212.

308. Ibid.

309. Ibid. Note that these authors are speaking for western, industrialized cultures, and more specifically, American culture. Although some of the authors lecture outside of the United States on occasion, their work predominately entails educating and helping women from the United States.


311. Ibid., 6.

312. Ibid., 4.


314. Ibid.


316. In Kendall-Tackett and Kantor’s, Postpartum Depression: A Comprehensive Approach For Nurses, 64. Tackett and Kantor cite several studies that link a woman’s expectations on herself as a new mother with the outcome of postpartum depression. See Whiffen, 1988; Cutrona and Troutman, 1986; and Campbell, Cohn, Flanagan, Popper, and Myers, 1992.

Ibid. Kruckman cites several other studies that have supported the hypothesis that postpartum depression is relatively unknown in non-western cultures characterized by large, supportive kin groups. Among the research is, Harkness (1987); Laderman (1987); Macintyre (1992); Tseng et al. (1994); and Stewart et al. (1996).

Ibid. Kruckman elaborates that providing structure, social recognition, and support through rituals helps new mothers by: “1) postpartum rituals are a set of evocative devices for rousing, channeling, and domesticking powerful cultural emotions such as fear linked to birth, 2) postpartum rituals function to enhance and solidify social roles such as “motherhood,” 3) rituals serve as a learning process. Through ritual, the responsibilities, attitudes, and techniques of motherhood are revealed to the younger members of the group, and, 4) rituals are also a form of support. Rituals marshal regular, reliable, and predictable physical support from family members and the community, crucial to the new mother during birth and the postpartum.”

Ibid. Kruckman references several studies researching the influence of native customs on new mothers, including research in Nigeria, Southeast Asia, Nepal, China, Kenya, Spain, Guatemala, the Caribbean, the Philippines, Mexico, and Punjab and Muslim cultures. Kruckman maintains that “…a review of the ethnographic literature on childbirth show remarkably little evidence for postpartum depressions in non-Western settings.” 139.

It goes beyond the scope of this study to elaborate on the varied traditions surrounding birth and postnatal care, however Wolf, Cartwright Jones, and Davis-Floyd have written in varying detail about the birth and the postpartum period. See Wolf, Misconceptions, 7 and 217-223; and Catherine Cartwright Jones, “Traditional Postpartum Rituals of India, North Africa, and the Middle East: Seclusion, Henna, and 40 Day Homecare,” [article on-line] Kent State University, Medical Anthropology (2002, accessed 17 August 2007); available from http://www.lotusfertility.com/Postpartum_Wisdom_Rituals.html; Internet; and Robbie Davis-Floyd, Birth as an American Rite of Passage (Berkeley, CA: University of California Press, 2002). In addition to these sources, three other important books on birth practices include Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives, ed. Robbie Davis-Floyd and Carolyn F. Sargent (Berkeley, CA: University of California Press, 1997); and the groundbreaking work by Suzanne Arms, Immaculate Deception II: A Fresh Look at Childbirth (Berkeley, CA: Celestial Arts, 1994); and Tina Cassidy, Birth: The Surprising History of How We Are Born (New York: Atlantic Monthly Press, 2006).

Wolf, Misconceptions, 5-6.


Ibid.

Ibid., 139. Kruckman elaborates that birth and the postpartum period are vulnerable times for the mother and child. As such, rituals and policy have been in place for centuries to safeguard this transitional time and provide protection, rest, and seclusion for both mother and baby.

Ibid., 140-141.

Wolf, Misconceptions, 218.

Ibid., 219.

Kruckman, 143.

Kruckman, “An Anthropological View of Postpartum Depression,” 143; Wolf, Misconceptions, 220; and D. Rafael, The Tender Gift: Breastfeeding (New York: Schocken Books, 1976). Kruckman suggests that many of the rituals performed in non-western cultures provide the necessary dietary regulations, rest, seclusion, and help from husband and relatives needed by the recovering mother.

Kruckman cites several studies that conclude postpartum depressions to be rare among non-western cultures in which postpartum rituals are maintained. See “Rituals and Support: Cross-Cultural Research” in his article, “An Anthropological View of Postpartum Depression,” 139-143.

Wolf, Misconceptions, 220-222. Wolf decries, “Little in my birth experience, or in those of my hardworking women friends, was designed to support us postpartum in the intensive way that other cultures have relied upon. On the contrary, we were supposed to…produce the baby, and get on with it, nearly alone.”


Rosenberg also points out that in cultures where postpartum rituals are practiced, women do not experience postpartum depression.


Ibid.


Ibid.

Ibid. It is important to correlate Cutrona’s findings with Kruckman’s assertion that ritual provides the new mother with much needed rest, support in learning how to become a mother, and the re-emergence of the new mother in her changed status.


Ibid.

Ibid.

Ibid.

349. Ibid.

350. Ibid.

351. Ibid.

352. Wolf, Misconceptions, 221.

353. Ibid., 230.

354. Ibid., 283-287.

355. Ibid.

356. Warner, Perfect Madness, 268-274.


358. Ibid.

359. Ibid.


362. Ibid.

363. Ibid.

364. Ibid.

365. Wolf, Misconceptions, 1-10.


367. James Hillman, A Blue Fire, ed. Thomas Moore (New York: Harper Perennial, 1989), 19-20. Hillman’s complete list of words analogous to soul are: “…mind, spirit, heart, life, warmth, humanness, personality, individuality, intentionality, essence, innermost, purpose, emotion, quality, virtue, morality, sin, wisdom, death, God.” Of soul Hillman writes it is “…a perspective rather than a substance, a viewpoint toward things rather than a thing itself.”

368. Ibid., 21.

369. Ibid., 122.

371. Hillman, *Re-Visioning Psychology*, 110. Hillman says of symptoms, “But my symptoms point to my soul as my soul points to me through them.” Hillman puts a spotlight on pathology as the way into knowing the soul’s desires. He asks us to stay with the pathology in order to understand what the soul is asking of us.

372. Ibid., 57. Hillman states that psychology must offer this perspective of pathologizing as neither right nor wrong, but as necessary, with purpose and value.

373. Ibid., 88-89. Hillman describes normative identity as an ideal or statistical definition for the norm of man. He suggests that psychology must not use external standards to explain away behavior. He states that the brand of psychology that uses these standards has directed consciousness in a “…one-sided, suppressive narrowness regarding life, health, and nature.” Instead, Hillman suggests attention be drawn to a person’s pathology as a way of knowing where a person is now, not where they ought to be by some norm or standard. This practice allows the soul to have its say, to inform by its own measures.

374. Ibid. In Hillman’s view, psychology needs to address this multiplicity and be aware that soul, and therefore man, has many sources of meaning, direction, and value. Hillman suggests that the motive here is to honor all sides, to be “…flexible, embracing, tolerant, patient…” and mindful of the richness and complexity of not only psyche, but self as carrier of psyche.

375. Ibid., 74. Hillman states that serving soul “…implies letting it rule; it leads, we follow.” Regarding pathology he insists, “Before any attempt to treat, or even understand, pathologized phenomena we meet them in an act of faith, regarding them as authentic, real, and valuable as they are… They are ways of the psyche and ways of finding soul.”


377. Ibid. Omer states that the web of habits forms a shape or pattern that we run our life within. When the web gets shaken, perhaps through pathology, it wants to snap back into its familiar shape. That familiar shape or pattern, in an individual, can be thought of as one’s adaptive identity.

378. Aftab Omer, *Key Definitions* (Petaluma, CA: Institute of Imaginal Studies, November 18, 2005). The working definition for adaptive identity, as introduced by Omer, is: “In the course of coping with environmental impingement, as well as overwhelming events, the developing soul constellates self images associated with adaptive patterns of reactivity. These self-images persist as an adaptive identity.”


380. This idea is expressed by Claire James in her doctoral dissertation, “Imagining Her Womb: Exploring Women’s Connection to Their Bodies” (Ph.D. diss., Institute of Imaginal Studies, 2007), 59. In a personal communication with Omer, James reproduces Omer’s statement that “Imaginal structures are assemblies of sensory, affective, and cognitive aspects of experience constellation into images; they both mediate and constitute experience. The specifics of an imaginal structure are determined by an interaction of personal, cultural, and archetypal influences. These influences may be teased apart by attention to the stories that form personal character and myths that shape cultural life. During the individuation process, imaginal structures are transmuted into emergent and enhanced capacities as well as a transformed identity. Any enduring and substantive change in individual or group behavior requires a transmuting of imaginal structures. This transmutation depends upon an affirmative turn toward the passionate nature of soul.”

381. Omer, *Imaginal Process IV* course notes.
Omer states that much of our attention is locked up tending our adaptive identity, which creates limitations on the rest of our being. Adaptive identity is one pattern of being, but there are many other “selves” present. The concept of multiplicity is implicit in this notion.


Somé writes, “Doing a ritual once is not sufficient to awaken gifts that have lain dormant in a person for a lifetime, for it is only by inserting the self in the repeated practice of ritual that one gives these gifts the room to emerge. Until this dormancy is awakened, the person remains incomplete, unavailable, and incapable of fully blossoming.” This principle is similar to Aftab Omer’s thought that ritual practice is the structure necessary for holding the contents of the psyche, which includes the complex of imaginal structures.

Somé expounds upon the territory of ritual: “This unfamiliarity can appear frightening, but when a part of you becomes willing to proceed with a ritual, you find that the rewards is worth the momentary loss of control. You enter a space where you are allowed to feel, allowed to move, allowed to cry, allowed to feel true compassion…people…feel seen and heard.”


Hillman contends that a psychological sickness is “…an enactment of a pathologizing fantasy…” and it is psychology’s task to find the archetypal backdrop presented in myths. He ponders, “What archetypal pattern is like my present behavior and fantasy? Who am I like when I do and feel this way? “Likeness” here refers to the idea that what is concretely manifested in an individual psyche has its likeness in a cluster of archetypal resemblances where the pathologizing I am undergoing finds place, makes sense, has necessity….”
401. C. G. Jung, *The Archetypes and the Collective Unconscious* (Princeton, NJ: Princeton University Press, 1969), 4-5. Jung defines the collective unconscious as impersonal or transpersonal, common to all men, and “…the inherited possibilities of human imagination as it was from time immemorial.”


403. Ibid., 18.

404. Ibid. See Neumann’s illustration of the archetype’s development, which he refers to as Schema I.

405. Ibid.

406. Ibid., 19-22.

407. Ibid.

408. Ibid.

409. Ibid. Neumann states that the “effect of the archetype…appears…in positive and negative emotions, in fascinations and projections, and also in anxiety, in manic and depressive states, and in the feeling that the ego is being overpowered. Every mood that takes hold of the entire personality is an expression of the…effect of an archetype…”


413. Ibid.

414. Ibid.


418. Ibid., xi.


420. Ibid., xii-xiii. Gadon writes that the feminine principle or Goddess religion was “earth-centered, not heaven-centered, of this world not otherworldly, body-affirming not body-denying, holistic,
not dualistic. The goddess was immanent, within every human being, not transcendent, and humanity was viewed as part of nature, death as a part of life.”

421. Baring and Cashford, xii and Gadon, xii.

422. Gadon, 2.

423. Ibid., 23.

424. Ibid., 24.

425. Ibid.

426. Ibid.

427. Baring and Cashford, 104.

428. Ibid., 105.

429. Ibid., 40.

430. Ibid., 660.

431. Ibid.

432. Ibid.

433. Ibid., 661.

434. Ibid., 662.

435. Ibid.

436. Ibid.

437. Ibid., 663.

438. Ibid.


440. Ibid., 4.

441. Ibid., 6.

442. Ibid., 36.


445. Ibid.
446. Hillman, *Re-Visioning Psychology*, 74. Hillman defines pathologizing the myth onward as “…staying in the mess while at the same time regarding what is going on from a mythical perspective. We try to follow the soul wherever it leads, trying to learn what the imagination is doing in its madness.”

447. Ibid.

448. Ibid., xiv.

449. Hillman, *Re-Visioning Psychology*, 57. Hillman speaks in general terms about all pathology or pathologizing as a psychological necessity. He asks the reader to see pathologizing as neither right nor wrong, but as necessary and containing value and purpose. He proposes that psychology must find a place for and accept pathology, to be with and listen to it before making moves to treat, condemn, or justify it.

**Chapter 3**

1. Elizabeth Strong, Personal Communication to Dolora Dossi (Sonora, CA, September, 2005).

2. Ibid.

3. Ibid.

4. Ibid.

5. Ibid.

6. Ibid.

7. Ibid., (March 9, 2006).

8. Ibid.

9. Ibid., (May 19, 2006).

10. Ibid.

11. Ibid.

12. Ibid.

13. Ibid.

14. Ibid.

15. Ibid.

16. Ibid., (November 9, 2005).

17. Ibid.

18. Ibid.

19. Ibid.

20. Ibid.
21. Ibid.

22. Ibid.

23. Ibid.

24. Ibid.

25. Ibid.


27. Ibid., (November 16, 2005).

28. Ibid.

29. Ibid.

30. Ibid.

31. Ibid.

32. Ibid.

33. Ibid.

34. Ibid.

35. Ibid.

36. Ibid., (November 23, 2005).

37. Ibid.

38. Ibid.

39. Ibid.

40. Ibid.

41. Ibid

42. Ibid


44. Strong, (November 25, 2005).

45. Ibid.

46. Ibid.

47. Ibid.
48. Ibid.
49. Ibid.
50. Ibid.
51. Ibid.
52. Ibid.
53. Ibid.
54. Ibid.
55. Ibid.
56. Ibid.
57. Ibid.
58. Ibid.
59. Ibid.
60. Ibid.
62. Ibid.
63. Strong, (December 3, 2005).
64. Ibid.
65. Ibid.
66. Ibid.
67. Strong’s husband, (December 3, 2005).
68. Ibid.
69. Ibid.
70. Ibid.
71. Strong, (December 13, 2005).
72. Ibid.
73. Ibid.
74. Strong, (January 2006).
75. Ibid.
04. Ibid.


06. Strong, (May 22, 2006).

07. Ibid.

08. Ibid.

09. Ibid.

10. Ibid.

11. Ibid.

12. Ibid.

13. Ibid.

14. Ibid.

15. Ibid.

16. Ibid.

17. Ibid.

18. Ibid.

19. Ibid.

20. Ibid.

21. Ibid.

22. Ibid.

23. Ibid.

24. Ibid.

25. Ibid.

26. Ibid.

27. Strong, (June 6, 2006).

28. Ibid.

29. Ibid.

30. Ibid.
31. Ibid.
32. Ibid.
33. Ibid.
34. Ibid.
35. Ibid.
36. Strong, (June 10, 2006).
37. Ibid.
38. Ibid.
39. Ibid. The Landmark Forum is a self-help institution that teaches participants new skill sets. It uses highly specialized language particular to its curriculum. Programs are offered throughout the United States.
40. Ibid.
41. Ibid.
42. Ibid.
43. Ibid.
44. Ibid.
45. Ibid.
46. Ibid.
47. Ibid.
48. This is an imaginal technique used in art therapy. This way of working with client art was introduced in Suzanne Lovell’s Myth, Ritual, Story-Telling course at the Institute of Imaginal Studies, Fall 1995.
49. Strong, (June 10, 2006).
50. Ibid.
51. Ibid.
52. Ibid.
53. Ibid.
54. Cox, Holden and Sagovsky, “Detection of Postnatal Depression: Development of the 10-item Edinburgh Postnatal Depression Scale,” 782-786. The EPDS is a 10-item questionnaire to help clinicians detect the probability of a postpartum depressive illness.
55. Ibid.
156. Strong, (June 19, 2006).
157. Ibid.
158. Ibid.
159. Ibid.
160. Ibid.
161. Ibid
162. Ibid.
163. Ibid.
164. Ibid.
165. Ibid.
166. Ibid.
167. Strong, (June 24, 2006).
168. Ibid.
169. Ibid.
170. Ibid.
171. Ibid.
172. Ibid.
173. Ibid.
174. Ibid.
175. Ibid.
176. Ibid.
177. Ibid.
178. Ibid.
179. Ibid.
180. Ibid.
181. Ibid.
182. Ibid.
183. Ibid.
184. Ibid.


186. Strong, (June 24, 2006).

187. Ibid.

188. Ibid.

189. Ibid.

190. Ibid.

191. Ibid.

192. Ibid.

193. Strong, (July 3, 2006). The following two paragraphs is a retelling of Elizabeth’s recollection of the events that led her to decide to leave her husband.

194. Ibid.

195. Ibid.

196. Ibid.

197. Ibid.

198. Ibid.

199. Ibid.

200. Ibid.

201. Ibid.


203. Strong, (July 30, 2006).

204. Ibid.

205. Ibid.


207. Ibid.

208. Ibid.

209. Ibid.
Chapter 4

2. Ibid., xi.


4. Ibid., 104.

5. Ibid., 105.

6. Ibid., 40.

7. Ibid., 662.

8. Ibid.

9. Ibid.

10. Ibid., 663.


12. Ibid., 38. Jung, describing the vast and near incomprehensible nature of the archetypes, states, “…these archetypes are true and genuine symbols that cannot be exhaustively interpreted, either as signs or allegories. They are genuine symbols precisely because they are ambiguous, full of half-glimpsed meanings, and in the last resort inexhaustible… indescribable because of their wealth of reference… for what we can above all establish as the one thing consistent with their nature is their manifold meaning, their almost limitless wealth of reference….”

13. Ibid., 42. Jung states that the archetypes are pre-existent forms held within the collective unconscious, which does not develop in the individual conscience, but is inherited by all. One of the functions of the archetypes is to give form to certain contents of the psyche.


15. Ibid., 135. Jung challenges psychology to ask the question: What biological purpose do the archetypes serve? He answers this question by underscoring the importance of maintaining our relationship with the archetype, so that our link with the original, primordial, and universal experience remains unbroken.


17. Ibid.

18. Ibid., 136. Jung uses the example of the child archetype as representing something in the distant past and something that exists presently.

19. Ibid.

20. Ibid. 130-131.

21. Ibid. Jung gives an account of the importance of archetypes in his statement, “In reality we can never legitimately cut loose from our archetypal foundations unless we are prepared to pay the price of a neurosis, any more than we can rid ourselves of our body and its organs without committing suicide. If we cannot deny the archetypes or otherwise neutralize them, we are confronted, at every new stage in the differentiation of consciousness… with the task of finding a new *interpretation* appropriate to this stage, in order to connect the life of the past that still exists in us with the life of the present, which threatens to slip
away from it. If this link-up does not take place, a kind of rootless consciousness comes into being no longer oriented to the past, a consciousness which succumbs helplessly to all manner of suggestions and, in practice, is susceptible to psychic epidemics.”

22. Ibid., 128. Jung discusses how archetypes, as they manifest in neurotic or psychotic behavior and thought, give us a glimpse into the workings of the psyche. He states that archetypes are, “…self-portraits of what is going on in the unconscious, or as statements of the unconscious psyche about itself.”

23. Ibid., 129.

24. Ibid.

25. Ibid., 131.

26. Ibid., 128. Jung writes that myth is the psychic life within us, not merely a representation of some event. Myth is a culture’s living religion, without which culture and the individual falls into moral collapse.


28. C. G. Jung, *Psychology and Alchemy*, trans. R. F. C. Hull (Princeton, NJ: Princeton University Press, 1953), 25. Jung is quoted as saying, “I asked myself, ‘What is the myth you are living?’ and found that I did not know. So I took it upon myself to get to know my ‘myth,’ and regarded this as the task of tasks…I simply had to know what unconscious or preconscious myth was forming me.”

29. Hillman, *Re-Visioning Psychology*, 57. Hillman goes on to say that psychology must offer this perspective of pathologizing as neither wrong nor right, but as necessary, with purpose and value.

30. Ibid., 101.

31. Ibid., 107. Hillman states, “The soul sees by means of affliction. …Pathologizing is itself a way of seeing.” Hillman would say that what we are seeing through our pathologizing is our very experience as told through the mythical metaphors of soul.

32. Ibid., 100.

33. Ibid., 101. About pathologies, Hillman writes, “…in my disturbances there really are forces…which want something from me and intend something with me.”

34. Ibid., 102.

35. Ibid. Hillman is using this idea to suggest that normative reality—the way things are out in the real world—may not bear the capacity to house what is truly being experienced by soul through an individual. The soul is not only allowing a glimpse into the personal experience, but also into the levels of cultural and universal experiencing. Hillman proposes that pathologies are both “…facts and fantasies, both somatic and psychic, both personal and impersonal.”


38. Ibid., 88-89.

39. Ibid.

40. Ibid., 32.
41. Omer, Personal Communication with Claire James (Petaluma, CA: Institute of Imaginal Studies, March 10, 2006.)

42. Ibid.

43. James, “Imagining Her Womb,” 59.

44. Ibid.


46. Ibid.

47. Strong, Personal Communication to Dolora Dossi (Sonora, CA: November 23, 2005.)

48. Ibid.

49. Baring and Cashford, *The Myth of the Goddess*, 40. They maintain that we can find the great mother goddess within the images that mankind brings forth. They state that these images exist as testimony within the human psyche of the feminine principle with its vision of unity of life.


51. Jung, *The Archetypes and the Collective Unconscious*, 48. Jung writes, “When a situation occurs which corresponds to a given archetype, that archetype becomes activated and a compulsiveness appears, which… gains its way against all reason and will, or else produces a conflict of pathological dimensions, that is to say, a neurosis.” I am equating Jung’s idea here with the organic presentation of Elizabeth’s concerns, i.e. that they possessed a universal motif, that of the mother archetype, but also a personal component having to do with various experiences within her own biography. The activation of the archetype appeared to coincide with Elizabeth’s fall into conflicts of “pathological dimensions.”

52. Ibid., 81-82. Here, Jung provides a partial list of qualities and symbols associated with the archetype of the mother.

53. Ibid.

54. Ibid.

55. Strong, Personal Communication to Dolora Dossi (Sonora, CA: November 16, 2005).

56. Ibid.

57. Ibid. Elizabeth’s father and mother had a long-term affair before marrying and having Elizabeth. She tells the story of how her father’s ex-wife found her father’s journal detailing his affair with Elizabeth’s mother. The former wife made copies of the more lurid passages and passed them out as people were walking out of the church that they all attended. As Elizabeth mentioned, the former wife’s action was not an example of the powerless mother. Whereas, her own mother’s shame drove her into deeper levels of submission, mirroring her own mother’s shame over her husband’s sexual infidelity and abuse of their children.

58. Ibid. Elizabeth mentioned that her mother told her that she “doesn’t do anger because when adults get angry, they beat and hurt their children.” Elizabeth noted that she always felt that her mother was angry although she never expressed this emotion after becoming out of control once with Elizabeth when she was four, breaking a wooden spoon over her resulting in multiple contusions.
Hillman, *Re-Visioning Psychology*, 3. In describing the multiplicity of soul, Hillman refers to soul as containing many rooms with many voices.

Strong, personal communication to Dolora Dossi (Sonora, CA: February 2007). With Elizabeth’s permission, I kept the name *Motherlode Storage* without altering it. I felt it was important to note that even her place of retreat showed the wisdom of her soul, its name being a metaphor for what she sought. Not only did she work here, but she also lived in an apartment above the office.

Ibid.

Strong, June 19, 2006. Elizabeth and I used her pathologizing as a map to uncover its source. In the case of her unworthiness, what reality created it? She realized that ever since she could remember, she lived with the belief that she was alone in the world and could not count on her parents. She saw life as merely survival. She was not entitled to anything beyond staying alive. The next question becomes, what other reality is psyche trying to create through this pathologized sense of unworthiness? Elizabeth answered, a life of abundance. In her words, “Now I feel like I can have what I want.”

As a ritual holding the ritual between myself and client, I light a candle before the client arrives to remind myself that I am more than my will or ego and that the client is more than the pathology or imaginal structure they bring into the room. This helps provide a container to hold the therapeutic practice and whatever unfolds during that time.

Omer, *Imaginal Process IV* class notes. Omer points out the word for river in Sanskrit, Rita, is also the word for ritual.

Omer, Personal Communication to Claire James (Petaluma, CA: Institute of Imaginal Studies, March 10, 2006).

Ibid. Omer states it is crucial to identify the imaginal structure in place, as well as the individual’s “embeddedness in the structure.” This provides the potential for the imaginal structure to be “transmuted towards a freer, more authentic self. Disidentification is a key dimension in the transformation of identity associated with the emergence of a spacious awareness free from frozen images of the self.” Connected to this principle is that this transformation depends on our attention turning to the soul’s voice for direction.

Strong, Personal Communication to Dolora Dossi (Sonora, CA: February 9, 2007).

Ibid.

The Guest House was created at the Institute of Imaginal Studies as a way for students to explore what subjectivities were living in the moment. The students created this form as a way to embody complex and difficult expressions in a non-personalized way.


Ibid.
Omer, Personal Communication to Claire James. Omer states that imaginal structures must be transmuted for lasting change to identity. This transmutation depends on our turning “toward the passionate nature of the soul.”


The notion of collaboration and therapy as a reflective and generative action is taken from ideas first expressed by Aftab Omer.


Hillman, *Re-Visioning Psychology*, 75.

This list provides a partial rendering of the many contributors to an imaginal approach and is not suggesting that an imaginal approach is limited only to these orientations.


**Chapter 5**


Hillman, *Re-Visioning Psychology*, 104.

Ibid., 74.

Omer, *Imaginal Process IV* course notes.
REFERENCES


Bender, Eve. “Law Directs Physicians to Counsel Mothers-To-Be About Depression.” *Psychiatric News* 41, no. 10 (2006); [journal on-line]; http://pn.psychiatryonline.org/cgi/content/full/41/10/2; Internet; accessed 18 September 2006.


Leathe, M. “Postpartum Depression.” Mothering Fall 1987, 72-77.


i. Abbe Smith, “Searchers Find Missing Woman’s Body in Creek,” *The Union Democrat* newspaper (Sonora, CA, November 6, 2006).


x. Kathryn A. Leopold and Lauren B. Zoschnick, “Postpartum Depression,” [site on-line] OBGYN.net, (accessed 2 July 2007) available from http://www.obgyn.net/femalepatient/default.asp?page=Leopold; Internet. Here the authors speak to the connection made between childbirth and psychiatric illness as far back as 460 BC when Hippocrates described a puerperal fever. Their point is that even though the awareness of postpartum psychiatric illness dates back centuries, our understanding of this disorder remains incomplete.

xi. Ibid., 1.

xii. Ibid., 4.


xvi. Ibid, 375.


xviii. Ibid.


xxii. Ibid.

xxiii. Ibid, 3.

xxiv. Ibid, 3.


xxvii. Ibid.


xxx. Elizabeth Strong, personal communication to Dolora Dossi (Sonora, CA, May 2005).


xxxiii. Ibid.

xxxiv. Ibid.

xxxv. Ibid.


xxxvii. Valerie Thurtle, “Post-natal Depression: The Relevance of Sociological Approaches,” *Journal of Advanced Nursing*, 22 (1995): 416-424. The term puerperal is used in medicine to mean pertaining to the process of childbirth; lochial discharge is a specific medical term to distinguish a specific vaginal discharge related to the final stages of pregnancy.


xlii. Ibid.

xliii. Ibid.

xliv. Ibid.
xlv. Ibid.
xlvi. Ibid.
xlvii. Ibid.
xlviii. Ibid.
xlix. Ibid.
l. Ibid., 8.
li. Ibid.
lii. Ibid.
lvi. Ibid.
lvii. Hamilton outlines, in the book Postpartum Psychiatric Illness, 16, the three categories that were conceptualized at this time: 1) dementia praecox—later known as schizophrenia; 2) Manic and depressive syndromes; 3) toxic-exhaustive psychoses or organic psychoses. Typical patterns and symptoms were assigned to each grouping and psychiatric illnesses were placed within this category accordingly. Postpartum psychiatric illnesses were tricky because a woman could present with symptoms belonging to one group and later develop symptoms from another. A woman could even exhibit symptoms from all three categories at the same time. Wanting to preserve the integrity of psychiatry as a medical science, Hamilton notes the classifiers were eager to drop the term postpartum and record only those presenting symptoms that fit into the nomenclature.
lxi. Ibid.
lxii. Ibid.
lxiii. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 2nd ed. (Washington D. C.: American Psychiatric Association, 1994), 387. A specifier, according to the DSM, provides “an opportunity to define a more homogenous subgrouping of individuals with the disorder who share certain features.”
lxiv. Hamilton, *Postpartum Psychiatric Illness*, xiii. It is important to note Ian Brockington’s pivotal work, *Motherhood and Mental Health*, published in 1996. This 600-plus-page book is a tremendous resource for not only postpartum illnesses, but for many other subjects related to motherhood, such as fertility, pregnancy, birth, and child-rearing.

lxv. Ibid.

lxvi. Ibid., xiv.

lxvii. Ibid.

lxviii. Ibid., xiii.


lx xix. Ibid.

Ibid.


Andrea Yates and Susan Smith are examples of women who were most likely suffering from a postpartum psychosis during the time they committed their crimes. Both women killed their infants and their other children. Their stories and subsequent trials were much publicized. Yates, whose murder conviction was overturned, remains in a prison psychiatric ward (Associated Press, “Yates’s Attorneys Won’t Seek Release,” CNN.com); Smith received a sentence of life in prison (Cable News Network, Inc., “Year in Review,” CNN.com).


 Ibid.

 Ibid.


 Ibid.

 Ibid.

 Ibid.


 Ibid.


civ. Ibid., 8.

cv. Ibid.


cviii. Ibid., 12.

cix. Ibid., 13.

cx. Ibid.

cxi. Ibid.


cxv. Ibid., 7.

cxvi. Ibid.

cxvii. This idea is expressed in numerous publications, including Rosenberg, Greening and Windell’s *Conquering Postpartum Depression*. See especially Chapter 3 “What Is My Risk for Postpartum Depression?,” 29-31. See also Dunnewold and Sanford’s *Postpartum Survival Guide*, Chapter 3 “Am I At Risk?,” 56-64.


cxxii. Ibid.


cxxiv. Kendall-Tackett and Kantor, 23.

cxxv. Ibid.


cxxvii. Ibid.

cxxviii. Ibid.

cxxix. Campbell, 95-98.

cxxx. Campbell, 95.


cxxxiv. Campbell, 96-7.


cxxxvii. Campbell, 97-8.

cxxxviii. Leopold and Zoschnick, 5.

cxl. Ibid.


cxlii. Ibid.

cxliii. Campbell, 99.


cxlvi Ibid.


cxlviii. Ibid.

cxlix. Ibid.

cli. Ibid.

clii. Kruckman and Smith, 14.

cliii. Ibid.

cliv. Ibid.

clv. Ibid.


clxii. Venis and McCloskey, 100.
clxiii. Kruckman and Smith, 14.

clxiv. Nonacs, “Postpartum Depression,” 4; Bennett, Beyond the Blues, 93; Rosenberg, Conquering Postpartum Depression, 117.


clxvi. Ibid.

clxvii. Rosenberg, Greening and Windell, Conquering Postpartum Depression, 9-10.

clxviii. Kleiman and Raskin, This Isn’t What I Expected, 16-20.

clxix. Bennett, Postpartum Depression For Dummies, 41-59; and Venis and McCloskey, Postpartum Depression Demystified, 16-7.

clx. Bennett, Postpartum Depression For Dummies, 50.

clx. Ibid.

clxii. Ibid., 51.

clxiii. Ibid., 54.

clxiv. Ibid.


clxvi. Ibid., 37.

clxvii. Bennett, 47.

clxviii. Ibid., 48.

clxix. Kleiman and Raskin, 16.

clx. Ibid., 17.

clxii. Ibid., 18.

clxiii. Venis and McCloskey, 16.

clxiv. Bennett, 57.

clxv. Venis and McCloskey, 16.

clxvi. Ibid.

clxvii. Ibid., 17.

clxviii. Thurtle, “Post-Natal Depression.”
Venis and McCloskey, 206. The authors discuss current research being sponsored by The National Institute of Mental Health (NIMH), namely studies interested in prevention of and treatment for postpartum depression.


cxic. Ibid.


cxcv. Ibid.

cxcvi. Ibid.


cxcix. Ibid.

c. Ibid.

cci. Ibid.

ccii. Ibid.

cciii. Ibid.

cxiv. See, for example, Rosenberg, Greening and Windell, *Conquering Postpartum Depression*, 119-20 or Bennett, *Postpartum Depression for Dummies*, 11.

ccv. Rosenberg, Greening and Windell, 120.

ccvii. Ibid.


cxcviii. Ibid.

cxix. Ibid., 25-7.
ccx. Ibid., 27-9.
ccxi. Ibid.
ccxii. Rosenberg, Greening and Windell, 121.
ccxiii. Ibid., 120-1.
ccxiv. Ibid., 121.
ccxvi. Ibid.
ccxvii. Ibid.
ccxviii. Ibid.
ccxx. Ibid., 194.
ccxxi. Ibid., 193.
ccxxii. Ibid.
ccxxiii. Ibid.
ccxxiv. Ibid., 194.
ccxxv. Ibid.
ccxxvi. Ibid.
ccxxvii. Ibid.
ccxxviii. Ibid.
ccxxix. Ibid.
ccxxxii. Ibid., 28-9.
ccxxxiii. Ibid., 29.

ccxxxvi. Ibid.

ccxxxvii. Ibid.

ccxxxviii. Ibid.

ccxxxix. Ibid.

cxli. Ibid.

cxl. Ibid.

cxli. Ibid.


cxl. Ibid.

cxlii. Ibid.

cxliv. Ibid.


ccxlvi. Ibid.

ccxlvi. Ibid.


cccl. Ibid.

cccl. Ibid.

cccl. Ibid.

cccl. Ibid.

cccl. Ibid.

cccl. Ibid.


cccl. Ibid.
cclviii. Ibid.

cclix. Ibid.


cclxi. Ibid.

cclxii. Ibid. It is important to note here the other therapies the research cited to be beneficial in treating postpartum depression: group therapy (CBT, educational, and transactional analysis); interpersonal psychotherapy; psychodynamic; and educational counseling.

cclxiii. Again, see Cooper *et al.*, Appleby *et al.*, Misri *et al.*, and Milgrom *et al*.

cclxiv. See Cooper *et al.* and Misri *et al*.

cclxv. Kleiman and Raskin, *This Isn’t What I Expected* and Rosenberg, Greening and Windell, *Conquering Postpartum Depression*.

cclxvi. Kleiman and Raskin, 137.


cclxix. Ibid.

cclxx. Ibid.

cclxxi. Rosenberg, Greening and Windell, 120.


cclxxiii. Ibid.

cclxxiv. Ibid.

cclxxv. Ibid., 10.

cclxxvi. See Rosenberg *et al.*, *Conquering Postpartum Depression*, 120; also Kleiman and Raskin, *This Isn’t What I Expected*, 137.

cclxxvii. Ibid. Also note Bennett, *Postpartum Depression for Dummies*, 117. The author discusses the importance of a short-term, structured therapy focusing on the here and now issues of the client.


cclxxix. Ibid.

cclxxx. Kleiman and Raskin, *This Isn’t What I Expected*, 137.
cclxxi. Ibid., 140.

cclxxii. Rosenberg, Greening and Windell, *Conquering Postpartum Depression*, 121.

cclxxiii. Some of the individual research studies will be highlighted and referenced as they are discussed in this section.

cclxxiv. Cooper, Murray, Wilson and Romaniuk, “Controlled Trial of the Short- and Long-Term Effect of Psychological Treatment of Postpartum Depression.”

cclxxv. Ibid.

cclxxvi. Ibid.

cclxxvii. Ibid. It is important to note that non-directive counseling and cognitive behavioral therapy also had a significant impact on maternal mood at the four and one half month phase of treatment.

cclxxviii. Ibid.

cclxxix. Ibid. The conclusion of Cooper et al’s study was that psychodynamic therapy for PPD improved maternal mood in the short term, but appeared to have no benefit beyond a woman’s spontaneous remission of PPD in the long term.


cxcii. Ibid.

cxciii. Ibid.

cxciv. Ibid.


cxcvii. Ibid.

cxcviii. Ibid.

cxcix. Ibid.


ccci. Ibid.

In exploring the theories of Erikson, Hall and Lindzey’s text on personality theory is consulted. For Bowlby, see Robert Karen, *Becoming Attached: First Relationships and How They Shape Our Capacity to Love* (New York: Oxford University Press, 1998).


Hall and Lindzey, *Theories of Personality*, 55.

Karen, *Becoming Attached*, 91. Karen continues by noting the significance of Freud’s daughter Anna’s work in furthering the concept of the importance of the mother on a child’s psychological development. Karen states that Anna Freud saw the mother as “…the person whose relationship with the child forms the prototype for future relationships; an auxiliary ego, who helps the child cope with difficult situations; and the social legislator who inducts the child into the world of rules and standards….”

Judith Warner, *Perfect Madness: Motherhood in the Age of Anxiety* (New York: Riverhead Books, 2005), 73. Warner cites psychoanalyst Helene Deutsch and her notion of ideal motherhood, as well as Edward Strecker’s account of the doting mother whose emotional attachment to her children was producing a nation of mama’s boys. She goes on to mention psychoanalysts Rene Spitz and D. W. Winnicott; the former, alleging that a mother’s personality is a “psychological toxin,” and the latter being responsible for the notion of the “good-enough mother”—a mother at one with her infant. Warner’s case is that the ideas set forth in the 1940s, 50s and 60s put too much pressure and prevalence on the mother as the end-all determinant of how a child turns out in adulthood.


Hall and Lindzey, *Theories of Personality*, 91.

Ibid., 91-92.

Ibid., 92.


Ibid.

De Kanter supplies a list of seven central points comprising what women feel “real mothers” ought to do. Her list includes: “All women want to be mothers; a biological mother always loves her biological children; the biological mother is the best caretaker for her children; mothers know intuitively what their children need; infants need the constant presence of their mothers; love, marriage, and motherhood are naturally linked; motherhood within the heterosexual structure of marriage is the best way to raise children.”

Bennett, in *Postpartum Depression for Dummies* outlines ten common fantasies about motherhood, which include “This Should Be the Happiest Time My Life; I Should Be Able to Do Everything Myself; I Shouldn’t Need Breaks; My Life Won’t Change That Much; My Needs Shouldn’t Matter; Bonding Happens Immediately at Birth; Breastfeeding Is Natural, So It Should Come Easily; Mothering Is Instinctual; I Should Feel Satisfied Being a Stay-at-Home Mom; and My Baby Will Be My Companion,” 331-336. In *Postpartum Survival Guide*, Dunnewold and Sanford look at the ways motherhood is romanticized in our culture, 258-60. Finally, Kleiman and Raskin, in *This Isn’t What I Expected*, devote a chapter of their book to the fantasies and expectations of motherhood, 196-212.

Note that these authors are speaking for western, industrialized cultures, and more specifically, American culture. Although some of the authors lecture outside of the United States on occasion, their work predominately entails educating and helping women from the United States.


Ibid., 6.

Ibid., 4.


Ibid.


In Kathleen Kendall-Tackett and Glenda Kaufman Kantor’s, *Postpartum Depression: A Comprehensive Approach For Nurses* (Newbury Park, CA: Sage Publications, 1993), 64. Tackett and Kantor cite several studies that link a woman’s expectations on herself as a new mother with the outcome of postpartum depression. See Whiffen, 1988; Cutrona and Troutman, 1986; and Campbell, Cohn, Flanagan, Popper, and Myers, 1992.


Kruckman cites several other studies that have supported the hypothesis that postpartum depression is relatively unknown in non-western cultures characterized by large, supportive kin groups. Among the research is, Harkness (1987); Laderman (1987); Macintyre (1992); Tseng et al. (1994); and Stewart et al. (1996).

Kruckman elaborates that providing structure, social recognition, and support through rituals helps new mothers by: “1) postpartum rituals are a set of evocative devices for rousing,
channeling, and domesticating powerful cultural emotions such as fear linked to birth, 2) postpartum rituals function to enhance and solidify social roles such as “motherhood,” 3) rituals serve as a learning process. Through ritual, the responsibilities, attitudes, and techniques of motherhood are revealed to the younger members of the group, and, 4) rituals are also a form of support. Rituals marshal regular, reliable, and predictable physical support from family members and the community, crucial to the new mother during birth and the postpartum.”

cclv. Ibid. Kruckman references several studies researching the influence of native customs on new mothers, including research in Nigeria, Southeast Asia, Nepal, China, Kenya, Spain, Guatemala, the Caribbean, the Philippines, Mexico, and Punjab and Muslim cultures. Kruckman maintains that “...a review of the ethnographic literature on childbirth show remarkably little evidence for postpartum depressions in non-Western settings.” 139.

cclvi. It goes beyond the scope of this study to elaborate on the varied traditions surrounding birth and postnatal care, however Wolf, Cartwright Jones, and Davis-Floyd have written in varying detail about the birth and the postpartum period. See Wolf, Misconceptions, 7 and 217-223; and Catherine Cartwright Jones, “Traditional Postpartum Rituals of India, North Africa, and the Middle East: Seclusion, Henna, and 40 Day Homecare,” [article on-line] Kent State University, Medical Anthropology (2002, accessed 17 August 2007); available from http://www.lotusfertility.com/Postpartum_Wisdom_Rituals.html; Internet; and Robbie Davis-Floyd, Birth as an American Rite of Passage (Berkeley, CA: University of California Press, 2002). In addition to these sources, three other important books on birth practices include Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives, ed. Robbie Davis-Floyd and Carolyn F. Sargent (Berkeley, CA: University of California Press, 1997); and the groundbreaking work by Suzanne Arms, Immaculate Deception II: A Fresh Look at Childbirth (Berkeley, CA: Celestial Arts, 1994); and Tina Cassidy, Birth: The Surprising History of How We Are Born (New York: Atlantic Monthly Press, 2006).

cclvii. Wolf, Misconceptions, 5-6.


cclx. Ibid.

cclxi. Ibid., 139. Kruckman elaborates that birth and the postpartum period are vulnerable times for the mother and child. As such, rituals and policy have been in place for centuries to safeguard this transitional time and provide protection, rest, and seclusion for both mother and baby.

cclxii. Ibid., 140-141.

cclxiii. Wolf, Misconceptions, 218.

cclxiv. Ibid., 219.

cclxv. Kruckman, 143.


cclxvii. Kruckman, “An Anthropological View of Postpartum Depression,” 143; Wolf, Misconceptions, 220; and D. Rafael, The Tender Gift: Breastfeeding (New York: Schocken Books, 1976). Kruckman suggests that many of the rituals performed in non-western cultures provide the necessary dietary regulations, rest, seclusion, and help from husband and relatives needed by the recovering mother.
Kruckman cites several studies that conclude postpartum depressions to be rare among non-western cultures in which postpartum rituals are maintained. See “Rituals and Support: Cross-Cultural Research” in his article, “An Anthropological View of Postpartum Depression,” 139-143.

Wolf, Misconceptions, 220-222. Wolf decries, “Little in my birth experience, or in those of my hardworking women friends, was designed to support us postpartum in the intensive way that other cultures have relied upon. On the contrary, we were supposed to…produce the baby, and get on with it, nearly alone.”


Rosenberg also points out that in cultures where postpartum rituals are practiced, women do not experience postpartum depression.


It is important to correlate Cutrona’s findings with Kruckman’s assertion that ritual provides the new mother with much needed rest, support in learning how to become a mother, and the re-emergence of the new mother in her changed status.


ccclxxxv. Ibid.

ccclxxxvi. Ibid.


ccclxxxviii. Ibid., 230.

ccclxxxix. Ibid., 283-287.

cccx. Ibid.


cccxiii. Ibid.

cccxiv. Ibid.


cccxvii. Ibid.

cccxviii. Ibid.

cccxix. Ibid.


cdiii. Ibid., 21.

cdiv. Ibid., 122.

Hillman, *Re-Visioning Psychology*, 110. Hillman says of symptoms, “But my symptoms point to my soul as my soul points to me through them.” Hillman puts a spotlight on pathology as the way into knowing the soul’s desires. He asks us to stay with the pathology in order to understand what the soul is asking of us.

Ibid., 57. Hillman states that psychology must offer this perspective of pathologizing as neither right nor wrong, but as necessary, with purpose and value.

Ibid., 88-89. Hillman describes normative identity as an ideal or statistical definition for the norm of man. He suggests that psychology must not use external standards to explain away behavior. He states that the brand of psychology that uses these standards has directed consciousness in a “…one-sided, suppressive narrowness regarding life, health, and nature.” Instead, Hillman suggests attention be drawn to a person’s pathology as a way of knowing where a person is now, not where they ought to be by some norm or standard. This practice allows the soul to have its say, to inform by its own measures.

In Hillman’s view, psychology needs to address this multiplicity and be aware that soul, and therefore man, has many sources of meaning, direction, and value. Hillman suggests that the motive here is to honor all sides, to be “…flexible, embracing, tolerant, patient…” and mindful of the richness and complexity of not only psyche, but self as carrier of psyche.

Regarding pathology he insists, “Before any attempt to treat, or even understand, pathologized phenomena we meet them in an act of faith, regarding them as authentic, real, and valuable as they are… They are ways of the psyche and ways of finding soul.”


Ibid. Omer states that the web of habits forms a shape or pattern that we run our life within. When the web gets shaken, perhaps through pathology, it wants to snap back into its familiar shape. That familiar shape or pattern, in an individual, can be thought of as one’s adaptive identity.

Aftab Omer, *Key Definitions* (Petaluma, CA: Institute of Imaginal Studies, November 18, 2005). The working definition for adaptive identity, as introduced by Omer, is: “In the course of coping with environmental impingement, as well as overwhelming events, the developing soul constellates self images associated with adaptive patterns of reactivity. These self-images persist as an *adaptive identity* into subsequent contexts where they are maladaptive and barriers to the unfolding of Being.”

Omer, Personal Communication to Susan Day (Petaluma, CA: Institute of Imaginal Studies, June 2007).

This idea is expressed in Claire James’ doctoral dissertation, “Imagining Her Womb: Exploring Women’s Connection to Their Bodies” (Petaluma, CA: Institute of Imaginal Studies, 2007), 59. In a personal communication with Omer, James reproduces Omer’s statement that “Imaginal structures are assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experience. The specifics of an imaginal structure are determined by an interaction of personal, cultural, and archetypal influences. These influences may be teased apart by attention to the stories that form personal character and myths that shape cultural life. During the individuation process, imaginal structures are transmuted into emergent and enhanced capacities as well as a transformed identity. Any enduring and substantive change in individual or group behavior requires a transmuting of imaginal structures. This transmutation depends upon an affirmative turn toward the passionate nature of soul.”

Omer, *Imaginal Process IV* course notes.

Ibid.
Omer states that much of our attention is locked up tending our adaptive identity, which creates limitations on the rest of our being. Adaptive identity is one pattern of being, but there are many other “selves” present. The concept of multiplicity is implicit in this notion.


Somé writes, “Doing a ritual once is not sufficient to awaken gifts that have lain dormant in a person for a lifetime, for it is only by inserting the self in the repeated practice of ritual that one gives these gifts the room to emerge. Until this dormancy is awakened, the person remains incomplete, unavailable, and incapable of fully blossoming. This principle is similar to Aftab Omer’s thought that ritual practice is the structure necessary for holding the contents of the psyche, which includes the complex of imaginal structures.


Hillman contends that a psychological sickness is “…an enactment of a pathologizing fantasy…” and it is psychology’s task to find the archetypal backdrop presented in myths. He ponders, “What archetypal pattern is like my present behavior and fantasy? Who am I like when I do and feel this way? “Likeness” here refers to the idea that what is concretely manifested in an individual psyche has its likeness in a cluster of archetypal resemblances where the pathologizing I am undergoing finds place, makes sense, has necessity….”

C. G. Jung, *The Archetypes and the Collective Unconscious* (Princeton, NJ: Princeton University Press, 1969), 4-5. Jung defines the collective unconscious as impersonal or transpersonal, common to all men, and “…the inherited possibilities of human imagination as it was from time immemorial.”


Ibid. See Neumann’s illustration of the archetype’s development, which he refers to as Schema I.

Ibid. Neumann states that the “effect of the archetype…appears…in positive and negative emotions, in fascinations and projections, and also in anxiety, in manic and depressive states, and in the feeling that the ego is being overpowered. Every mood that takes hold of the entire personality is an expression of the…effect of an archetype…”


Ibid. Neumann states that the feminine principle or Goddess religion was “earth-centered, not heaven-centered, of this world not otherworldly, body-affirming not body-denying, holistic, not dualistic. The goddess was immanent, within every human being, not transcendent, and humanity was viewed as part of nature, death as a part of life.”

cdlvi. Baring and Cashford, xii and Gadon, xii.

cdlvii. Gadon, 2.

cdlviii. Ibid., 23.

cdl_ix. Ibid., 24.

cdlx. Ibid.

cdlxi. Ibid.

cdlxii. Baring and Cashford, 104.

cdlxiii. Ibid., 105.

cdlxiv. Ibid., 40.

cdlxv. Ibid., 660.

cdlxvi. Ibid.

cdlxvii. Ibid.

cdlxviii. Ibid., 661.

cdlxix. Ibid., 662.

cdlxx. Ibid.

cdlxxi. Ibid.

cdlxxii. Ibid., 663.

cdlxxiii. Ibid.


cdlxxv. Ibid., 4.

cdlxxvi. Ibid., 6.

cdlxxvii. Ibid., 36.

cdlxxviii. Hillman, Re-Visioning Psychology, 74.


cdlxxx. Ibid.

cdlxxxi. Hillman, Re-Visioning Psychology, 74. Hillman defines pathologizing the myth onward as “…staying in the mess while at the same time regarding what is going on from a mythical perspective. We try to follow the soul wherever it leads, trying to learn what the imagination is doing in its madness.”
Hillman, *Re-Visioning Psychology*, 57. Hillman speaks in general terms about all pathology or pathologizing as a psychological necessity. He asks the reader to see pathologizing as neither right nor wrong, but as necessary and containing value and purpose. He proposes that psychology must find a place for and accept pathology, to be with and listen to it before making moves to treat, condemn, or justify it.

Elizabeth Strong, Personal Communication to Dolora Dossi (Sonora, CA, September, 2005).
dvi. Ibid.

dvii. Ibid.

dviii. Ibid.

dix. Ibid.


dxi. Ibid., (November 16, 2005).

dxii. Ibid.

dxiii. Ibid.

dxiv. Ibid.

dxv. Ibid.

dxvi. Ibid.

dxvii. Ibid.

dxviii. Ibid.

dxix. Ibid.

dxx. Ibid., (November 23, 2005).

dxxi. Ibid.

dxxii. Ibid.

dxxiii. Ibid.

dxxiv. Ibid.

dxxv. Ibid.

dxxvi. Ibid.


dxxix. Ibid.

dxxx. Ibid.

dxxxi. Ibid.

dxxii. Ibid.

dxxiii. Ibid.
dxxxiv. Ibid.
dxxxv. Ibid.
dxxxvi. Ibid.
dxxxvii. Ibid.
dxxxviii. Ibid.
dxxxix. Ibid.
dx. Ibid.
dx. Ibid.
dxii. Ibid.
dxiii. Ibid.
dxiv. Ibid.
dxvi. Ibid.
dxvii. Strong, (December 3, 2005).
dxviii. Ibid.
dxix. Ibid.
dx. Ibid.
d XI. Strong’s husband, (December 3, 2005).
dxii. Ibid.
dxiii. Ibid.
dxiv. Ibid.
dxv. Strong, (December 13, 2005).
dxvi. Ibid.
dxvii. Ibid.
dxviii. Strong, (January 2006).
dxix. Ibid.
dx. Strong, (March 1, 2006).
dlxi. Ibid.
dlxii. Ibid.
dlxiii. Ibid.
dlxiv. Ibid.
dlxv. Strong, (May 19, 2006).
dlxvi. Ibid.
dlxvii. Ibid.
dlxviii. Ibid.
dlxix. Ibid.
dlxx. Ibid.
dlxxi. Ibid.
dlxxii. Ibid.
dlxxiii. Ibid.
dlxxiv. Ibid.
dlxxv. Ibid.
dlxxvi. Ibid.
dlxxvii. Ibid.
dlxxviii. Ibid.
dlxxix. Ibid.
dlxxx. Ibid.
dlxxxi. Ibid.
dlxxxii. Ibid.
dlxxxiii. Ibid.
dlxxxiv. Ibid.
dlxxxv. Ibid.
dlxxxvi. Ibid.
dlxxxvii. Ibid.
dlxxxviii. Ibid.


dxci. Ibid.

dxcii. Ibid.

dxciii. Ibid.

dxciv. Ibid.

dxcv. Ibid.

dxcvii. Ibid.

dxci. Ibid.

dcx. Ibid.

dxi. Ibid.

dxii. Ibid.

dxiii. Ibid.

dxiv. Ibid.

dxv. Ibid.

dxvi. Ibid.

dxvii. Ibid.

dxviii. Ibid.

dxix. Ibid.
dcxv. Ibid.
dcxvi. Ibid.
dcxvii. Ibid.
dcxviii. Ibid.
dcxix. Ibid.
dcx. Strong, (June 10, 2006).
dcxi. Ibid.
dcxii. Ibid.
dcxiii. Ibid. The Landmark Forum is a self-help institution that teaches participants new skill sets. It uses highly specialized language particular to its curriculum. Programs are offered throughout the United States.
dcxiv. Ibid.
dcxv. Ibid.
dcxvi. Ibid.
dcxvii. Ibid.
dcxviii. Ibid.
dcxix. Ibid.
dcxl. Ibid.
dcxli. Ibid.
dcxlii. Ibid.
dcxliii. Ibid. This is an imaginal technique used in art therapy. This way of working with client art was introduced in Suzanne Lovell’s *Myth, Ritual, Story-Telling* course at the Institute of Imaginal Studies, Fall 1995.
dcxliv. Strong, (June 10, 2006).
dcxlv. Ibid.
dcxlvi. Ibid.
dcxlvii. Ibid.
dcxlviii. Ibid.
dcxlix. Ibid.
dcxlxi. Ibid.
dcxlii. Ibid.
dcxxxix. Ibid.
dcx. Strong, (June 19, 2006).
dcxli. Ibid.
dcxlii. Ibid.
dcxliii. Ibid.
dcxliv. Ibid.
dcxlv. Ibid
dcxlvi. Ibid.
dcxlvii. Ibid.
dcxlviii. Ibid.
dcxlix. Ibid.
dcl. Ibid.
dcli. Strong, (June 24, 2006).
dclii. Ibid.
dcliii. Ibid.
dcliv. Ibid.
dclv. Ibid.
dclvi. Ibid.
dclvii. Ibid.
dclviii. Ibid.
dclix. Ibid.
dclx. Ibid.
dclxi. Ibid.
dclxii. Ibid.
dclxiii. Ibid.
dclxiv. Ibid.
dclxv. Ibid.
dclxvi. Ibid.

The following two paragraphs is a retelling of Elizabeth’s recollection of the events that led her to decide to leave her husband.

Strong, (June 24, 2006).

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Strong, (July 3, 2006).

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Strong, (July 10, 2006).

Strong, (July 30, 2006).

Ibid.

Ibid.

Strong, (August 7, 2006).

Ibid.
dcxcii. Ibid.
dcxciii. Ibid.
dcxciv. Ibid.
dcxcv. Ibid.
dcxvi. Ibid.
dcxvii. Ibid.
dcxviii. Ibid.
dcxix. Ibid.
dcc. Ibid.
decii. Ibid.
deciii. Strong, (September 9, 2006).
deciv. Ibid.
decv. Ibid.
dcex. Ibid.
dcexi. Ibid.
dcxii. Ibid.
dcxiii. Ibid.
dcxv. Strong, (February 17, 2007).
dcxvi. Strong, (February 24, 2007).
dcxvii. Ibid.
dcxix. Ibid., xi.

dccxxi. Ibid., 104.

dccxxii. Ibid., 105.

dccxxiii. Ibid., 40.

dccxxiv. Ibid., 662.

dccxxv. Ibid.

dccxxvi. Ibid.

dccxxvii. Ibid., 663.


Jung, describing the vast and near incomprehensible nature of the archetypes, states, “…these archetypes are true and genuine symbols that cannot be exhaustively interpreted, either as signs or allegories. They are genuine symbols precisely because they are ambiguous, full of half-glimpsed meanings, and in the last resort inexhaustible… indescribable because of their wealth of reference… for what we can above all establish as the one thing consistent with their nature is their manifold meaning, their almost limitless wealth of reference….”

dccxxx. Ibid., 42. Jung states that the archetypes are pre-existent forms held within the collective unconscious, which does not develop in the individual conscience, but is inherited by all. One of the functions of the archetypes is to give form to certain contents of the psyche.


dccxxxii. Ibid., 135. Jung challenges psychology to ask the question: What biological purpose do the archetypes serve? He answers this question by underscoring the importance of maintaining our relationship with the archetype, so that our link with the original, primordial, and universal experience remains unbroken.

dccxxxiii. Ibid., 135-136.

dccxxxiv. Ibid.

dccxxxv. Ibid., 136. Jung uses the example of the child archetype as representing something in the distant past and something that exists presently.

dccxxxvi. Ibid.

dccxxxvii. Ibid. 130-131.

dccxxxviii. Ibid. Jung gives an account of the importance of archetypes in his statement, “In reality we can never legitimately cut loose from our archetypal foundations unless we are prepared to pay the price of a neurosis, any more than we can rid ourselves of our body and its organs without committing suicide. If we cannot deny the archetypes or otherwise neutralize them, we are confronted, at every new stage in the differentiation of consciousness…with the task of finding a new interpretation appropriate to
this stage, in order to connect the life of the past that still exists in us with the life of the present, which threatens to slip away from it. If this link-up does not take place, a kind of rootless consciousness comes into being no longer oriented to the past, a consciousness which succumbs helplessly to all manner of suggestions and, in practice, is susceptible to psychic epidemics.”

dccxxxix. Ibid., 128. Jung discusses how archetypes, as they manifest in neurotic or psychotic behavior and thought, give us a glimpse into the workings of the psyche. He states that archetypes are, “…self-portraits of what is going on in the unconscious, or as statements of the unconscious psyche about itself.”

dccxl. Ibid., 129.

dccxli. Ibid.

dccxl ii. Ibid., 131.

dccxl iii. Ibid., 128. Jung writes that myth is the psychic life within us, not merely a representation of some event. Myth is a culture’s living religion, without which culture and the individual falls into moral collapse.


dccxl v. C. G. Jung, *Psychology and Alchemy*, trans. R. F. C. Hull (Princeton, NJ: Princeton University Press, 1953), 25. Jung is quoted as saying, “I asked myself, ‘What is the myth you are living?’ and found that I did not know. So I took it upon myself to get to know my ‘myth,’ and regarded this as the task of tasks…I simply had to know what unconscious or preconscious myth was forming me.”

dccxl vi. James Hillman, *Re-Visioning Psychology* (New York: Harper Perennial, 1975), 57. Hillman goes on to say that psychology must offer this perspective of pathologizing as neither wrong nor right, but as necessary, with purpose and value.

dccxl vii. Ibid., 101.

dccxl viii. Ibid. 107. Hillman states, “The soul sees by means of affliction…Pathologizing is itself a way of seeing.” Hillman would say that what we are seeing through our pathologizing is our very experience as told through the mythical metaphors of soul.

dccxl ix. Ibid., 100.

dccl. Ibid., 101. About pathologies, Hillman writes, “…in my disturbances there really are forces…which want something from me and intend something with me.”

dccli. Ibid., 102.

dccl ii. Ibid. Hillman is using this idea to suggest that normative reality—the way things are out in the real world—may not bear the capacity to house what is truly being experienced by soul through an individual. The soul is not only allowing a glimpse into the personal experience, but also into the levels of cultural and universal experiencing. Hillman proposes that pathologies are both “…facts and fantasies, both somatic and psychic, both personal and impersonal.”


dccl v. Ibid., 88-89.
Ibid.

32.

Aftab Omer, Personal Communication with Claire James (Petaluma, CA: Institute of Imaginal Studies, March 10, 2006.)

Ibid.

Claire James, “Imagining Her Womb” (Ph.D. diss., Institute of Imaginal Studies, 2007), 59.

Ibid.

Aftab Omer, Imaginal Process IV course notes (Petaluma, CA: Institute of Imaginal Studies, June 12, 1999).

Ibid.

Elizabeth Strong, Personal Communication to Dolora Dossi (Sonora, CA: November 23, 2005.)

Ibid.

Ibid.

Baring and Cashford, The Myth of the Goddess, 40. They maintain that we can find the great mother goddess within the images that mankind brings forth. They state that these images exist as testimony within the human psyche of the feminine principle with its vision of unity of life.

Jung, Psyche and Symbol, 129.

Jung, The Archetypes and the Collective Unconscious, 48. Jung writes, “When a situation occurs which corresponds to a given archetype, that archetype becomes activated and a compulsiveness appears, which... gains its way against all reason and will, or else produces a conflict of pathological dimensions, that is to say, a neurosis.” I am equating Jung’s idea here with the organic presentation of Elizabeth’s concerns, i.e. that they possessed a universal motif, that of the mother archetype, but also a personal component having to do with various experiences within her own biography. The activation of the archetype appeared to coincide with Elizabeth’s fall into conflicts of “pathological dimensions.”

Ibid., 81-82. Here, Jung provides a partial list of qualities and symbols associated with the archetype of the mother.

Ibid.

Ibid.

Elizabeth Strong, Personal Communication to Dolora Dossi (Sonora, CA: November 16, 2005).

Ibid.

Elizabeth’s father and mother had a long-term affair before marrying and having Elizabeth. She tells the story of how her father’s ex-wife found her father’s journal detailing his affair with Elizabeth’s mother. The former wife made copies of the more lurid passages and passed them out as people...
were walking out of the church that they all attended. As Elizabeth mentioned, the former wife’s action was not an example of the powerless mother. Whereas, her own mother’s shame drove her into deeper levels of submission, mirroring her own mother’s shame over her husband’s sexual infidelity and abuse of their children.

dclxxv. Ibid. Elizabeth mentioned that her mother told her that she “doesn’t do anger because when adults get angry, they beat and hurt their children.” Elizabeth noted that she always felt that her mother was angry although she never expressed this emotion after becoming out of control once with Elizabeth when she was four, breaking a wooden spoon over her resulting in multiple contusions.

dclxxvi. Hillman, Re-Visioning Psychology, 3. In describing the multiplicity of soul, Hillman refers to soul as containing many rooms with many voices.

dclxxvii. Elizabeth Strong, personal communication to Dolora Dossi (Sonora, CA: February 2007). With Elizabeth’s permission, I kept the name Motherlode Storage without altering it. I felt it was important to note that even her place of retreat showed the wisdom of her soul, its name being a metaphor for what she sought. Not only did she work here, but she also lived in an apartment above the office.

dclxxviii. Ibid.

dclxxix. Strong, June 19, 2006. Elizabeth and I used her pathologizing as a map to uncover its source. In the case of her unworthiness, what reality created it? She realized that ever since she could remember, she lived with the belief that she was alone in the world and could not count on her parents. She saw life as merely survival. She was not entitled to anything beyond staying alive. The next question becomes, what other reality is psyche trying to create through this pathologized sense of unworthiness? Elizabeth answered, a life of abundance. In her words, “Now I feel like I can have what I want.”

dclxxx. As a ritual holding the ritual between myself and client, I light a candle before the client arrives to remind myself that I am more than my will or ego and that the client is more than the pathology or imaginal structure they bring into the room. This helps provide a container to hold the therapeutic practice and whatever unfolds during that time.

dclxxx. Omer, Imaginal Process IV class notes. Omer points out the word for river in Sanskrit, Rita, is also the word for ritual.


dclxxxiii. Ibid. Omer states it is crucial to identify the imaginal structure in place, as well as the individual’s “embeddedness in the structure.” This provides the potential for the imaginal structure to be transmuted towards a freer, more authentic self. Disidentification is a key dimension in the transformation of identity associated with the emergence of a spacious awareness free from frozen images of the self.” Connected to this principle is that this transformation depends on our attention turning to the soul’s voice for direction.

dclxxxiv. Elizabeth Strong, Personal Communication to Dolora Dossi (Sonora, CA: February 9, 2007).

dclxxxv. Ibid.

dclxxxvi. Ibid.

dclxxxvii. Ibid.

dclxxxviii. Ibid.

The Guest House was created at the Institute of Imaginal Studies as a way for students to explore what subjectivities were living in the moment. The students created this form as a way to embody complex and difficult expressions in a non-personalized way.


Omer states that imaginal structures must be transmuted for lasting change to identity. This transmutation depends on our turning “toward the passionate nature of the soul.”


Baring and Cashford cite three discoveries that point to both the necessity of redefining our governing myth of the god and to the inevitable conclusion that the myth of the Great Mother Goddess lives on in the collective unconscious. One is the splitting of the atom, by which mankind has achieved such distance from the structure of the material world that he can change it and therefore threaten all life. The second discovery made through the various disciplines of archeology, anthropology, archetypal psychology, and comparative mythology suggests that humans across time and place have shared a common, thematic interpretation for the human condition. Thirdly, the field of subatomic physics has shown that observer and observed are deeply interconnected, whereby man cannot speak about nature without at the same time speaking of himself.


The notion of collaboration and therapy as a reflective and generative action is taken from ideas first expressed by Aftab Omer.


Hillman, *Re-Visioning Psychology*, 75.

This list provides a partial rendering of the many contributors to an imaginal approach and is not suggesting that an imaginal approach is limited only to these orientations.


Hillman, *Re-Visioning Psychology*, 104.

Ibid., 74.

Omer, *Imaginal Process IV* course notes.