

# An Integrative Psychotherapy of Postpartum Adjustment

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## **Abstract:**

**Becoming a mother is a time of transition, transformation and sometimes trauma. The immediacy of meeting the needs of an infant, combined with the immediacy of becoming a mother, often collide to produce depression, anxiety and stress. Shame, confusion, isolation and cultural expectations often prevent women from seeking the postpartum support they need, which may result in long lasting depression, anxiety and unresolved trauma. Integrative Psychotherapy, Transactional Analysis and Attachment Theory offer ways to understand postpartum adjustment as well as methodologies for addressing this unique developmental event in the life of women.**

**Key Words:** Postpartum Adjustment; Integrative Psychotherapy; Pregnancy; Birth

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Becoming a mother presents a unique opportunity in the life of a woman for transformation, integration and redefinition. Prior to childbirth, many women are unaware and unprepared for the deep impact motherhood will have on their lives. While opportunities for childbirth preparation abound, there is a contrasting and alarming lack of preparation for the many tasks and responsibilities of motherhood. As a result, many women are often surprised, shocked and confused by the life changes that occur with the arrival of a baby, sometimes feeling betrayed that they were not forewarned (Maushart, 1999). As women rapidly transition from pregnancy to parenthood, they express wonder and anger, often thinking that they were protected from well kept secrets about the truth of early motherhood, which some describe as “mother shock.” (Buchanan, 2003). Comments like, “this is not what I expected,” “it wasn’t supposed to be like this,” or “why didn’t anyone tell me it would be this way?” are common from postpartum women.

The postpartum experience is uniquely different for every woman, and can even differ dramatically with each child she bears. Defined medically, “postpartum” refers to the time during which a woman still has the physical symptoms of birth; an enlarged uterus, stretched and swollen cervix, and lochia. These symptoms typically resolve at the end of six weeks (Bing and Coleman, 1997), and when they do, women are generally released from medical care to navigate new motherhood on their own. In contrast, “psychological postpartum recovery,” the time during which women experience the emotional symptoms of birth, may last for months or even years, with some women reporting that they are “postpartum for the rest of their lives because they feel permanently changed by the birth of their child.” (Bing and Coleman, 1997, p.98). Most women are left to resolve their psychological postpartum recovery alone; a recovery that impacts the rest of their lives, their children’s lives and the culture at large; a recovery with long lasting and far reaching social and relational implications. Family members, friends, medical professionals and psychotherapists alike frequently overlook, misinterpret or misunderstand the lingering effects of postpartum recovery. As Erskine notes, “The recent literature on neuroscience, child development, and early child/parent attachment research has been a siren call reemphasizing the importance of psychotherapists focusing the therapeutic relationship on the client’s early childhood preverbal relational experiences.” (2009, p.2), a focus which by default must also include an examination of their own mother’s postpartum recovery.

At best, the postpartum period is a time of sleepless nights cushioned by the loving presence of relatives and friends who come to admire the new baby and help welcome this new little person into the world. At its worst, the postpartum period is a nightmare; a seemingly endless, unanticipated excursion into sleep deprivation, uncertainty, confusion, physical recovery from an unexpected cesarean section and/or traumatic birth, failed attempts at breast feeding, lack of connection to the infant and an overall sense of loss of self and any ability to anchor to familiar markers of a life previously known and lived. As the daily needs of the infant increase and intensify, self care is often necessarily neglected. Sleeping, eating, and bathing become longed-for luxuries. Recreation, relaxation, contact with one’s partner, friends and even the outside world, become distant memories. The acute needs of the new family can lead to cumulative self and relational neglect, chronic stress, and an unanticipated experience of trauma, during what was supposed to be one of the happiest times of life. The immediacy of meeting the needs of an infant, intertwined with the immediacy of learning how to parent, often collide to produce depression, anxiety and stress.

Literature about the postpartum period, both popular and clinical, often contributes to misconceptions about postpartum women by failing to normalize psychological postpartum adjustment. Early clinical literature about postpartum women often emanated from a psychoanalytic perspective, with countless case studies pointing

to conflict, ambivalence and repressed fantasies which interfere with “healthy” mothering (Mendell & Turrini, 2003) and seemed to inherently blame women for postpartum or parenting difficulties. Currently, postpartum women who report any difficulties or “symptoms” are grouped according to three categories of increasing pathology: **baby blues**, defined as “transient feelings of unexplained crying, fleeting despair, or brief moments of not feeling quite yourself lasting the first few weeks after birth” (Bing & Coleman, p. 24); **postpartum depression**, defined as a more intense and longer lasting version of baby blues, which may include feeling sad, anxious, guilty, and/or worthless, in addition to changes in eating patterns, sleeping patterns, activity levels, panic attacks, difficulty concentrating, preoccupation with death and/or suicide, mood swings, obsessions about the baby and/or intense fears of hurting the baby (Bing & Coleman, p. 226); or **postpartum psychosis** defined as intensified blues or depression, which may include confusion, incoherence, irrational thinking, and/or delusions and hallucinations which seriously impair self-care and/or care of the baby (Bing & Coleman, p. 241). Although presented as distinct categories, these experiences may actually flow together or cycle back and forth, with “psychosis” occurring during periods of acute stress. Missing from this standard taxonomy is the simple, yet necessary, concept that all women and their partners experience **postpartum adjustment**, a psychological reorganization after the birth of a child which is a required and necessary adaptation to a change in the structure and homeostasis of the individual and the family. This, like any change to a dynamic system, requires time and support as new internal and external adaptations and accommodations emerge. It is understandable that women may feel disoriented, depressed, anxious, preoccupied or even irrational, while exhibiting changes in appetite, sleep and activity levels. Their entire physical, psychological and social homeostasis has been altered. However, rather than normalize their unique adaptive responses, women are defined, categorized and “pathologized,” if they demonstrate anything other than a seamless, happy adjustment to motherhood.

Popular literature and media also subtly reinforce unreasonable expectations regarding the adjustment to becoming a parent. Attractive, cheerful, smiling women and babies fill the pages of parenting magazines and television commercials. Women look at these advertisements and wonder, “what is wrong with me?”. They fantasize that every other young mother they encounter in public “has it all together,” while they desperately try to respond and adapt to the culture at large, as well as the unique cultural, relational and historical demands of their own families of origin. Sometimes the only information women receive about postpartum adjustment comes from highly publicized stories of celebrities who have experienced postpartum difficulties, but rarely do these celebrity women mirror the life of a typical new mother (Shields, 2005). In the privacy of their homes, women often feel isolated, lonely and overwhelmed by the demands of the new baby. They often feel shame about their adjustment to

motherhood. In a culture prone to scrutinizing and criticizing mothers for their failings, women feel vulnerable and frightened by internal and external demands to perform. Under these circumstances, many women go into hiding, literally and/or figuratively. As the DSM-IV (1994) notes “women feel especially guilty about having depressive feelings at a time when they believe they should be happy. They may be reluctant to discuss their symptoms or their negative feelings toward their child.” (p. 386). According to a study published in the Journal of the American Medical Association in 2006, one in seven new mothers is estimated to suffer from postpartum depression. Even more alarming, is the study’s estimate that postpartum depression goes undiagnosed in roughly 40 - 50% of new mothers, leading researchers to believe that postpartum issues are even more common than previously believed (Munk-Olsen, Laursen, Pedersen, Mors, & Mortensen, 2006).

Women who have experienced an unexpected premature delivery, cesarean section, prolonged, difficult or traumatic birth with or without physical injury to either themselves or their babies, or are themselves previous survivors of emotional, physical or sexual abuse, are even further at risk for difficulties during postpartum adjustment (Simkin & Klaus, 2004). Add to this list a history of depression, anxiety, infertility, miscarriage, still birth, inability to establish successful breast feeding, adoption, or emotional or physical loss of one’s own mother at an early age, and the nuances and possibilities for challenge and trauma during postpartum adjustment expand even further. In the absence of explicit memory, difficulties during pregnancy, childbirth and postpartum recovery may be the first indicators of a previous history of cumulative neglect, trauma and/or emotional and physical abuse, leading the way to recovery of previously unconscious memories (Erskine, 2008). Health care providers who understand this are invaluable in guiding pregnant or postpartum woman towards the help they need to resolve these issues so they may successfully approach childbirth, postpartum adjustment and parenting with appropriate here and now expectations, as free as possible from the burdens of past trauma, unresolved neglect or relational failures.

Given the many varied possibilities of postpartum adjustment, it is imperative that women be offered opportunities for normalization of their experience. As Erskine & Trautmann write, “...normalization [helps] clients or others categorize or define their internal experience or their behavioral attempts at coping from a pathological or “something’s- wrong- with- me” perspective to one that respects archaic attempts at resolution of conflicts. It may be essential for the therapist to counter societal or parental messages.... and communicate that the client’s experience is a normal defensive reaction - a reaction that many people would have if they encountered similar life experience.” (1997, p.32). In this regard, each woman’s entry into motherhood requires normalization, an understanding based on her own unique history, relationships and

attachments, rather than definition of “problematic” postpartum responses based on clinical descriptions and pathology.

### **A Clinical Model for Understanding Postpartum Adjustment: *Integrative Psychotherapy***

Integrative Psychotherapy offers a comprehensive theory and methodology which encompasses a view of “human development in which each phase of life presents heightened developmental tasks, unique sensitivities in relationship with other people, and opportunities for new learning,” (Erskine & Trautmann, 1996, p.316). In this way, Integrative Psychotherapy provides an excellent framework for understanding and working with postpartum recovery; a specific phase in the life of a woman which presents the heightened developmental task of learning to parent, unique relational sensitivities to both one’s partner and children, and increased opportunities for many areas of new learning inherent in raising a family.

#### ***The Self in Relationship***

The Self in Relationship model as delineated by Erskine (1980) provides a way to understand the cognitive, behavioral, affective and physiological functioning of the new mother. All four of these domains of the self are deeply affected by the birth of a child, and require consideration and integration during recovery in order to meet the required, yet often unanticipated, internal and external demands of motherhood. The developmental task of becoming a mother must occur in “real time” in response to the accelerated physical and psychological development of a baby in the first year of life. In a culture increasingly reliant on technology to inform behavior and response time, it can be challenging to realize that babies do not come with a pause button, or “operating instructions” (Lamott 1993). As the daily needs of the baby emerge, the mother is simultaneously confronting her own cognitive, affective, behavioral and physiological reorganization. While on a roller coaster of emotional highs and lows, often stimulated or influenced by hormonal fluctuations, memories of her own infancy and childhood are being subtly stimulated, often out of awareness. Women often report experiences of love and attachment never before known or anticipated. In contrast, other women report feelings of extreme loneliness and neglect. In either case, the world of affect and emotion becomes deeply activated. Concurrently, the new mother must engage in immediate problem solving regarding infant care, think through new and unexpected situations, develop a new social and/or medical support system, and learn a vast array of care taking skills and behaviors ranging from breast feeding, to bathing a baby, to managing work and motherhood, while restructuring all aspects of personal and family

time management. Many often feel that they are in a continual game of catch up, attempting to keep up with rapid developmental in their baby. They often report that just as they come to understand the current needs of the baby, new needs emerge. For example, a baby who was sleeping through the night last week, is now this week an uncomfortable, wakeful teething baby. The mother's cognitive and behavioral domains became challenged, stimulated and often stressed.

Cozolino (2006) discusses the physiological changes to the brain which occur in response to the cognitive and affective stimulation from parenting. He describes the "experience dependent plasticity" of the maternal brain, noting that "having children enriches, stimulates and challenges the brain to grow." (p. 82). His review of research on brain development leads to an inference that "mothers and children stimulate each other's brains to grow" (p. 83), noting "parents and non parents have been shown to demonstrate different patterns of brain activation in response to the crying and laughing of infants, reflecting experience dependent brain changes resulting from parenting experiences." (p. 83). He suggests the possibility that "the emotional lability we see in many new mothers is an expression of a heightened sensitivity to interpersonal cues required for optimum attunement and learning." (p. 83). In this regard, emotional lability may be viewed as normal and necessary, not pathological.

While physically recovering from childbirth, the cognitive, affective and behavioral domains of the self are also challenged. Women put their own needs aside in order to meet the survival needs of the infant. All forms of self-care and self-regulation including sleeping, eating, bathing, exercising, entertainment, social interaction and even necessary medical appointments may fall to the wayside, significantly contributing to the potential for cumulative stress, anxiety and depression as the mother attempts to keep up with this highly intensified period of growth and development for both her child and herself. If the mother must return to work, and/or there are other children or family members who require her care and attention, her ability to attend to her own physical and emotional care is even further undermined. The way in which a woman approaches all these cognitive, affective, behavioral and physical challenges is necessarily informed by her own history and attachment style; a history revealed through both implicit and explicit memory and/or disruptions of attachment (Cozolino, 2006). In a remarkable parallel of development, a woman integrates, reinvents and grows into motherhood, as her baby simultaneously develops and grows into a human being.

### ***Life Script, Memory and Attachment***

According to Berne (1972) "the first script programming takes place during the nursing period, in the form of short protocols which can later be worked into complicated

dramas.” (p. 83). For example, the baby who is typically rushed, ignored or lovingly attended to during feeding, will each carry this early protocol into future interactions. Erskine (2009) expanded on Berne’s idea by delineating the association between life script and attachment patterns formed in early infancy, emphasizing “the significance of infancy and early childhood sub-symbolic, pre-verbal, physiological survival reactions and implicit experiential conclusions that form unconscious procedural maps or internal working models of self in relationship.” This comprehensive definition of life script takes into account the “profound influences of infancy and early childhood (Erksine, 2009, p. 4), thus underscoring that the mother’s postpartum adjustment has the potential to deeply influence the psychological development of her infant. The mother’s physical recovery, adjustment to parenting, family and social supports and own attachment patterns must, by definition, affect the creation of the infant’s working models of self-relationship and script formation. The child is being “profoundly influenced” in relationship with a woman who is undergoing one of the most life altering experiences of adulthood, involving the activation of her own implicit, pre-verbal and sub-symbolic memories of her own infancy and postpartum mother. The mother’s own style, patterns or disorders of attachment, formed in response to her own infancy and childhood, quickly manifest as she begins to care for her own child. Layers of past, present and potential relationships begin to emerge in the context of the postpartum dyad; a dynamic and intricate orchestration of two intertwined lives representing the archaic past, present and future relational possibilities.

### **Case Example: Natalie**

*Natalie had spent many years in psychotherapy with a variety of therapists. A divorced mother of three, now remarried, she had a history of choosing partners who were unwilling to meet her relational needs beyond the sexual arena, and had discovered as a young teenager that sexual contact was a way to meet needs for affection, validation and security. Natalie maintained a staunch adherence to the core belief, “something is wrong with me,” continually searching for the “right” therapist who would agree with her and finally heal her so that other people would love her and be emotionally available to her.*

*As we explored Natalie’s family history, stories about her infancy validated her deep internal sense of fragmentation and that something was “very wrong.” There was the time her mother left her in a drawer in a hotel room when she was 6 months old while she went to the movies; the time her mother left 3 month old Natalie with a neighbor to go grocery shopping, but did not return in time to feed her. Natalie was exclusively breast fed, and by the time her mother returned, Natalie was reportedly hysterical with hunger and distress. There was the “blue arm in the bath-tub” story.*

*Mother was giving Natalie a bath, usually a pleasant experience, so she could not understand why Natalie was crying so hard. "Then she looked down and realized she was holding my arm so tightly, that my arm had turned blue." Natalie knew these stories because they had become part of the fabric of family history, often light heartedly told by her mother at family gatherings. In addition, Natalie still experienced in the present that "my mother's hugs are all wrong. She couldn't even hold my children when they were babies. She seemed so uncomfortable."*

*Through her on-going therapy, Natalie came to realize that her mother had been terrified and isolated as a new mother, unable to be fully present for Natalie, to see her, know her and meet her needs. Natalie's deep internal experience that "something is wrong with me," was an on-going creative attempt to change herself in order to get the care taking she so desperately needed. Her story was inextricably intertwined with her mother's postpartum experience.*

Women who thought they had adequately prepared for motherhood are often surprised, or even overwhelmed, by the flood of postpartum emotions and memories stimulated by the birth of a baby and necessary requirements of caring for an infant. Psychotherapy with postpartum women provides an exceptional opportunity to understand the mother's own infancy, early-child dramas and/or script protocols, as lived through the current relationship with her new baby, partner, extended family and friends. As she begins to care for her baby and attempt to self regulate, the woman's own early story is enacted and embodied as implicit and explicit memories are revealed in her thoughts, feelings, behavior and body. We are able to observe the growing attachment patterns between mother and baby, which offer a window into possible formation of the infant's own life script. As women grapple with issues related to feeding, sleeping patterns, expressions of love and affection, returning to work versus staying home, the embedded stories of secure, anxious, ambivalent, disorganized or isolated attachment emerge (Erskine, 2009). As the story of these two lives unfold and intersect, we are at the confluence of memories and relationship, old and new, with all of the attending opportunities for repetition or reparation.

Attachments, memories and postpartum adjustments occur even when a woman loses a child. Women who have miscarried, had abortions, or a still birth are often maintain deep attachments to their child (Davis 1996). Marion, 43, provides a heartfelt example of this.

She and her husband spent six years and thousands of dollars attempting to conceive a child. They were ecstatic when their second in-vitro fertilization procedure resulted in a viable pregnancy. However, genetic testing at 16 weeks revealed severe chromosomal

damage, and the news that their daughter had not survived the pregnancy. Given the choice of being induced versus naturally going into labor, Marion chose to wait for labor, and within two days gave birth. Although both the doctor and her husband assured her in the midst of her painful contractions that it would all be over soon, she dreaded the end when her baby would finally leave her body. Fortunately, she and her husband were allowed to hold, name and photograph the baby, bringing some sense of closure to the experience. Marion continued to grieve her lost baby in her therapy sessions, eventually sharing with me the pictures they taken of her, and the baby book she had carefully and lovingly put together filled with early memories, sonogram pictures, happy pictures of Marion holding her pregnant tummy, and pictures of family members her daughter would never meet.

Miraculously, and against many odds, Marion conceived another IVF baby 10 months later. As the birth of this healthy baby drew near, Marion suddenly slipped into an unexpected depression and anxiety one afternoon after her childbirth class. Memories of her first labor and delivery came pouring out. She grieved and berated herself for not asking the nurse to unwrap her daughter so she could have seen *all* parts of her tiny body. She realized that she had not been able to choose a name for the new baby, also a girl. She could only think about her first daughter, and the perfect name that she had been given. She agonized over what to say when people, seeing her swollen belly, would ask if this was her first baby. On all levels, she began to feel that the coming baby was a betrayal of her love for her first baby. I suggested to Marion that she was telling me an important story about attachment and love. She was attached and in love with her first daughter, but at a loss as to how to express this. She needed permission that it was okay to love and welcome another baby. I encouraged Marion to write a letter to her lost baby and bring it to her session. She resisted this suggestion for a number of weeks, even though she continually told me about the on-going internal conversation she was having with the lost baby. Finally, she arrived at her session with a letter; a poignant expression of her love for this child, regrets over the lost opportunity to ever know her, and commitment to maintain her memory. She asked the baby to watch over her new little sister, and thanked her for being the first to make her a mother. It was a wrenching and painful session for Marion. The following week, Marion arrived in my office cheerful and energetic. Over the weekend she'd had her first pregnancy dream about the coming baby. "I was overwhelmed by the new baby, but I saw her. She was here. I didn't know what to do with her but it's all okay because I had a dream about her! I had a normal pregnancy anxiety dream! That's so exciting! I didn't understand how writing that letter was going to help me, but it did. Thank you." Marion's final and full acknowledgment of attachment to her lost daughter had now opened the way for her to birth and welcome her next baby.

### ***Inquiry, Attunement, Involvement and Relational Needs***

Inquiry, attunement and involvement help us reach beyond typical therapeutic empathy towards a deeper relationship in which the client experiences being fully known, responded to and understood by the therapist. On the most fundamental level, this process mirrors the process of early parenting which relies on exquisite and intuitive forms of inquiry, attunement and involvement. In the absence of a shared verbal language or concrete knowledge of the infant's subjective experience, the mother must rely solely on nonverbal forms of communication, which require an on-going refinement of intuition and sensitivity to her infant (Stern 1985,1990). As Erskine et. al (1999) writes, "(I)n integrative psychotherapy, our inquiry begins with the assumption that the therapist knows nothing about the client's subjective experience." (p.19). As with therapist and client, so it is with the mother and her new baby; a brand new meeting of two individuals, a relationship where neither one yet fully knows the other. Engaging in non-verbal modes of inquiry, attunement and involvement become the means by which the mother begins to meet early relational needs for security, value, acceptance, mutuality, self definition, impact, initiation, and love in order to establish secure attachment and promote healthy development (Erskine, Moursund & Trautmann,1999). Historical as well as current deficiencies or disruptions in the fulfillment of the mother's relational needs all necessarily inform how that mother will care for her infant and create a healthy reciprocal relationship.

As the mother begins to care for her baby the landscape of her relational past and present begins to emerge. Un-met needs from the past may converge and collide with the present in the form of unconscious attempts to repair failures via the relationship with her baby. Just as the baby looks to the mother for security, value, acceptance, mutuality, self definition, impact, initiation, and love, the mother is also looking to the infant and others around her for assurance that she is valued, accepted and secure in her new role as a mother. New relational challenges often appear between the woman and her parenting partner, as she turns to him/her as the central figure to meet present needs, as well as repair historical failures. New parents are often completely unprepared for the extent of these challenges to even the most stable marriage or partnership. If a woman felt undervalued by her own mother, or other important people in her development, these memories are likely to emerge as she approaches this most important task of her adult life. She will invariably look to her partner for continual reassurance, acknowledgment and appreciation. If her partner is unable to support her in these ways, a relational crisis is almost certain to ensue.

Women who felt insecure, unloved, or impotent in their ability to initiate or make an impact early in life, often look to their babies and their partners for validation, acceptance and love. Women who have used careers to repair and replace relational deficits, finding value and self definition for their performance in the work place, often find themselves struggling to get through a day where the biggest victories lie in getting a fussy baby to sleep or finding an opportunity to bathe, eat and get dressed (Maushart, 1999). They find themselves suddenly and unexpectedly looking to their baby and/or partner to meet the full array of relational needs, as their partners, also coping with their own version of postpartum adjustment, feel befuddled, overwhelmed and also bombarded by their own early memories, as competition for simple physical and emotional needs such as sleep and affection escalate. As one client poignantly expressed in the midst of unexpected postpartum marital conflict, "I finally realize that I need my husband to give to me what I give to the baby every day. If I don't get that from him, I feel depleted and overwhelmed taking care of the baby, and completely resentful and unavailable to meet any of his needs." On the other hand, mothers who have a history of secure attachments and relational successes may also struggle with postpartum adjustment due to a variety of unexpected circumstances. For example, a baby suffering from months of colic will challenge and eventually wear down even the most emotionally secure and stable parents.

Even the partner who has not given birth is prone to postpartum adjustment. As Cozolino (2006) writes of one of his patients, " the birth of his child... contained many cues that triggered painful and violent memories from his childhood... triggered by crying, the smell of baby powder, and the intense feelings of love for, and even the dependency of, his child." (p.137). Men are often unprepared for such surges of memories and feelings in the midst of attending to the dependency needs their new babies and, once highly independent, partners now exhibit. In addition, men commonly experience some degree of loss, as their partners become intensely involved with their babies or preoccupied with their own adjustment. They often report feeling neglected, and typically resort to working hard, justifying long hours at work; a socially acceptable solution as they are often now the primary wage earner. As a result, fathers avoid an array of feelings about their partners, themselves, their babies, and their own early memories. Sadly, a vicious and long lasting cycle often begins here, with both parents feeling neglected, angry and resentful, with little support as to how to break this cycle and move forward in a positive direction. Further, for a myriad of reasons, men often have even less emotional support available to address this brewing crisis than women do.

### **Case Example: Gina**

*Gina came to therapy in the wake of an intense and unexpected postpartum recovery. Within one year she had experienced a first trimester*

*miscarriage and full term pregnancy, and was now suffering from anxiety, inability to sleep or eat and an increasing loss of interest in her baby. Within a week of her daughter's birth by cesarean section, Gina had hit the ground running, organizing tasks, interviewing day care providers and seeking support groups. Now exhausted, she had missed out on the important rest, bonding and emotional and physical recovery necessary during the early postpartum weeks. She felt especially depressed and anxious while nursing, finding it intolerable not knowing how much milk her daughter was getting. After three weeks she switched exclusively to bottle feeding. The immediate drop in hormones further exacerbated her anxiety, panic and loss of interest in mothering, leading to a referral from her doctor for psychotherapy and prescription for anti-anxiety medication.*

*A personal assistant to the CEO of a multi-million dollar corporation, Gina now had the ultimate personal assistant job: Mother. Yet, she was at a complete loss as to how to get through the day with a new baby, finding the time endless, lonely and empty. She missed her friends, a sense of purpose and accomplishment and independence. Although having a family had been an important part of her life plan, she felt intense guilt about her feelings of emptiness and longing for her old life, and could not understand how this had happened when she had planned so well for everything. In addition, Gina's husband, a highly motivated, self employed consultant worked long hours and often traveled for days at a time. Although thrilled with the arrival of his child, he was intensely invested in Gina "getting better," in order to lessen the demands on his time and energy. As we began to focus on Gina's experience of emptiness, and I inquired more about her childhood and parents, important clues began to emerge. Her immigrant parents had come to America and "worked hard" to make a living and raise their children. Gina burst into tears as soon as she uttered the words "worked hard." She realized that an important part of her anxiety was about being home and giving up her job. Despite attending to the constant needs of her baby, she believed that she was not doing enough. She could not rest, she could not just "be" with her baby. She had not even allowed time to grieve her miscarriage before embarking on becoming pregnant again "like a mission," according to her husband. She could not remember her own mother ever just sitting still. In fact, when her mother came to take care of Gina after the baby was born, she had managed to cook, clean, do the laundry, take care of Gina and the baby, and run a few errands in between. Gina realized, "If I am not frazzled crazy busy, then I am not doing enough. This is the way it is at work. This is the way I have always set up my life. Now that I am just home with the baby, I continually feel like I need to be doing something else; like this is not enough, like there has to be something more." Transgenerational script messages (Noriega, 2010), deeply embedded in Gina's postpartum story and now brought to awareness, contributed to a life plan focused on performance, success and accomplishment, significantly impacting Gina's postpartum adjustment.*

The unique nature of postpartum adjustment can also present paradoxes. At times, women who may be expected to experience postpartum difficulties actually flourish and thrive as new mothers. Sarah, 28, presented a perfect example of this. With a history of difficulty completing tasks or establishing a direction in life, she was forgetful, and scattered; constantly apologetic, resolving to become more organized and focused. Although extremely intelligent, she had flunked out of college. In the midst of pursuing therapy, exploring her formidable artistic talents and looking for a career path, Sarah married and soon became pregnant. I was concerned that new motherhood would be immensely challenging for her. How would she be able to care for a baby, when it was so difficult for her to structure her own life? On the contrary. Sarah took to motherhood with a passion, commitment and love she had never before experienced. Paradoxically, the lack of daily structure or predictability suited Sarah perfectly. She thrived and blossomed in the midst of open-ended days devoted to breast feeding and watching her baby grow. As she noted, "I realize now how well suited I am for this. I'm a roll with the punches girl. I feel very comfortable sitting around all day nursing, changing diapers and making silly faces." Motherhood provided an unexpected reparative life experience for Sarah, as she found purpose in her daily life, and comfort in being exactly who she is.

Since postpartum adjustment represents a significant developmental milestone in a woman's life, it is essential that it be explored even with clients with older or grown children; an exploration that is often overlooked by therapists and other professionals unaware of how misunderstanding, embarrassment and shame often inhibit women from discussing their postpartum experiences, thus depriving them of important opportunities for insight and healing. In addition, women who have experienced miscarriages or stillbirths, have adopted children or have served as surrogates, have postpartum adjustments that are often completely overlooked by friends, family and medical professionals.

### ***Case Example: Rachel***

*Rachel and her husband came to marital counseling to address the crippling effects of her anxiety on their marriage and three teenage children. She was constantly anxious, hyper-vigilant and at times terrified, regarding their whereabouts, friends, and activities outside the home. Through many varied and creative manipulations, she found ways to keep the children at home when not at school. When her children were permitted to pursue social interests, they were required to constantly check in with her, and would often have to withstand her anger and resentment in the aftermath of not being included in their plans. Her inability to allow for their emerging and appropriate independence was impacting all levels of family life.*

*Rachel knew she was ambivalent about her children growing up. All she had ever wanted was to be a mother and make up for the family she had never had as a child. As we talked about what it had been like to pursue that dream, I learned about the birth of her oldest child. She had a normal full term pregnancy until she went into labor. When her water broke, she knew right away that there was meconium in the amniotic fluid. By the time she got to the hospital, the baby was in distress, and delivered by emergency C-section and then immediately transferred to a tertiary care hospital. Rachel did not have an opportunity to hold her baby after he was born or see him for the first week of his life. While recovering in the hospital, she was visited by hospital social workers who seemed to be preparing her for the possibility that the baby would not survive. Throughout the ordeal, no one offered any possibilities for her to see the baby or options for her to recover in close proximity to him. To manage her mounting anxiety, she began checking in with the Neonatal Intensive Care Unit almost hourly, telling me "I learned what to ask for.... for example, how are his blood gasses today?" When told that the baby was rapidly failing, she checked out of the hospital against doctor's orders, and went to meet her son for the first time, refusing to leave his side. Remarkably, the baby began to recover, and within days was released. However, once home, Rachel became anxious and over-protective of the baby, afraid to leave the house with him, or allow others to have contact with him as he grew into a colicky, fragile baby, difficult to manage and prone to illness. Gently introducing the idea of birth trauma and postpartum stress, I began to validate and normalize the intense anxiety and fear Rachel had experienced when the baby was first taken from her, worrying that he might die, and unable to protect, hold or help him. She had been required to shut down and override every biological instinct and imperative in her postpartum body. My suggestion that she was actually still recovering from a misunderstood and undiagnosed postpartum trauma brought tears of relief. Eighteen long years of anxiety and parental over protection had been an attempt to tell this long buried postpartum story.*

An anxious mother who obsessively worries about her baby's health, childcare, sleeping patterns or feeding schedules is invariably telling a story from her own past. It is rarely helpful to diminish or dismiss her worries. Sensitive inquiry which supports, rather than judges or criticizes, is necessary to help bring the underlying story of her worry into awareness. A sensitive, caring, relationally based psychotherapy can offer immense support and relief to a new mother, as the relationship with the therapist models, parallels and enacts the very process she must engage in with her infant; inquiry, attunement and involvement, in a relationship designed to provide security, consistency, validation, acceptance and growth. With the reciprocal here and now involvement of the therapist, the new mother can explore and understand her postpartum responses and relational history, while being supported, encouraged and normalized in meeting the relational needs of her infant. As Erskine et. al (1999) writes, "(E)very person, especially every child, requires relationships in which the other person is

reciprocally involved.... clients experience not only the needs of the here and now relationship, but the unmet relational needs of the past as well... the echo of a cry for relationship that has been ringing in the client's psyche for years." (p. 123). Never is this process more apparent than in working with postpartum women.

### ***Mothers Talking Together***

The potent effects of a relationally based approach to working with new mothers is even more powerful when working in groups with postpartum women. Group work offers yet another view of the display of relational needs between the mother and her child, as well as the mother and her peers. When offered opportunities for honest dialogue free from shame and judgment, with the guidance of a therapist able to model normalization, inquiry, attunement and involvement, women experience immense relief, perhaps even the best relief, in discovering they are not alone in confronting the challenges of new parenthood. Reassurance or advice from health care providers, family members or partners rarely carries the same strength as that delivered in a postpartum peer group. To witness another mother struggle through the door with a baby stroller, cry with frustration while trying to soothe a colicky baby, or attempt to manage the intensity of internal criticism and self judgment while juggling baby, home, career and marriage, are all powerful antidotes for the isolation and shame many women experience as new mothers. Cozolino (2006) helps us understand the value of groups through his explanation of the development of the social brain, which is reliant on interaction with others to stimulate mirror neurons and resonance behaviors. Just as the baby needs mirroring and empathy from the mother, so does the mother need social interaction with other mothers to stimulate her mothering behaviors, empathy and resonance with her infant. In addition to providing a venue for the delivery of acceptance, mutuality and impact, these groups provide valuable experiences of social learning, now frequently missing in a culture increasingly reliant on technology to provide information and relationships. Women, their children, and their partners suffer when there is an absence of face to face contact to provide relational needs with other human beings engaged in the process of raising human beings.

### ***Ego States***

Eric Berne's original concept of ego states provides a powerful conceptual and operational model for understanding how a woman may approach the adult developmental task of becoming a mother. Berne (1961) postulated three ego states: Parent, Adult, Child, defining the Parent ego state as comprised of the thoughts, feelings and behaviors of parents or significant caretakers; the Child ego state as comprised of the thoughts, feelings and behaviors of the person's

past, and the Adult ego state as the thoughts, feelings and behaviors of the person's present; a here and now developmentally appropriate approach to the world.

Berne (1961) expanded on ego state theory in his hypothesis of ego state contamination, the process by which ego states overlap and influence present day functioning. Integrative Psychotherapy has further elaborated Berne's ideas by describing a clinical approach based on "the process of integrating the personality... helping clients to become aware of and assimilate the contents of their fragmented and fixated ego states into an integrated neopsyche ego..." (Erskine & Trautmann, 1997). Understanding ego state contamination within an integrative psychotherapy model helps illustrate how many women approach new motherhood. According to Berne (1961) contamination is most likely to occur when the individual is under stress, either internally or externally, thus increasing the likelihood that archaic or introjected patterns of thoughts, feelings and behavior will be called upon to manage stress and problem solving, and encroach upon the awareness of other options for thinking, feeling and/or behaving in the here and now. Since the postpartum period inevitably presents stress and challenge to all domains of the self in relationship, postpartum adjustment is fraught with opportunities for ego state contamination. Even if a new mother has had the opportunity to care for infants in some other personal or professional capacity, she is now presented with a completely new and unique life experience. Her Adult ego state ( neopsyche) is devoid of here and now information and experience about being a mother to this particular infant. Although she may feel immediate "mother love" and attachment to her infant, it is the rare woman who instinctively knows exactly how to care for her new baby in every new circumstances that is presented. Under the stress of physical recovery and psychological adjustment, even under the most optimum of circumstances, meeting the physical demands of an infant is stressful. In the absence of medical, familial and/or social support and information, a woman may understandably access her Child or Parent ego state to inform, problem solve, and manage stress.

Raising a child creates the potential for continuous stimulation of the Parent and Child ego state. Parenting provides a daily opportunity to experience the memories of one's own infancy and childhood as well as be reminded of parental influences (Siegel & Hartzell 2003). In particular, caring for an infant may offer the very first potent reminders of pre-symbolic, pre-verbal memories, often hidden or inaccessible from conscious memory, but held within the Child and Parent ego states and demonstrated through embedded, embodied and/or enacted stories and behavior (Erskine, 2009). How a woman holds her baby, responds to her baby's cries and demands, and approaches the daily challenges of motherhood, can yield a potent clues into not only what her own infancy may have been like, but how she herself was parented. An understanding of ego states and the potential for postpartum contamination helps women integrate

past fragments and introjected fixations, so they may fully encounter and care for their baby in the here and now.

### **Case Example: Leah**

*Leah came to therapy reporting intense anxiety and insomnia as a result of caring for her 4 month old son. Although her early adjustment to motherhood had seemed uneventful, a recent change in his sleep schedule had thrown her into an unexplained tailspin. She found herself increasingly unable to leave her house, feeling guilty about doing anything other than caring for her baby and structuring her days around his needs. She described herself as a highly organized person who likes to keep a schedule, always on time for appointments and events, often just sitting in her house and watching the clock until it is time to leave. Caring for a baby was challenging. As he was changing, so was the daily schedule. She could not anticipate when to go out and do errands, lest she miss his nap time or a feeding. If she stayed home and waited for him to wake up, she became restless, resentful and angry. She was in an increasingly uncomfortable bind of competing needs.*

*An exploration of Leah's childhood revealed an agoraphobic mother who never learned to drive, and kept a strict schedule of household chores and events. Grocery shopping always occurred on Saturdays, dinner was always at 5 p.m., and no-one was allowed in the kitchen because things might get "messed up." In addition, her mother's anxiety led to extreme over-parenting. "If we were thirsty, she would jump up and get us a glass of water before we could do it ourselves. If we needed to cut something out for a craft project, she would take the scissors out of our hands and do it for us. She would do everything for us before we had an opportunity to do it for ourselves."*

*Now a mother herself, Leah knew that she needed to get out of the house and do things for herself and the baby, but could not figure out how to do so. She felt tired and resentful taking care of her son, lonely in her self-imposed isolation and guilty for having these feelings. She felt ridiculous for not being able to figure all this out, compelled to stick to the routine, yet angry at what was expected of her. Leah's postpartum story was a prime example of new motherhood stimulating memories of a little girl raised by an obsessive and frightened mother, as well as the introjected experience of that mother, while desperately trying to function in the here and now. Her inability to modulate this archaic internal battle provided fertile ground for postpartum anxiety and stress.*

## Conclusion

A woman's postpartum recovery enters the arena of psychotherapy because she has been in on-going therapy when she gives birth, has sought therapy soon after childbirth due to postpartum stress, or as part of on-going psychotherapeutic inquiry about her history, marriage and/or relationship with older children. Every new mother desperately seeks to be more than just a "good enough mother." Whether in or out of their awareness, women enter parenting with the intention of being the best mother there ever could be. Difficult or unexpected postpartum adjustment issues are often the first insult to this very understandable fantasy. Healthy psychological postpartum adjustment depends on the ability of family, friends, professionals and the supporting environment to inquire, attune and become involved with the new mother as she reinvents herself into a parent. With the presence of a loving family and community, she can embrace the opportunity to remember, understand and heal old wounds, and avoid the transmission of relational failures to her new baby. Every new mother needs and deserves sensitivity to her unique personal history and current relationships in order to fully understand her adjustment to motherhood. Only in this way can we properly accompany women through one of the most important journeys of their lives, motherhood.

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