1951

A social study of eleven post-partum psychotic patients.

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http://hdl.handle.net/2144/10730

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A SOCIAL STUDY OF ELEVEN POST-PARTUM
PSYCHOTIC PATIENTS

A Thesis

Submitted by
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(A.B., American University of Beirut, Lebanon, 1943)
In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service
1951
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CHAPTER I

INTRODUCTION

Purpose

This is a study of eleven post-partum patients who succumbed to schizophrenic or manic-depressive psychoses within a period not exceeding six months following parturition. The study was undertaken in order to find out if there are any common social and emotional factors in the lives of these women that might be related to the development of their illness. In connection with this general purpose it is the plan of the writer to determine the following:

1. Whether there was a history of mental or emotional illness in the families.
2. Whether there were earlier evidences of personality maladjustment.
3. Whether there were significant factors pertaining to the marital situation.
4. Whether there were similarities in the circumstances of the illness.

It is necessary to point out that this study is descriptive rather than evaluative.

Scope

Since post-partum psychosis as an entity per se does not exist in the classification of the American Psychiatric Association, no such diagnosis was found in the records of the Rhode Island State Hospital.
where this study was undertaken. It was therefore necessary to secure from the field work supervisor, the medical and administrative staff, names of patients that could be used for the study. Eleven cases of post-partum psychotic patients, excluding unmarried mothers and patients in the menopause, were supplied. These patients were admitted during the years 1949 and 1950, within a period not exceeding six months following successful childbirth, which is the time limit set by several authorities for citing parturition as the precipitating factor in the psychosis.

Method

The eleven case histories, selected as described above, form the basis for this study. Material was selected from these records according to a schedule drawn up by the writer to ascertain the facts regarding the questions under consideration. This was preceded by a careful perusal of the literature dealing with the phenomena of psychoses following childbirth.

Limitations

Material in the case records regarding earlier family relationships was somewhat inadequate in that informants were often reluctant to furnish details regarding this subject matter. It is also possible that in some cases, information as to the later history may have been colored by

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1 A copy of this schedule will be found in the Appendix.
the subjective anxieties and guilt feelings of the husbands who served as informants.

It is obvious that a study of eleven cases is not a sufficient number from which to draw valid conclusions. However, it is felt that the material may indicate certain common factors in the illness, which could be significant if used in relation to other similar studies.

Presentation

The general plan for presenting the project is as follows:
Chapter II will be devoted to a description of the psychopathology of post-partum psychosis. In view of the fact that the patients studied were given the diagnosis of either schizophrenia or manic-depressive psychosis, an attempt will be made in Chapter III to review the literature relevant to the diagnosis of the patients. Chapter IV will be devoted to the presentation of the eleven cases, and Chapter V to the analysis of this case material. In some instances, the writer will compare the observations made with those of authoritative studies. Conclusions will be summarized in Chapter VI.
CHAPTER II
DESCRIPTION OF THE PSYCHOPATHOLOGY

Statistical surveys of psychoses following childbirth reveal that the frequency is not very high. Clouston found that post-partum psychoses constituted 5 per cent of the female admissions to mental hospitals, while Kraepelin’s figure was 7 per cent, and Zilboorg gave the figure of 8.7 per cent.\(^1\) In a recent study, Brew and Seidenberg came out with a figure of 3.0 per cent.\(^2\) Despite this small proportion of post-partum cases, all modern writers on the subject agree that the peculiar nature of the illness warrants further social and psychiatric studies for purposes of understanding and prevention, as well as treatment.

Post-partum psychotic reactions are undoubtedly abnormal phenomena, since motherhood is normally the aspiration of all women, and in many cultures the woman’s fertility has been and is viewed as a blessing. Recognition of these abnormal post-partum phenomena, however, is as old as medicine itself.

As late as the 19th Century, medical authorities were divided as to the reasons for psychoses following childbirth; some maintained that the

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\(^1\) Betty Jacobs, "Aetiological Factors ... in Psychosis Following Childbirth," *Journal of Mental Science*, 89:242, 1943.

etiology was physiological, and others claimed it was psychological. In
the progress of modern medicine, the opinion gradually crystallized that
psychotic reactions associated with parturition are like all other psy-
chooses; they are caused by a multiplicity of factors giving rise to pure-
ly functional psychoses which are psychogenically conditioned.3

According to Helene Deutsch,4 reproduction provokes new traumas and
reactivates old ones. If the woman’s ego has been well organized, the
traumas of pregnancy and childbirth constitute a kind of psychic cathar-
sis, and the ego then expands in motherhood. Normally, the reproductive
experience gives woman the opportunity to master old anxieties by mas-
tering new ones. These old anxieties are mainly a certain amount of
helpless dependence, aggressive tendencies of revenge for frustration,
guilt feelings and a desire for masochistic self-punishment, all of which
have been repressed and are unconscious.

This combination of old anxieties centers around penis envy. Although
little girls and boys have the same fantasies about birth, the boy soon
diverts his preoccupation with the "insides" to the outside world, while
the girl gives up her emotional reactions to the lack of an organ and her
interests turn gradually to the idea of the "child-penis." The penis and
the child are identified with each other in that both are considered parts

3 Gregory Zilboorg, "The Dynamics of Schizophrenic Reactions
Related to Pregnancy and Childbirth," American Journal of Psychiatry,
8:733-738, January, 1929.

of the girl's body; femininity or motherliness is an instinctual striving for possession of the envied penis.

Gradually the young girl finds opportunities to be active in a motherly way, such as in taking care of her younger sisters or brothers. As she enters puberty, the girl might become interested in other activities, but nevertheless, desire for the possession of a child always lingers in her mind. When she marries on reaching adulthood, she may fulfill her wish for pregnancy, that is, the wish for a bodily possession, which conceals the old penis envy. The psychopathologically predisposed woman refuses to renounce the established unity (of penis-child), which she has incorporated in her ego. After the unity has been split by childbirth, two tendencies are present in the mother - one progressive, aiming at helping her ego to regain its equilibrium; the other regressive, aiming at reunion with the child and the preservation of the psychic umbilical cord. Whether or not the mother will resolve her new traumas and anxieties in a flight from motherhood, rejection of the baby, and retirement in psychotic regression, will depend on the degree of her ego strength, which is of course determined by the environmental and emotional factors in the course of her development.5

Gregory Zilboorg gives his account of the psychodynamic constellations of post-partum psychotic reactions in the following manner:

The numerous types of energy (oral, anal, urethral), which are deeply rooted in the primary narcissism of the individual and which gradually reach the genital level and thus the Oedipus

5 Ibid., Chapters III, VI and VII.
situation continue to grow and evolve and undergo modification until they achieve a modified sublimatory level in the adult personality. On the other hand, the Oedipus complex loses its genital frankness and incestuous nakedness and in such forms as "love in general," altruism, etc., enters into the adult personality to occupy a central point to which the various modified energies are drawn to be utilized by the adult personality. It is in this way that the total personality then appears to revolve around the Oedipus complex as an axial line and forms a double cone, the lower part of which presents the older reservoir of libidinous energy. If we try now to imagine a woman in whom the Oedipus complex happens to be too strong at one or another level of its active development, "the axial Oedipus line" will then never be actually completed; it will become a weak artificially stretched thread; any situation (such as childbirth) which calls upon fully mature, individual responses to life will make this thread snap, the woman will find herself back at the Oedipus level; moreover, the variety of libidinous energy with which she will find herself primarily equipped at that moment will be the one which will be utilized by the woman for her regression to a lower level. The Oedipus axis having been broken, the line of energy which happens to be the strongest becomes then an axial line of the total personality...... This new axial line, regressive in nature of course, happens to be the anal component of the libido. It is around this axis that the total personality begins to revolve. The constellation, or configuration around this axis could be formulated as follows: Positive Oedipus complex; penis envy of the revenge type combined with a strong anal cathexis.6

It has been said that the trauma of childbirth is a precipitating factor in the reactivation of earlier emotional conflicts. However, as previously noted, only a small minority of married women succumb to psychosis after parturition. It seems logical to assume, therefore, that some women are predisposed to such a breakdown, and that the factors contributing to the weakening of the ego and leading to the development of the illness should be sought for in the social and emotional life of each patient.

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6 Zilboorg, op. cit., pp. 759-763.
In reviewing the works of the medical authorities cited above (namely: Zilboorg, Jacobs, Deutsch, and Brew and Seidenberg), the writer has gathered their findings regarding the significance of certain pre-disposing factors in post-partum psychosis which seem to be related to the four major questions of this study. These findings are listed briefly hereunder, grouped according to their bearing on each of the major questions.

A - Findings pertaining to mental illness or emotional maladjustment in the family.

1 - Mental disorder in the ancestry \(^7\) and/or siblings \(^8\) appears to play an important part in the development of the patient's psychosis.

2 - Alcoholism in the family was a frequent finding.\(^9\)

B - Findings pertaining to personality maladjustment of the patients, and early traumatic experiences which might have a bearing on later adjustment.

1 - The majority of cases studied by Jacobs \(^10\) and Brew and Seidenberg revealed abnormal personality trends of neurotic and manic depressive type.\(^11\)

2 - Jacobs' patients seemed to have had gross psychological

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7 Jacobs, op. cit., p. 250.
8 Brew and Seidenberg, op. cit., p. 413.
9 Zilboorg, op. cit., p. 737.
10 Jacobs, op. cit., p. 249.
11 Brew and Seidenberg, op. cit., p. 413.
difficulties, based on experiences in the parental home, which affected their attitudes toward childbirth.\textsuperscript{12}

\textbf{3 - According to Deutsch\textsuperscript{13} every death of a sibling and every actual or suspected miscarriage of her mother's, becomes in the woman's mind a criminal action perpetuated by herself that may later be atoned for in her own reproductive function.}

\textbf{C - Findings pertaining to the marital situation.}

\textbf{1 - The majority of Zilboorg's cases\textsuperscript{14} appear to have sought little or no contact with men, and hence they were usually married late (twenty-five to thirty-five), usually to men whom they had known since adolescence, or by whom they had been courted a very long time. If some of them married earlier, a history of compulsion on the part of one of the parents or relatives was usually found.}

\textbf{2 - Some of his cases\textsuperscript{15} showed masculine executive ability and many declined to give up their jobs, or did so reluctantly, even after marriage. Deutsch concurs, and comments that under the impact of double activity - home and job - there arises a vicious circle of anxiety and nervousness.\textsuperscript{16}}

\textbf{3 - Deutsch points out that these women are infantile and have deep dependency needs of their own, though they yearn for motherhood. Such women may enter marriage just to defy their immaturity and to compete with their friends.\textsuperscript{17}}

\textbf{4 - It is Zilboorg's opinion\textsuperscript{18} that despite psychosexual handicaps, his patients were comparatively well adjusted and}

\begin{flushleft}
\textsuperscript{12} Jacobs, \textit{op. cit.}, pp. 250, 253.  \\
\textsuperscript{13} Deutsch, \textit{op. cit.}, p. 64.  \\
\textsuperscript{14} Zilboorg, \textit{op. cit.}, pp. 735, 739.  \\
\textsuperscript{15} Ibid., p. 746.  \\
\textsuperscript{16} Deutsch, \textit{op. cit.}, pp. 73, 116.  \\
\textsuperscript{17} Ibid., pp. 116, 272.  \\
\textsuperscript{18} Zilboorg, \textit{op. cit.}, p. 755.
\end{flushleft}
reasonably well satisfied in life; they appeared to be able to adjust themselves to an apparent womanhood and assume all the normal social attributes, including marriage, except complete and unconditional motherhood. This is in contrast with Jacobs, who considered unhappiness of married life a contributory factor.19 Deutsch comments that the husband's passive disposition, his unreliability, and the excessive demands he makes upon his wife, add to the development of her disorder.20

5 - Zilboorg21 and Brew and Seidenberg22 agree that these women are consistently frigid. Jacobs maintains that sexual difficulties are characteristic of all schizophrenic women whether post-partum or not.23

6 - Zilboorg24 and Brew and Seidenberg25 also agree that the main characteristic of the typical personality of these women appears to be a pronounced narcissism with strong attachments to the maternal parent, and that the child is a threat to their narcissism.

D - Findings pertaining to the circumstances of the illness.

1 - Pregnancy generally passes by with no psychological difficulty, according to Zilboorg, who relates this to the desire of the woman for the possession of the penis, which is represented by the foetus.26 If vomiting occurs, it is a manifestation of ambivalence (retention or expulsion of the

19 Jacobs, op. cit., p. 250.
20 Deutsch, op. cit., p. 73.
21 Zilboorg, op. cit., p. 736.
22 Brew and Seidenberg, op. cit., p. 415.
23 Jacobs, op. cit., p. 254.
24 Zilboorg, op. cit., p. 737.
26 Zilboorg, op. cit., p. 750.
Ages on admission of Brew and Seidenberg's patients ranged from fifteen to forty-six; the average age was 28.5 years with the majority around that age. Jacobs found the average age around twenty-five years. Zilboorg put it around the middle or end of the third decade of life and quite frequently in the late thirties.

Zilboorg found that the psychotic process begins in the puerperium and in a few cases in the last months of pregnancy; the acute phase usually sets in within the first six or ten months after childbirth. Brew and Seidenberg maintained that in a manic-depressive psychosis, the onset may occur early in pregnancy.

All four of the sources studied agreed that the psychotic reaction occurs mostly in multiparous women, with a period in between marked by more or less definite withdrawal from domestic interests. Brew and Seidenberg found that there may be moderate to severe emotional upset during or following a previous parturition.

Deutsch makes an interesting interpretation: "It seems to me that in these women - emotionally deranged, schizoid - the psychic balance is harder to preserve when the maternal relationship must be spread to several children than when it is concentrated on one child."

27 Deutsch, op. cit., p. 129.
28 Brew and Seidenberg, op. cit., p. 412.
29 Jacobs, op. cit., p. 252.
30 Zilboorg, op. cit., p. 735.
31 Ibid., p. 737.
32 Brew and Seidenberg, op. cit., p. 411.
33 Zilboorg, op. cit., p. 736; Jacobs, op. cit., p. 299; Deutsch, op. cit., p. 271; Brew and Seidenberg, op. cit., p. 412.
34 Brew and Seidenberg, op. cit., p. 412.
35 Deutsch, op. cit., p. 271.
As to the sex of the baby, Brew and Seidenberg found that it has no correlation with the development of the psychosis, but they quoted Smalldon, who found that the majority of his cases had psychotic reactions following the birth of a male child. 36

36 Brew and Seidenberg, op. cit., p. 413.
CHAPTER III

CLINICAL DIAGNOSES OF THE ELEVEN PATIENTS
(Etiology and Description)

Of the eleven patients under study, eight were diagnosed as schizophrenia, while three were given the diagnosis of manic-depressive. Information regarding these diagnoses is summarized in Chart I.

CHART I

CLINICAL DIAGNOSES OF THE ELEVEN PATIENTS

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<td>Simplex</td>
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<tr>
<td>Hebephrenic</td>
<td>VII</td>
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<tr>
<td>Catatonic</td>
<td>III, IV, XI</td>
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<tr>
<td>Paranoid</td>
<td>I, VIII, IX</td>
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<tr>
<td>Manic-depressive</td>
<td></td>
</tr>
<tr>
<td>Manic</td>
<td>II, X</td>
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<tr>
<td>Depressed</td>
<td>V</td>
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Description of these two types of mental disorder will be reviewed below, followed by a brief discussion of the etiology of mental illness.

Schizophrenia

Schizophrenia is a disease characterized by progressive deterioration of the personality. The individual evades any interest in environmental situations; he shuns reality and actually withdraws into a world of his own where the flight of his fantasies can go along without in-
trusion. He no longer shows normal affect or emotions, and cannot display appropriate feelings of sorrow at times of tragedy or gaiety at times of happiness. There is disharmony of feeling, thought and conduct.\(^1\)

While schizophrenia may appear at any age, it appears most frequently in adolescence or early life. Persons of the asthenic body type, thin and angular in build, are found to be most susceptible to it. Many schizophrenics come from families where there is a past history of mental breakdown in direct or collateral lines.\(^2\)

Schizophrenia usually occurs in persons who have a schizoid or "shut-in" personality. Persons such as these are quiet and serious and oftentimes shy. They lack self-confidence, are over-sensitive of any criticism, are prone to excessive daydreaming, and tend to keep their problems and difficulties to themselves. They are very tense and uncomfortable in the presence of others, and are inclined to avoid people. It must be remembered, however, that many individuals who possess the schizoid type of personality are able to make satisfactory adjustments, and a schizoid personality does not necessarily point to mental illness.

The American Psychiatric Association recognizes four types of schizophrenia.\(^3\) In the course of the illness, however, a person may

\(^1\) Louis J. Karnosh and others, *Psychiatry for Nurses*, p. 131.

\(^2\) Ibid., pp. 129-130.

\(^3\) Lawson G. Lowrey, *Psychiatry for Social Workers*, p. 179.
change from one type to another, and in many instances the various types overlap and result in a mixture of symptoms.

**Schizophrenia simplex** usually begins in adolescence and is characterized by the gradual withdrawal from environmental situations and from reality. The person tends to be dreamy, apathetic and indifferent, lacks the ability to concentrate, and, in general, shows little interest in the outside world. Persons such as these usually appear "queer" and are able to work only under close supervision. It is not uncommon to find that persons thus afflicted become petty delinquents or vagrants.4

The **hebephrenic** type is the term used in referring to that group of patients who display a general childlike behavior. They laugh and grin inappropriately and very frequently show silly facial expressions. This illness is usually gradual in onset and is characterized by preoccupation and loss of all interest in personal appearance. Auditory and visual hallucinations and delusions ordinarily accompany this illness, and masturbation is commonly and openly practiced. It is not uncommon to hear the patient make up his own words and the train of thought is incoherent.5

**Catatonic schizophrenia** is the most acute of the four types and is characterized by an episode of depression, excitement, or stupor, or of phases of all three. In the stuporous episode, the patient is often

4 Ibid., pp. 189-190.

5 Ibid., pp. 182-184.
negativistic, doing the very opposite of whatever is asked of him, and he may remain in bed, completely withdrawn, and ordinarily in one position. The patient may refuse to eat or speak. Hallucinations, paranoid delusions and ideas regarding religion are common.  

The paranoid type of schizophrenia is characterized by well organized delusions, ideas of persecution and sometimes ideas of grandeur. The paranoid person may appear quite normal, but his suspicious attitude toward people makes him particularly dangerous, especially if he focuses his delusions on specific persons. It is not uncommon for a paranoid patient to attempt to defend or avenge himself by inflicting bodily harm. In general, paranoid schizophrenia appears later in life than the other types.

Manic-depressive Psychosis

Three patients in this study were diagnosed manic-depressive. This illness is characterized by periods of elation or depression, or by alternating periods of each. In cases where the patient alternates between elation and depression, he is said to be afflicted with the circular type of manic-depressive psychosis. More often than not, the onset of this illness is acute. Whereas the schizophrenic retreats from normal behavior, both the elated and depressed phases of the manic-

6 Ibid., pp. 185-187.
7 Ibid., pp. 188-189.
depressive are not so different from the moods of the normal individual except that they are more intense. Both stages are considered exaggerated emotional states, and appear to be closely related to reality situations. Attacks of either the manic or depressive type are very often preceded and precipitated by unpleasant environment or family life situations.⁸

The manic phase is characterized by three outstanding phases which include a mood of elation, a flight of ideas involving a quick change from one topic to another, completely different and seemingly unrelated, with no continuity of thought, and an increase in psychomotor activity which is often almost constant and ceaseless. The opposite picture appears in the depressive state, where the mood is very sad, the flow of ideas is greatly reduced and psychomotor activity is sharply decreased.⁹

A manic-depressive psychosis need not be directly inherited, but it is believed that certain individuals inherit the tendency for it. In fact, it is not uncommon to find that this illness may appear frequently in certain families.¹⁰

Persons having a cycloid personality are most commonly afflicted with manic-depressive psychoses. These are persons who are generally sociable, optimistic and ambitious, but tend to be anxious and worrisome. They tend to go to extremes in their moods, being either very

⁸ Ibid., pp. 162-164.
⁹ Karnosh and others, op. cit., pp. 92-94.
happy or very sad. Those of a pyknic type physique are more commonly susceptible to the illness. They are short, obese, broad-chested persons with barrel-shaped trunks.

Although manic-depressive patients usually have more than one attack of the illness during their lifetime, chances for recovery from any single attack are very good. In fact, there are often periods of several years between psychotic episodes when the patient's recovery is complete.

**Etiology of Mental Illness**

Although there are differences of opinion regarding the relative importance of heredity and environment as a causative factor in mental illness, an accepted opinion today is that certain emotional strengths and weaknesses are inherited, that "the seed may be of very great importance, but the soil upon which it is cast and from which it draws its nourishment has an important influence on the crop."\(^1\)\(^1\) This means that in addition to his physical assets and liabilities, each individual has certain innate mental and emotional potentialities which can be developed by proper care, education and training. The future personality and adjustment is determined by two factors, therefore: predetermined innate qualities and complex environmental factors.\(^1\)\(^2\)

Healthy social and environmental factors are conducive to the development of a sound, healthy mind. The human raw material with which

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\(^1\) Charles M. Campbell, *Towards Mental Health*, p. 69.

a new baby is endowed may be modified by life experiences. Although there may be a tendency in some families toward the development of mental illness, the strengthening of an individual's personality by careful training may sharply decrease this tendency.

Each individual is at birth endowed with methods of defense against the actual development of a mental illness. From the very moment of birth, however, according to the personal reactions to his physical and emotional experiences, the individual's resistance varies. If several emotional disturbances occur in succession to the individual, his resistance may be so impaired that even a slight and insignificant disappointment can result in a severe neurosis or even an actual psychosis.¹³

¹³ Edward A. Strecker, Fundamentals of Psychiatry, pp. 32-34.
CHAPTER IV

PRESENTATION OF CASES

One factor common to all the eleven women under study is already known; each, in her reaction to the life situation culminating in childbirth, reached a state of mental disequilibrium which necessitated her commitment to a mental institution. In other words, the ego of each of these women has failed in performing its function under the conditions existing prior to her admission.

The ego in its development and growth is similar to the crop whose seed draws its nourishment from the soil upon which it is cast, despite the innate quality of the seed. Research for the determinants of the reactions of these women should be directed towards the stories of their lives. The cases in this chapter are presented in detail for the purpose of describing some of the social and emotional factors in the life of each individual which may be related to the mental disequilibrium that resulted in a psychosis.

CASE I

Selma, age twenty-four, was admitted two months after the birth of her second child, a three weeks premature baby girl. She had been depressed during the pregnancy, especially the last month, when she became panic stricken and prayed not to have gas; (at the age of nine she had a tooth extracted under gas, which had been a very frightening experience for her). The diagnosis in this case was schizophrenia, paranoid type.

The patient was a quiet child, fearful of dark, lightning and mice. She was her mother’s constant companion. The father was a
strict, hard-working man, and very quick-tempered. The mother was nervous, sensitive, and domineering. The paternal grandfather and an uncle had a history of mental illness. Selma was the third of five sisters, among whom there was much rivalry and quarreling. The mother had difficult deliveries, and the patient was very frightened when the mother's last delivery was done at home. Financial situation of the family was barely adequate.

In her later youth, the patient was of a pleasant nature, though of the excitable and worrying type. She was much concerned about her appearance, as all her sisters were prettier. She graduated from high school and business school, where she was a popular and successful student. She worked as a secretary for two years, gave this up to be married, and resumed work later after marriage. She was quite reserved about dating, and often declared that she didn't want to get married as she was "scared" of childbirth. Selma was very close to her mother, who used to accompany her and the other sisters to the movies and social gatherings before they were married. The patient's habits as to smoking and drinking were moderate, and she was always considered to be healthy. She was very religious and attended the synagogue regularly.

The patient met her husband on a blind date, and they were married after a year and a half of courtship. Her father liked the husband very much, and encouraged the patient to marry him. She was nineteen and the husband twenty-three at the time of marriage. The husband had three years of college; he was a good provider and had a steady work history, although he was a rather emotional and pessimistic person. The patient never showed any interest in sexual activities; she just wanted to please her husband. Patient resumed her work for only one month after marriage, and left because of what she felt was racial prejudice. Her attitude toward her husband varied from extreme suspicion to extreme love. She insisted on living close to her parents. After the birth of her first child, a boy, she was extremely upset and decided to go to work "to forget many things."

This patient's early phobia of dark, lightning and mice is a defense against anxiety, which could be related to the fear of her father, who was strict and quick-tempered. Certainly, the temperamental dispositions of both parents, the sibling rivalry, and the poor cultural background of the parents did not foster the development of healthy defense mechanisms.
Selma did very well in business school, and adjusted satisfactorily in her job for two years. She reluctantly gave up her work to marry, and resumed working again after her first child was born. Her outstanding interest in synagogue attendance in comparison with the rest of her family, including her husband, may be indicative of compensation for underlying feelings of guilt and inferiority.

The patient's relationships with the opposite sex were apparently not normal. One wonders whether she would have married had it not been for the encouragement of her father. Although she made a superficial marital adjustment, she was frigid sexually, and her insistence on living close to her parents reveals her immaturity. The pessimistic, emotional disposition of the husband, and the association, in the patient's mind, of childbirth with the earlier traumatic tooth extraction, may also have contributed to the collapse of the ego and retreat into a psychosis.

CASE II

At the time of admission, Alice was twenty-three years of age; her illness occurred three weeks following the birth of her first baby, a boy. Her pregnancy had been very satisfactory, and she had been happy in making preparations for the baby. However, just before delivery, Alice expressed fear that the child might be born dead. She demanded that her husband hold her tight and embrace her, and was afraid that she would lose him. The diagnosis was manic-depressive, manic.

Alice was rather shy and seclusive in her childhood; she feared lightning very much. Her father was abusive and treated his wife and children harshly. He died of brain hemorrhage when the patient was eight. The mother was said to be of a 'masculine type'; she worked to support her children, and it appeared that she was somewhat overprotective of them. The maternal grandmother died in a mental institution. Although the patient seemed to enjoy doing things around the house, she was envious of her older brother who was "lucky to have no responsibilities."
The patient did not finish high school and preferred to work "to help mother out." She kept on working, first in a laundry and then in a jewelry company, until the seventh month of pregnancy. Alice always had a fear of boys, yet she told her mother once that she wished she were a boy. She used to go on picnics and swimming only with girl friends. She had two particular friends, one of whom her mother did not like because of her reputation as a "bad girl." A great deal of the patient's salary was spent on clothes and beautifying herself. She was healthy physically; had an appendix removed at the age of thirteen. Alice smoked a lot, but never drank; she was devout in her religion and never missed a mass.

The patient and her husband met through their mothers, who were working in the same factory. Courtship and engagement lasted one year. Alice was twenty and the husband two years older at time of marriage. She was not outgoing with him and let him kiss her very reluctantly. The husband had a high school education; he was of pleasant nature, though rather demanding and attached to his mother. The patient decided to work after marriage and did so until the seventh month of pregnancy, despite the protests of her husband, who provided reasonably well. She insisted on living with her mother and felt sorry for her because both of her sons were away. The patient left the housework to her mother, although the latter was working too. Her husband and mother later quarreled a lot and the patient had to "stick up for" both. Sexual relationship was questionable since the patient did not like it very much and just "got it over with." Both enjoyed going to church together, but gave this up during the patient's late pregnancy.

Fears such as the fear of lightning which appeared in this patient's childhood are associated with anxiety, frequently of a sexual nature. The death of her father when she was eight was undoubtedly a traumatic experience for her, and may have reinforced her insecurity and tendency to fear. During her high school period, the patient had many girl friends, but no boy friends, and she evidently did not make a satisfactory heterosexual adjustment. Her mother had a great deal to do with arranging her marriage, and the patient's attachment and dependency on her mother are evident from the fact that she insisted on living with
her and continuing in the role of child rather than wife. She failed to make an adequate sexual adjustment in marriage, and being infantile herself, could not cope with the demands of her rather immature husband.

Although the patient appeared happy during pregnancy, her ambivalence was shown in the fact that she continued to work until the seventh month of pregnancy despite her husband's protests, and in her fear just before delivery that the baby might be born dead.

CASE III

Marie, age twenty-two, was admitted twelve days after the birth of her first baby, a boy. During the first few months of pregnancy, she vomited and was rather frightened of the impending delivery. Later she calmed down, but became scared again on the eve of confinement and was suspicious that her husband might go out with other women. Diagnosis: schizophrenia, catatonic type.

The patient was stubborn as a child and always wanted her way; she had temper tantrums and enuresis. Her father was said to be friendly and sociable, but until a few years ago used to drink excessively. The mother was described as nervous, temperamental, and moody. Once she had a "nervous breakdown." A brother of the father and one of his cousins were patients at mental institutions. Marie, the only girl, was the second of three siblings. A third brother, younger than the patient, died in childhood. When the mother fell sick, the patient became overprotective of her. Marie spoke of how much she missed of what the other girls had as the financial condition of the family was on the marginal level.

The patient left second year high school to go to work. She was not much of a student. She worked as a cashier in a theater "off and on," and then as a sales girl, and continued working during marriage until she became pregnant. She had an occasional friendship with the opposite sex, but did not have a steady boy friend. Marie was very careful about her appearance. She liked driving very much. She was very religious and wanted to go to church "to wash out her sins." She had a tonsillectomy at ten.

The patient and her husband "knew" each other for four years. Marie was twenty and her husband twenty-two at marriage. The
latter had three years of high school, although he was thought to
be of low intelligence. He was reserved in nature, and when angry
he would walk out of an argument. He provided satisfactorily and
the patient managed money matters well. The husband was quite de-
pendent on the patient, and there was some "nagging" between them.
The husband felt that the wife did not satisfy him sexually. She
always wanted to visit her mother and leave him alone at home.

Temper tantrums and enuresis in the patient's childhood may be an
expression of her protest against her mother's rejection of her and
favoring of her brothers. The death of the younger brother possibly
reactivated her guilt feelings about her hostility towards him and the
others. The home situation was notably unhappy due to the father's
drunkenness and the mother's nervous breakdown; the parents surely did
not provide their children with good figures for identification. Due to
poor financial circumstances, the patient also felt deprived of many
things that other girls got from their parents. Wanting to go to
church "to wash out her sins" may be evidence of a reaction to her
feelings of rejection and guilt.

The fact that the patient did not have a steady boy friend for some
time suggests some difficulties in heterosexual adjustment. She married
a boy whom she just "knew" for four years. During marriage, she could
not overcome her dependency on her mother and, being herself dependent,
could not tolerate the dependency of her husband. Sexually, she was
frigid. Her vomiting during pregnancy is indicative of her ambivalence
toward approaching motherhood, and her paranoid ideas that her husband
might go out with other women during her confinement are also note-
worthy.
CASE IV

Violet was admitted at the age of twenty-five, three weeks following the birth of her first baby, a girl. The patient had mild morning sickness and nausea during pregnancy and showed a little irritability at the time when she ordinarily would have had her menstrual periods. She enjoyed sexual intercourse for the first time during pregnancy. Diagnosis was schizophrenia, catatonic type.

Violet could not walk until the age of two. Her parents, especially the mother, had a great faith in the healing power of St. Anne; while the mother was lighting candles at the altar in church, she asked St. Anne to help the patient. When the patient walked, they felt it was a miracle. The patient inherited this faith. She was very dependent on her mother, who was overprotective. Her father was a very strict person and drank heavily. The mother had a mental disorder which required hospitalization; also, she was known to have an I. Q. of only 75. The patient was the second of five siblings, all of whom died at birth or in early childhood. One younger brother, who was his parents' favorite, was drowned at the age of eight.

Violet was known to be a good student and graduated from junior high school. She worked for three years as an "all around girl" in a department store. She was self-conscious on account of her obesity and constantly tried to lose weight. She was of a jocular nature and was well liked everywhere. She kept aloof from boys and preferred the company of girls. One year before marriage she had a boy friend who later "jilted" her because she would not let him kiss her. The patient was religious and attended church regularly. At the age of nine she had a tonsillectomy.

There was only a three month period of steady courtship before the patient and her husband were married. She had known him while going out with her first boy friend. At marriage she was twenty-four and the husband twenty-nine. The husband had a high school education, was ambitious, and of a pleasant personality. He was satisfied with his wife as a person and housekeeper. The couple lived with the patient's parents, and she always consulted her mother before arriving at any decision. The patient consented to sexual intercourse, but never really enjoyed it; she demanded it for the first time during her pregnancy. In the lying-in hospital, she stated after delivery that she wanted to go to work again, and never to have any other pregnancy.

This patient did not have the healthy home atmosphere that fosters
building of a strong personality. Her alcoholic father was very strict; the mother was of low intelligence and had been hospitalized for a mental illness. Death of the three siblings at birth and one by drowning may have intensified the patient's fears of having a child. Undoubtedly these deaths increased the mother's overprotectiveness and, in turn, the patient's dependence on her. The patient's unresolved dependency needs are manifested by the fact that she continued living with her parents even after marriage. Although she showed some dissatisfaction with her appearance, Violet's obesity suggests that she tried to compensate for her frustrations through eating.

When the patient's boy friend kissed her she rebuffed him at the cost of losing him. Within three months after he "jilted" her she married another boy, possibly to negate her feeling of rejection and inadequacy. On the whole she adjusted superficially well in marriage, but did not show any sexual interest. Only during pregnancy did she have a desire for intercourse. Evidences of rejection of her child and herself as a feminine person are seen in her statement about not wanting to have another child.

CASE V

Lea, age thirty-seven, was admitted two months after the birth of a son who was her sixth child. She had four boys and one girl, the first two boys from her first husband. The present illness occurred six years after her second marriage. Mood during pregnancy was excellent; the patient wanted the child very much and so did the husband. Diagnosis was manic-depressive, depressed. After three months at the hospital the patient left against advice, to be readmitted eight days later on a charge of infanticide of her eighteen month old baby girl. She drowned her daughter "because she did not want to leave her at the mercy of men." She herself felt she
was going to die, and "who would protect her daughter then?" the patient asked. Lea had had a previous hospitalization during her first marriage following the birth of her second son when she was twenty-five. Diagnosis at that time was also manic-depressive, depressed.

The patient was a premature child. She was of a seclusive and shut-in nature; had nightmares and temper tantrums. Her father was a chronic alcoholic who was a poor provider. He had a history of immorality, and it was stated that he attempted sexual intercourse with the patient when she was young. Nevertheless, the patient had a strong attachment to him. The mother was a timid, shy, anxious person, and was considered nervous. Lea was the oldest of five siblings - one boy and three girls - whom she had to take care of while the parents went out to work. She felt "unwanted, as if her parents did not care for her." She completed ninth grade and was an average student. Most of the time she kept the company of girls because she felt more secure with them. She wanted to work because her mother was very tired and had a "tough" time with her father. She worked in mills until her first marriage. Her mother did not approve of the marriage as she felt the husband was not suitable. The patient was not happy with her married life; she had extra-marital relations, particularly with her second husband with whom she lived for one year before marrying him. When the first husband died of ulcers, she married the second one. The patient never attended church. She was a chronic drinker, and drank "to forget her miseries."

The patient lived with her present husband for one year although she was married and mother of two children. She was thirty-one and he was thirty-five at marriage. He only had an elementary education and was a barber by trade. He was alcoholic and treated patient harshly. On many days he would not go out to work and hence the financial condition was bad. The patient had to borrow money from her sister. The patient never wanted her husband sexually, but if he came home late at night she used to get upset thinking he might have been with other women. After each previous delivery, the patient had a period of depression with "religious spells."

The nightmares and temper tantrums in the patient's childhood may be evidences of emotional conflict. Considering the unfavorable home situation, it is not surprising that the patient was always a maladjusted person, shown in her later life in her drinking and promiscuity. The mother was evidently a weak and inadequate person; the father showed
evidences of severe personality disturbance in his alcoholism, irresponsibility, immorality and sexual interest in the patient. There was financial deprivation, and the patient was forced into early responsibility in caring for her younger siblings.

In her youth, the patient preferred the company of girls and women. She eventually married a man who was not "suitable," and repeated the same mistake in her second marriage, choosing a man who was almost the exact counterpart of her father in his behavior. The patient was not happy in either marriage; she did not really care for intercourse and consented only to satisfy her male mate. Although the patient was said to be happy during her pregnancies, she had periods of depression following every delivery and twice required hospitalization. In her own words she drowned her daughter "to save her from men," which indicates her own attitude toward men and the extent of her rejection of femininity and motherhood.

CASE VI

Emily was twenty-five at time of her admission, which occurred one month following the birth of her second baby, a girl. (Her first child, also a girl, was born two years earlier.) During the first months of this pregnancy, the patient was lazy and indifferent to her obligations, letting her husband do the housework. Later she became elated. Her diagnosis was schizophrenia simplex.

The patient was a premature child. She was crippled from infantile paralysis in childhood and was always lame. Her father was a heavy drinker. He was an unreliable person, was a sailor and travelled "around the world." He was described as "woman crazy." It was alleged that the father had illicit sexual intercourse with the patient and after this was repeated several times she ran away. The mother was also a heavy drinker and used to go out with other men "to get even with her husband." She was five years older than her husband, and was said to be a domineering woman. The patient's
maternal grandmother died in old age in a mental institution. Her maternal aunts were known to be "sex maniacs," and made a business of it. The patient's younger sister had to get married because she became pregnant. The patient had to care for her younger sister while the parents, each alone, went out at night. The father was not a good provider and while he was overseas, the family often suffered from lack of the necessities of life.

Emily completed one year of high school. At one time she worked as a practical nurse, but then took to drinking. She married at the age of seventeen, but deserted her husband after the birth of their first child, whose care she entrusted to her mother. She served a sentence at the House of Correction for bad behavior; then she went back to her husband and became pregnant again. Finally they were divorced and the second child was given up to the state. Subsequently Emily used to go back home or "entertained" men whom she met in bars. She never went to church.

The patient met her husband in a bar and for six months went around the country with him for fun, indulging in drinks and sexual intercourse. When they got married, she became nice and domestic. She was twenty-one and husband twenty-six at the time. He had only elementary education. He was often laid off from work, and the financial situation was difficult for them. When out of money they used to stay with the husband's parents. The patient hated intercourse but consented to it for fear of losing him. She described men to him as beasts. About two weeks after her second delivery, she demanded sexual intercourse, but husband refused because of her physical condition. The patient dressed up like a nurse and became "over-sanitary" in her care of the baby; she was afraid that dirt might poison it.

One of the earliest traumatic experiences in Emily's life was infantile paralysis, which left her rather lame, and naturally developed in her feelings of inferiority. She had exceedingly poor parental figures to identify with - both were immature, drank heavily, and were sexually unfaithful. The maternal relatives were also known to be corrupted. There was frequent financial deprivation in the patient's childhood because of the father's irresponsibility. Emily gave up school and ran away from home following the traumatic sexual assaults by her father. She was un-
successful in her attempts at work, and may have married to seek refuge, as well as the love and care she had missed at home. The fact that she took to drinking quite early may also show her need to seek gratification in an attempt to make up for her early frustrations and deprivations.

Emily could not make a success of marriage, and deserted her first husband twice, both times after a delivery. She began to frequent bar rooms to entertain men and earn a living. She never enjoyed sexual intercourse, but accepted it from her husband in order to become pregnant. Only after the second delivery did her sexual urge become strong. Emily never attained the stage of positive motherhood; her infantile behavior and pronounced narcissism were evident throughout her life.

CASE VII

Dora, age twenty-seven, was admitted four weeks after the birth of her second child, a boy; the first was a girl born five years earlier. Both pregnancies had been exceptionally good. Diagnosis: schizophrenia, hebephrenic type.

The patient was of the shut-in type of personality who kept all her feelings to herself. It was said that she liked things to run smoothly, never wanted to hurt anyone, and liked to share her toys with other children. Her father was an irritable person who drank excessively. He remarried after the death of the patient's mother, but was later divorced. Dora's mother, who had been hospitalized with a mental disorder, died when the patient was fourteen. The patient's younger sister was admitted to a mental hospital three years prior to her own admission. The father used to take this younger sister away over week ends, leaving the patient alone at home. The house had no electricity so the patient used to light candles and was very frightened. Financial condition of the family was on the marginal level.

As a young girl, Dora had to do a lot of work in the home besides her school duties. She was an exceptional student, but had to leave school and go to work after completing the tenth grade. She always said she wanted to become a nun. She kept on working until marriage and the last job she held was that of an inspector in a
worsted mill. She did not drink, but smoked moderately. She was a Catholic and attended church faithfully. Socially she was liked although she was said to be very reserved with boys. She had a tonsillectomy at the age of nine.

Courtship in this case lasted three years; the couple were working at the same concern. The husband was Protestant but was later converted. He was twenty-one and the patient twenty at marriage. He had a high school education, was said to be of an affectionate disposition. There was some interruption in his wage earning, and for a time they had to live with his parents. The husband had to be absent from home for some time during his service in the Navy. The patient became restless and was afraid of the huge house in which they lived.

As a child, Dora was a very "good" girl, was orderly and somewhat compulsive. She became introverted and shut-in, possibly because she felt rejected in contrast to a younger sister who was favored by both parents, particularly the father. The mental illness and death of her mother deprived her of a feminine figure for identification, and were doubtless very traumatic experiences for her. Dora blamed her father for the lack of financial stability, and hated him for his drinking habits and irritability, and because he used to desert her and leave her alone at home. The presence of a step mother for some time intensified her difficulties.

Dora did not appear to be interested in marriage and declared that she wanted to become a nun. Nevertheless, she was eventually married, after a lengthy courtship, but to a boy who was dependent and attached to his parents. The patient failed to achieve the hoped for security in marriage; she had to face financial insecurity, many demands from an immature husband, and perhaps the "nagging" of the parents-in-law with whom she lived. The later absence of the husband further mobilized her feelings of insecurity. Although she seemed happy during pregnancy she
evidently could not cope with the responsibilities of the second child, and succumbed to illness within four weeks following his birth.

CASE VIII

Lillian had two admissions, each following childbirth. Her second admission, when she was thirty, occurred four months after the birth of her second baby, a boy. Both pregnancies were very satisfactory. Diagnosis was schizophrenia, paranoid type.

As a child the patient was moody and hot headed. Her father was said to be nervous and strict, her mother domineering. There was no history of mental illness in the family. The patient was the youngest of three siblings and the only girl. She envied the attention and praise her mother gave to her brothers.

Lillian made a good school adjustment. After completing high school, she entered trade school to study dressmaking, and worked at this trade for six years, even after marriage. She was of a friendly and cooperative disposition. She would go out with a boy only once or twice and then refuse to go out with him again because she said that he got "fresh." When she menstruated at eleven she became very scared. The patient had a tonsillectomy at eight. She was an extremely religious person.

Courtship in this case lasted only three months. Her mother encouraged the marriage; the patient believed he was "good and not too fresh." She was twenty-five and the husband twenty-seven at time of marriage. He had a high school education. He was dependent on his parents and quite attached to his mother; the couple lived with his parents. They got along fairly well together, but husband was a miser and did not buy her enough clothes. Very often, the patient used to travel hundreds of miles back to her parents' home to get some "rest" from her husband, as he used to annoy her sexually. The husband was in the service for awhile during which time he had to be absent from home intermittently.

The patient's early moodiness may have been a reaction to her sense of rejection by her mother, who showered all her favors on the boys in the family, and thus intensified the patient's feeling that it was better to be a boy. Lillian first showed signs of dissatisfaction with the feminine role at the onset of menstruation, when she became quite upset.
Later on it seemed evident that she could not form satisfactory relationships with boys, and never went out more than once or twice with anyone. Although she eventually married, with encouragement from her mother, the marriage was unsatisfactory in many ways. The husband was himself dependent upon his parents and the couple went to live with them. The patient felt her husband was miserly and that she did not have enough money for clothes. Her insecurity was probably increased by his absences while in the service. Sexual adjustment was evidently not satisfactory, as the patient was "annoyed" by her husband's sexual demands to the extent that she felt she had to go home to "get some rest" from him.

The fact that Lillian preferred to continue working after marriage may be further evidence of her negation of the feminine role. Although she seemed happy during both pregnancies, a psychotic breakdown followed childbirth each time. Since her adjustment before marriage had been very good, it seems particularly evident in this case that the illness was a result of inability to adjust to the role of wife and mother.

CASE IX

Gloria was twenty-four at the time of her admission, which followed five months after the birth of her second son. Mood during pregnancy was characterized by happiness. Diagnosis was schizophrenia, paranoid type.

The patient was a smiling and playful child and enjoyed singing. She was always busy doing things around the house neatly and accurately. Her father was agreeable when sober, but often drank to excess. The mother was said to be meticulous, but a friendly and talkative person. She was Protestant, but reared her children as Catholics because the husband was Catholic. Gloria was the fourth born; there were two other girls and one boy. A brother and a sister younger than the patient died at birth, while two older sisters died in adulthood.
The patient made an excellent school adjustment. In Junior High she won a medal for English composition. She graduated from high school (commercial course) and took extension courses in pre-engineering mathematics and industrial psychology. She began working prior to graduation as a secretary to one of her former teachers. Later she worked as a secretary for a business firm until marriage, and resumed work off and on after the birth of her first child. She was described as a good leader and during the war, she started a club of mothers with young children. She had a tonsillectomy at seven and it was said she was very scared. She attended church regularly.

The patient had been going out with her husband for three years, though much of the courtship was through correspondence, as the boy was in the Navy. Gloria's mother encouraged her to marry him, although he was a Protestant. The patient was twenty-one and he was twenty-three at marriage. The husband had a high school education and was a good provider. He was of a rather serious disposition; later he became very attached to his mother-in-law. The couple lived with the patient's parents for two years. During the first pregnancy, her husband was absent for four months while in the Navy. Sexual intercourse was not satisfactory, as the patient was indifferent and inactive. After the couple went to a distant state, where they lived alone, Gloria was very lonely and continually expressed her wish to go back home and see her mother.

Early in life this patient developed the habit of occupying herself with play, singing, and constantly doing things around the house. Possibly she was compensating for her feelings of inferiority as the youngest sibling and the insecurity engendered by the many handicaps in the home situation, including the traumatic effects of the father's excessive drinking, the mental illness of one and the later death of both older sisters, in addition to the deaths of the younger brother and sister who died at birth. Later manifestations of her compensatory mechanisms may be seen in her continual striving for achievement - in her high school work; in taking a series of extension courses after graduation, in very technical subjects; in beginning work even before she finished school; the assumption of social leadership in her community.
Little is known of her earlier heterosexual adjustment, but more than three years of courtship passed before her marriage took place; possibly she would never have married had it not been for the encouragement of her mother. She continued to live with her parents for two years after marriage, which may be indicative of her immaturity and dependency. Although she made a superficial marital adjustment, she was indifferent and inactive sexually. The fact that she resumed work off and on after the birth of her first child may be an evidence of her inability to accept wholeheartedly her role as a mother.

CASE X

Patricia, age twenty-two, was admitted three weeks after the birth of her first child, a son. During the first six months of pregnancy, she suffered from vomiting spells for which she had to take shots. Diagnosis: manic-depressive, manic.

The patient was described as a calm, quiet and shut-in child. She had to wear glasses from the age of three. Her parents were separated when the patient was six, and she remained in the custody of the mother; the grandmother was also living with them. The mother claims she left the father because he did not work regularly. The patient, however, used to visit him often, and was rather attached to him, although she had not seen him since her marriage. The mother was nervous, domineering and drank heavily; she went out with other men. Patricia was the second of two sisters; there was no social contact between them after they married. The family's financial condition was very poor.

As a young girl, the patient enjoyed dancing and drawing. High school adjustment was average. After graduation, she was sent by a maternal aunt to a school of design for one year. She later worked until marriage at a magazine and book distributing plant. She had many friends, but enjoyed dancing more with other girls than with boys. She attended church regularly. She did not drink and smoked moderately. At the age of ten it was said that she became almost paralyzed, and a tonsillectomy, which was done at eleven, was thought to have cured her.

Courtship in this case lasted four years. Patricia was twenty
at marriage and her husband was twenty-four. Nothing is known about his education; he earned well and recently bought a house. He was described as a reliable and affectionate person, who cried if offended. The couple lived with the husband's mother until the patient's admission, and before the new house was bought. The patient and her mother-in-law got along well. Financial condition was satisfactory. The patient "never bothered about" sexual intercourse. After discharge from the hospital the patient went to live with her own mother.

This patient displayed personality trends different from the normal early in life. The separation of the parents, which occurred at the crucial oedipal period, was a serious psychosexual handicap. The maternal home obviously did not provide a good figure for identification; the mother was nervous, drank excessively, and was evidently somewhat promiscuous. There also seemed to be a problem of sibling rivalry, and it could be assumed from the lack of visits between the sisters after both married that it was never resolved. The patient's serious physical illness at the age of ten and the tonsillectomy which followed should not be overlooked as traumatic factors which may have contributed to the development of her emotional problems.

Patricia apparently did not show a normal interest in boys during adolescence, and the period of courtship before her marriage was also longer than average. Sexually, she was frigid as she "never bothered about" sexual intercourse; yet she was able to make a superficial marital adjustment. Her real ambivalence toward marriage may be shown in the fact that after her discharge from the hospital she went to live with her mother rather than with her husband, in the new house.
CASE XI

Bertha was admitted at age twenty-four, twelve days following the birth of her first baby, a girl. She had slight nausea and vomiting until the third month of pregnancy, but suffered a lot later from constipation. Otherwise the patient was very happy during her pregnancy and prepared many things for the baby, who she hoped would be a boy. Diagnosis in this case was schizophrenia, catatonic type.

As a child Bertha suffered from diarrhea. She was shy and exclusive, and sensitive about her "small-boned" build. The father was a big man, strict, and drank excessively. The mother quarreled a lot with her husband, and was overprotective of the patient. A grandmother of the patient committed suicide in her early twenties by shooting herself some seven months after the birth of the patient's father, a fact which the patient repeated again and again. One great grandfather was mentally sick, and a sister of the paternal grandmother committed suicide by drowning herself as a young woman. For four years the patient's mother was in a mental hospital subsequent to an operation for hernia. When her mother fell sick, the patient was frightened, and was afraid to remain alone at home with her father. The patient was the only child in the family, and the mother had two miscarriages after her. Bertha herself always expressed fear of pregnancy.

The patient completed high school at the age of nineteen. She worked as a lace mender and resigned when she was seven months pregnant. She got along well with other girls, but was very reserved with boys. She never missed a mass. She smoked excessively but did not drink. At eight she had a tonsillectomy. Two years before marriage a small tumor on the right breast was excised; the patient knew about it for some years but failed to see a physician. She used to talk of how small-boned she was and concentrated on improving her figure.

The patient met her husband during his separation from his first wife. They had a short courtship of several months which was later interrupted by his going into the service for about one year. The patient's mother objected to the marriage because she was "too young." She was twenty-two and he was twenty-eight at marriage. The couple lived with the patient's family for one year, after which they moved to a newly constructed home. The husband was a high school graduate, provided well, and according to him, "babied" his wife. Several times she had crying spells during and after sexual intercourse. They enjoyed doing things together, but he refused to go to church with her.
Bertha's life history is full of traumatic experiences of an organic and psychological nature. Psychosomatic symptoms of diarrhea and schizoid tendencies were very early displayed by her. She had witnessed scenes of quarreling between the parents. Neither her relationship with her mother, who was overprotective, nor the relationship with her father, who was strict, and a drunkard, could have fostered a sense of security and confidence in herself or others. The miscarriages of her mother must have left an imprint of fear on her mind, and her mother's mental illness doubtless increased her fears and insecurity. At school she did not do normal work and graduated two years later than the average. Her rigid church attendance is noteworthy, as well as her preoccupation with physical attractiveness.

In the marital situation, Bertha could not perceive of herself as a person independent of mother, and the couple lived with her parents for one year. After they moved to a home of their own, the patient had to be "babied" by the husband. Although she was said to be happy during pregnancy, she suffered from constipation, and her refusal to give up work before the seventh month also suggests her ambivalence toward motherhood. When the baby was born, she refused to submit to unconditional motherhood, which was a threat to her narcissism, and succumbed to a psychosis.
CHAPTER V
ANALYSIS OF CASE MATERIAL

This chapter will be devoted to the analysis of case material presented in the previous chapter, in the light of the four major questions that form the focus of this project. Reference will be made in the discussion to the findings of the authorities cited earlier \(^1\) which appear to be related to the writer's observations.

1. History of mental illness or emotional maladjustment in the family.

Mental illness appears to be a familial factor in all but three of the eleven cases studied. Of the eight cases in which there was a history of mental illness in the family, there was illness in the immediate family of six patients: the mother, in three cases; a sister in two cases, and both the mother and a sister in one case.

These findings are in agreement with those of Jacobs and Brew and Seidenberg (A,1)\(^2\) that mental disorder in the ancestry and/or siblings plays a part in the development of the patient's psychosis. One might speculate not only on the hereditary factor in the illness, but also on the undoubtedly traumatic experiences associated with mental illness in

\(^{1}\) Chapter II, pp. 8-12.

\(^{2}\) For the sake of convenience these and following references will simply be noted by the number under which they are listed in Chapter II; the reader may refer to that Chapter for further information regarding these sources.
the immediate family.

The incidence of alcoholism among the parents of the eleven patients was noted, and the findings are presented in Table I:

<table>
<thead>
<tr>
<th>Parent</th>
<th>No. of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neither parent</td>
<td>3</td>
</tr>
<tr>
<td>Both parents</td>
<td>1</td>
</tr>
<tr>
<td>Mother</td>
<td>1</td>
</tr>
<tr>
<td>Father</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

It is also interesting to note that in two cases, the patients were alcoholic as well as the parents (in one case, the father only; in the other, both parents).

The fact that alcoholism was a factor in the family situation of eight of the eleven cases studied, appears to corroborate Zilboorg's report (A,2) that alcoholism in the family is a frequent finding in postpartum psychoses.

The predominance of alcoholism among the parents of these patients is noteworthy; not only because of the resulting unhealthy home environment, but also because alcoholism is well known to be indicative of underlying emotional disturbances, often of a very serious nature.
There was only one case (VIII) out of the eleven in which neither alcoholism nor mental illness appeared in the family history. However, in this case, as in many of the others, both parents were described as having personality traits which may be indicative of some form of maladjustment.

Although the personality patterns of the parents could not be studied intensively because of lack of information in the case records, the material available was nevertheless suggestive of certain features of maladjustment.

Six of the fathers (I, II, IV, VII, VIII, XI) were said to be strict and/or harsh or irritable. In case X, the patient's mother left the father because he was irresponsible and did not work regularly. The fathers in cases V and VI present pictures of immorality, and in both cases were alleged to have had sexual relationships with the patient. In only two cases (III and IX) was the father said to have an agreeable personality - when sober (both were alcoholic).

Four of the mothers (I, VI, VIII, X) were described as "domineering," and a fifth (II) as a "masculine type;" another (V) was timid and anxious. Three of these mothers (I, V, X) were also said to be "nervous." There was some question of promiscuity in two cases (VI, X). As previously noted, four of the mothers (III, IV, VII, XI) had had psychotic episodes. Only one mother (IX) was described in pleasant terms.

Consideration of these facts reveals a rather striking overall picture of mental illness, alcoholism and emotional abnormality in the family backgrounds of these patients. In not one case could it be said that the family picture was wholesome and "normal," and conducive to
development of a strong and healthy ego structure in the patient.

2. Evidences of personality maladjustment.

The early histories of the eleven patients were studied in order to determine whether there were evidences of early personality maladjustment. It seemed pertinent also to consider such factors as incidents of death in the family, sibling rivalry, early illness, or extraction of bodily organs, which might be related to development of personality deviations.

There were definite evidences in the case histories that nine of the patients displayed early personality deviations, either in the presence of phobias of such objects as mice, dark or lightning (I, II), in displaying introverted patterns (I, II, V, VII, X, XI), or compulsiveness (VII, IX). Two patients had histories of temper tantrums in childhood (III, VII); only one patient had enuresis (III). These findings are in part substantiated by the findings of Jacobs and Brew and Seidenberg (B,1) that the majority of cases revealed abnormal personality trends; however, these appeared to be mainly of a neurotic and manic-depressive type.

In three of the eleven cases there occurred deaths of one or more of the siblings. In one other case the father died, while in another, the mother died. In one case the parents were separated.

Eight patients had to deal with the problem of sibling rivalry. All eight patients had one or more siblings born after them. The other two patients had older siblings. The eleventh patient was the only child, but her mother had two miscarriages after her birth. However, in contrast with Jacobs' finding (B,2), there appeared to be an open fear of child
birth based on experiences of the mother in two cases only.

Relative to these observations is the following quotation from Helene Deutsch (B,3):

Every death of a brother or sister, every actual or merely suspected miscarriage of her mother's, becomes in the woman's mind a criminal action perpetuated by herself that may later be atoned for in her own reproductive function. Even if she is the only or the last child, psychoanalysis reveals that her unconscious behaves as though she had actually experienced all the impressions connected with her mother's having a pregnancy and all the feelings of protest against a child born after her.

One patient (VI) had infantile paralysis as a child and was never able to walk very well. Another (IV) was unable to walk until she was two, at which time she was supposedly "cured" by a miracle. Patient X had some sort of paralysis at the age of ten. Nine of the patients had traumatic experiences between the ages of seven and thirteen that could be associated with the castration complex. Seven had tonsillectomy, one had her appendix removed, and the ninth had a tooth extracted under anesthesia which was a very frightening experience.

In addition, as mentioned above, there were traumatic experiences associated with mental illness in the immediate families of six of the patients studied.

3. Factors pertaining to the marital situation.

None of the patients studied appeared to have made an entirely satisfactory heterosexual adjustment prior to marriage. Four of the patients showed open fear or resentment of the opposite sex; five others were hesitant to establish any relationship with boys. Patient IV was afraid to be kissed; patient VII wanted to become a nun; patient VIII
stated that boys became fresh, while patient X preferred to dance with girls rather than boys. Two of the patients were promiscuous before and during marriage.

Nevertheless, eight of the patients married between the ages of nineteen and twenty-two. In the case of three of these there was an outside influence in that the father or mother persuaded the patient to marry. Two other patients married at the ages of twenty-four and twenty-five respectively, and in the latter case there was influence on the part of the mother. One patient (previously psychotic) remarried at the age of thirty-one (age at first marriage was twenty-five).

Approximate length of courtship prior to marriage may be seen from Table II:

**TABLE II**

<table>
<thead>
<tr>
<th>PERIOD OF COURTSHIP BEFORE MARRIAGE OF THE ELEVEN PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period</td>
</tr>
<tr>
<td>One year or less</td>
</tr>
<tr>
<td>Two years or less</td>
</tr>
<tr>
<td>Three years or less</td>
</tr>
<tr>
<td>Four years or less</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Thus we see in at least five cases the courtship period was longer than one year. This trend toward long courtship agrees with Zilboorg's find-
ings, although the young age at which the majority of these girls married contrasts with his findings. Zilboorg found that women who developed post-partum psychoses seek little or no contact with men, and hence they are usually married late (twenty-five to thirty-five), and usually to men whom they have known since adolescence or by whom they have been courted a very long time. If the woman marries earlier, a history of compulsion on the part of one of the parents or relatives is usually found (0,1).

Surveying the attitude of these women towards work reveals a rather interesting trend:

Patient I was upset following parturition and decided to go to work "to forget many things." Patient II insisted on working until the seventh month of pregnancy, despite the protests of her husband, who was able to provide reasonably well. Patient III continued working after marriage until her pregnancy, although there was no financial need. Patient IV did not continue working, but stated after the delivery that she wanted to go to work again and never have another pregnancy. Patient VIII worked for six years following marriage. Patient IX resumed working after the birth of her first child.

One might speculate as to whether these attitudes may be in part a negation of their role of wife and mother.

Zilboorg found that many of his cases showed nanly executive ability and declined to give up their jobs, or did so reluctantly, even after marriage. Deutsch concurs and adds that under the impact of double activ-
ity - home and job - there may arise a vicious circle of anxiety and nervousness. (C,2)

It is also interesting to note that the majority of the patients seemed to have strong attachments to their own mothers, and that four of them lived with their mothers after marriage; a fifth insisted on living near her mother. These facts may be related to the opinion of Deutsch (C,3), that these women have deep underlying dependency needs; they enter marriage mainly to defy their immaturity and to compete with their friends.

Superficially, there appeared to be a good marital adjustment in at least eight of the eleven cases. However, there is some difference among the authorities on this point. It is Zilboorg's opinion that, despite psychosexual handicaps, these women are comparatively well satisfied in life; they appear to be able to adjust themselves to an apparent womanhood and assume all the social attributes, including marriage, except complete and unconditional motherhood (C,4). Jacobs, however, considers an unhappy married life a contributory factor in the illness; Deutsch comments that the husband's passive disposition or excessive demands on his wife may contribute to the development of the disorder (C,4).

Despite the apparently good marital adjustment in some cases, the histories of these patients show that every one of the eleven felt resentment of sexual intercourse or indifference to it. Zilboorg and Brew and Seidenberg agree that the women who develop post-partum psychoses are consistently frigid; Jacobs maintains that sex difficulties
are characteristic of all schizophrenic women, whether post-partum or not. (C,5)

To sum up, the fear or resentment of the opposite sex, or the hesitation to establish any relationship with boys prior to marriage; the trend towards long courtship; the trend towards continuing or resuming work after marriage or subsequent to childbirth; the strong attachment of a number of the patients to their mothers; the resentment of sexual intercourse or indifference to it, all seem to lead to the conclusion that the majority or perhaps all of these women were not psychologically ready to enter into mature heterosexual relationships and assume the responsibilities of marriage and motherhood. Zilboorg and Brew and Seidenberg agree that the main characteristic of the typical personality of these women appears to be a pronounced narcissism, with strong attachments to the maternal parent and the child is a threat to their narcissism (C,6).

4. Factors pertaining to the circumstances of the illness.

Information regarding the mood during pregnancy is shown in Table III, on the following page.

Mention should be made that information regarding the mood during pregnancy was given by the informants, usually the husband, and may therefore have some subjective coloring. However, the predominance of patients who appeared happy during pregnancy agrees with Zilboorg's findings (D,1). He relates this to the desire of the woman for the possession of the penis, which is represented by the foetus.
TABLE III
MOOD DURING PREGNANCY OF THE ELEVEN PATIENTS

<table>
<thead>
<tr>
<th>Description of Mood</th>
<th>No. of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed</td>
<td>1</td>
</tr>
<tr>
<td>Unstable</td>
<td>2</td>
</tr>
<tr>
<td>Happy</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

Nausea and vomiting during pregnancy, which occurred in four cases, is an expression of ambivalence, according to Deutsch (D,1).

A comparison of the ages of these patients at time of admission may be made with reference to Table IV

TABLE IV
AGE AT TIME OF ADMISSION OF THE ELEVEN PATIENTS

<table>
<thead>
<tr>
<th>Age</th>
<th>No. of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 - 24</td>
<td>6</td>
</tr>
<tr>
<td>25 - 27</td>
<td>2</td>
</tr>
<tr>
<td>28 - 30</td>
<td>2</td>
</tr>
<tr>
<td>31 - 33</td>
<td>0</td>
</tr>
<tr>
<td>34 - 36</td>
<td>0</td>
</tr>
<tr>
<td>37 - 39</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

It should be noted that the patient aged thirty-seven had a previous ad-
mission at age twenty-five; another patient age thirty also had a previous admission, at what age is not known. Range of ages was twenty-two to thirty-seven. Average age at time of admission was 25.7, but it can be seen that the largest number of cases fall in the first group (22 - 24).

This contrasts somewhat with the findings of the authorities as regards to age. In Brew and Seidenberg's study, the age range was fifteen to forty-six; the average age was 28.5, with the majority around that age. Jacobs found the average age around twenty-five, and Zilboorg around thirty. (D,2)

Table V shows approximately within what period after birth the illness occurred.

**TABLE V**

LENGTH OF TIME FOLLOWING PARTURITION AND BEFORE ADMISSION OF THE ELEVEN PATIENTS

<table>
<thead>
<tr>
<th>Length of Time</th>
<th>No. of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within one month</td>
<td>7</td>
</tr>
<tr>
<td>&quot; two months</td>
<td>2</td>
</tr>
<tr>
<td>&quot; three &quot;</td>
<td>0</td>
</tr>
<tr>
<td>&quot; four &quot;</td>
<td>1</td>
</tr>
<tr>
<td>&quot; five &quot;</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
</tr>
</tbody>
</table>

It seems that the acute phase of the illness which required hospitali-
zation set in within the first five months post-partum, the majority within the first month. According to the authorities, the psychotic process may even begin in the last few months of pregnancy; the acute phase usually sets in within the first six to ten months after childbirth (D,3), and the birth of the child is clearly a precipitating factor in the psychosis.

Following the birth of which child the psychosis developed is shown in the following table:

<table>
<thead>
<tr>
<th>TABLE VI</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCCURRENCE OF ILLNESS FOLLOWING THE BIRTH OF WHICH CHILD</td>
</tr>
<tr>
<td>Child</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>First</td>
</tr>
<tr>
<td>Second</td>
</tr>
<tr>
<td>Third</td>
</tr>
<tr>
<td>Fourth</td>
</tr>
<tr>
<td>Fifth</td>
</tr>
<tr>
<td>Sixth</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

The case in which the illness followed the sixth child was one in which the mother had a previous admission, following the birth of her second child. This was the second child of the other patient who had a previous psychotic episode.
It may be seen that in only five of the eleven cases did the present illness follow the birth of the first child. This is in partial agreement with the findings of several authorities that psychotic reactions occur most frequently in multiparous women (D,4). Brew and Seidenberg add that there may be moderate to severe emotional upset during or following a previous parturition (D,4).

As to the sex of the children born just previous to the illness of these patients, seven were boys and four girls. Brew and Seidenberg found no correlation between the sex of the child and the development of the psychosis, but they quote Smalldon, who found that the majority of his cases had psychotic reactions to the birth of a male child (D,5).
CHAPTER VI

SUMMARY AND CONCLUSIONS

It has been the purpose of this thesis to study the case histories of eleven post-partum psychotic patients, to find out if there appear to be any common social and emotional factors in their lives that might be related to the development of their illness.

1. Mental illness or emotional maladjustment in the family.

It was seen that the tendency toward mental breakdown existed in the families of eight of the eleven patients studied. It cannot be doubted that this factor played an important part in the illness of these women, both in terms of inheritance and of suffering the social and emotional ill effects of mental illness in the family.

Alcoholism, which occurred in the families of eight of the eleven cases studied, may also be of significance - not of itself, but as an indication of parental maladjustment and unhealthy home environment.

In only one case was there neither a history of alcoholism nor mental illness in the family. In addition, it was seen that there were evidences of maladjustment in the personality traits of even those parents who did not have a history of mental illness or alcoholism.

In reviewing the case presentations in Chapter IV, it seems evident that none of the patients had a normally happy, healthy home environment; the seed of the ego did not have healthy soil in which to grow and become strong.
2. Early personality maladjustment.

In all but one case the histories show some form of maladjustment, in phobias, patterns of introversion or compulsion, or dependence on the mother. Early traumatic experiences which might be related to the patient's maladjustment appear frequently. Deaths of father, mother, or siblings occurred in the cases of six of the eleven patients, and the parents were separated in one case. Nine of the patients had had operations; one was crippled from infantile paralysis. The probability of traumatic experiences associated with the incidence of mental illness and alcoholism in the families of these patients should be emphasized again here.

3. Marital situation.

Although the material is limited, there appears to be at least some evidence in every case of difficulty in heterosexual adjustment. These findings are borne out by the fact that all of these women later were unable to make a complete sexual adjustment in marriage.

A number of the patients married early, but after a long courtship. However, these findings do not appear to have much significance, in that no definite trend can be noted. The ambivalence of these women towards marriage and motherhood was brought out more clearly in the desire to work which was expressed by a large number. The marital adjustment appeared satisfactory in the majority of the cases.

4. Circumstances of the illness.

It appeared that the majority of these women were happy during pregnancy; were in their middle or early twenties at time of admission; were
admitted following the birth of their first or second child, within two months following parturition. The case presentations show also that most of these women had nervous and upset periods following the birth of previous children; two had previous psychotic episodes.

The main points brought out in this study appear to be as follows: Mental illness, alcoholism, parental maladjustment and unhappy home situations appear to be a factor in every case. Although a few patients showed signs of serious maladjustment, the majority of them were able to make superficially satisfactory social and marital adjustments with the notable exception of sexual adjustment. One might speculate as to whether these women would ever have suffered a mental breakdown had they never experienced motherhood. Most of the women were happy during pregnancy, but all developed a psychosis within five months of parturition. No single circumstance in the illness appears to be significant.

The evidence brings out the significance of child-birth as the precipitating factor in the illness, as well as the multiplicity of factors which may have a bearing on the development of the illness. These factors vary somewhat with the individual, but maladjustment in the family situation appears to be outstanding. It cannot be doubted that the consequent lack of opportunity for healthy emotional development has a significant relation to the woman's later reluctance to enter into mature heterosexual relationships and accept the responsibilities of marriage and motherhood.

Approved:

Richard K. Conant
Dean
BIBLIOGRAPHY

Books:


Periodicals:


APPENDIX

SCHEDULE

I. Circumstances of Illness

Name
Age at time of onset and admission
How long after parturition?
At birth of which child?
Sex of baby
Mood during pregnancy
Diagnosis
Previous psychotic episodes

II. Personal History

Childhood personality of patient
Personality of father
Personality of mother
History of mental illness in family
Family situation
  Social and economic conditions
  Siblings
Adult personality of patient
  School adjustment
  Job adjustment and duration
  Social adjustment
  Physical condition
  Habits

III. Marriage

Courtship
Age of couple at marriage
Personality of husband
Education of husband
Economic situation
Marital adjustment