Beyond pathology: women's lived experiences of melancholy and mourning in infertility treatment

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ABSTRACT

Throughout history, melancholy and mourning are predominantly understood within the tradition of psychopathology. Herein, melancholy is perceived as an ailing response to significant loss, and mourning as a healing experience. By taking the philosophies of Freud, Ricoeur and Kristeva together with relevant social scientific research as a theoretical framework and by drawing on women's accounts of melancholy and mourning in infertility treatment, we offer an exploration of melancholy and mourning beyond this pathological ailing/healing logic. We do so by asking what it means for women to actually live with melancholy and mourning in infertility treatment. In answering this question, we show that women in infertility treatment may have different kinds of melancholic longings: they desire their lost time as a pregnant woman, lost love life and lost future. Within these longings, women derive their sense of self predominantly from their lost past: they understand themselves as the mothers or lovers they once were or could have been. We further reveal that some of these women attempt to escape this dwelling of identity and mourn their losses by (re) narrating their pasts or through performing rituals. While these results show how melancholy and mourning are coshaped in relation to these women's embodied, temporal, sociocultural and material lived context, they also give insight into how melancholy and mourning may be understood beyond infertility treatment. We reveal how the binary dynamic between melancholy and mourning is inherently ambiguous: melancholy instigates a joyous painfulness, something that is or is not overcome through the agonising exertion of mourning. We show, moreover, that underlying this melancholy/mourning dynamic is a pressing and uncontrollable reality of not being able to make (sufficient) sense of oneself. At the end of this work, then, we argue that it follows out of these conclusions' urgency to have context-sensitive compassionate patience with those who live with melancholy and mourning.

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INTRODUCTION

Definitions of *melancholy* and *mourning* have taken on quite different forms throughout history, but they have always been firmly rooted in the tradition of psychopathology. Herein, melancholy and mourning are often understood in a binary relationship: respectively, as an abnormal and a normal reaction to loss, or as a mental illness and a cure. Based on an empirical exploration of women's melancholic and mourning experiences in infertility treatment, this article offers an alternative exploration of melancholy and mourning beyond a pathological logic.[1]

Melancholy has been part of medicine's system of pathology since antiquity. It was first defined as an imbalance of the four humours.[2–4] Over the following centuries, melancholy has manifested in various ways—in fleeting moods, severe sadness, paralysed dwelling, creative madness, delusional thinking or combinations thereof—but the common denominator is that they are understood as responses to loss and transience. For example, Freud—one of the most influential contemporary thinkers about melancholy—understands melancholy as a state of desperate longing for a reconciliation with an object that is lost.[5] In the current post-Freudian era and specifically within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a melancholic response to loss is classified as a specifying feature in major depression.[6] Contrarily, mourning is commonly recognised as a non-ailing, productive and culturally accepted reaction to loss.[7–12] In mourning, people are seen to negotiate and work through their losses, often with the help of rituals that are an integrated part of cultures.[13–15] By implication, such mourning is perceived as a way to overcome the disorderly, melancholic reaction to loss.[16 17]

Systematic empirical studies of melancholy and mourning echo this pathological logic. These—often psychological—studies predominantly attend to melancholy in the context of clinical depression and to mourning as a healing process.[18–27] While such studies are valuable—melancholy may indeed be part of depression, and mourning may be a healing process—there are valid arguments for exploring melancholy and mourning beyond a pathological logic. Defining melancholy as a mental disease and mourning as a way of combating it incorporates normative understandings of ab/normalcy, as well as how deviancy should be dealt with. Moreover, some pathological studies also include assumptions about the nature of human experience and a person's personality.[28 29] For example, some studies reduce melancholy and mourning to subjective mental structures. That is, they interpret these phenomena as merely belonging to the realm of the inner, mental experience of the self.[30 31] This kind of research fails to acknowledge that melancholy and mourning may also be an experience that is shaped within and through a person's embodiment and in her/his/its lived context. Such a reductive understanding is also reflected in the most recent DSM. This manual does not consider how melancholy is shaped within and through a person's life history and sociocultural environment. It mainly

understands melancholy through its emotional symptoms. Other studies understand melancholy as originating in a natural tendency to dwell and despair, and the in/ability to mourn as a personality trait acquired in early childhood.[32 33] In doing so, these studies paint the dismal picture that melancholy and the ability to mourn are predetermined and static personal qualities. The risk of defining melancholy and mourning along the lines of this pathological logic, then, is that one subscribes to a reductive, deterministic and normative template of disease, and to a potentially harmful one. After all, because this normative pathology may very well differ from the actually lived experience of melancholy and mourning, it may work as an excluding or stigmatising force for those women who display experiences of loss, melancholy and mourning, and who cannot or do not want to comply with such defining structures.[34 35]

In our aim to understand melancholy and mourning, we depart from the position that one must look beyond their pathological labelling, take a step back and explore what it means to live with and through melancholy and mourning. Here, we take up the phenomenological assumption that all our lived experiences—and thus also melancholy and mourning—are (made) meaningful for the ways in which we experience and understand ourselves as human beings.[36–41] We consider such meaning-making experiences, additionally, as coconstructed within and through bodily experiences, as well as in a person's sociocultural, material and constantly changing context.[42–47]

In this article, we account for such a phenomenological investigation by turning to women's lived experiences of what may be interpreted as melancholy and mourning in infertility treatment. Our empirical study discloses that, during infertility treatment, the loss of a certain bodily state, a past love life or a pregnancy is a very prevalent experience. Understandably, these women often long for what (or who) they have lost, and/or they try to come to terms with their losses. Describing and analysing such longing and conciliation experiences, we argue, reveal the significance of melancholy and mourning within infertility treatment, and offer a broader and more comprehensive understanding of these phenomena compared with the psychopathological tradition. We disclose and discuss that these women's melancholy and mourning are intrinsically embodied, interspersed with normative discourses and develop while life unfolds itself—aspects that all feed back to how these women construct and reconstruct their identities as women, mothers and partners. We further show that, for these women, mourning—as an effort to overcome their melancholic dwelling in the past—is both narrated and materialised in symbolic rituals of passage and closure. Then, in detailing these arguably context-specific melancholic and mourning experiences, we draw attention to melancholy and mourning's larger characteristics: their meaning-structuring potential within and through their embodied, sociocultural, material and dynamic features—attributes either largely rejected or taken for granted in the existing literature about melancholy and mourning. Before turning to this discussion of our empirical results, let us first elaborate on how we theoretically understand melancholy and mourning, as well as how we use this understanding to identify and interpret women's accounts of melancholy and mourning.

Conceiving of melancholy and mourning

Central to contemporary understandings of melancholy and mourning is Freud's extensive thinking on the subject and that of his successors Ricoeur and Kristeva. These philosophers appear to develop their understanding of melancholy and mourning against the background of a pathological logic. For Freud, melancholy is a highly disabling experience. It is akin to, or at best composite with, the experience of depression. Kristeva largely follows him in equating melancholy with depression. Ricoeur tends to avoid more the melancholy/depression amalgam, even though he still conceptualises melancholy as an experience that needs to be overcome through mourning. Paradoxically, however, within and through their pathologically informed understandings, these philosophers also give insight into melancholy and mourning beyond a reductive pathological understanding, namely as complex, lived experiences. Ricoeur and Kristeva, for example, show that melancholy and mourning may be inherently ambiguous: melancholy may also be sweet, and mourning may be ailing. Moreover, Ricoeur, in response to Freud, argues that mourning requires the difficult work of reworking of one's memories of loss. Given that these philosophers reveal what may be at stake in the complex experiences of melancholy and mourning, we begin interpreting women's melancholy and mourning in infertility treatment by particularly employing Freud's and Ricoeur's work and some of Kristeva's theories as a theoretical framework.[48–51]

In his essay Mourning and Melancholia, Freud understands melancholy as originating in a particular despair over and longing for a reconciliation with a loved object that is lost, something that significantly shapes the way a person makes sense of oneself and one's life. In melancholy, one desires the lost object to such an extent that the present is lived as if it were the past or, at least, as less vivid and meaningful than that earlier time. For Freud, this lost loved object may be a person or an actual object, but may also be some abstraction that has taken the place of one, such as an ideal or an experience. The melancholic person, Freud goes on to argue, intensely longs for the lost loved object, whereby this person comes to be mainly characterised by that loss of and want for that object. 'The shadow of the object', Freud poetically writes, 'falls upon the (self), and the latter could henceforth be judged by a special agency, as though it were (the lost) object'.[52] In this sense, the melancholic person has incorporated the lost object into her/his/its sense of self. Consequently, melancholy comes to be lived as a rather paradoxical identity.[53] After all, incorporating and identifying with a lost object signifies a selfhood as a loss of self as a non-object, and implies a loss of present selfhood, as the melancholic's main characterisation—the longed-for object—is already lost.

In his thinking, Freud emphasises the paralysing effect of the melancholic identity in that the melancholic resides in and identifies with what has been lost and, as such, experiences an incapacity for living.[54] While Kristeva underscores this disabling and annihilating power of melancholy, she also argues that melancholy's lived loss can still be experienced as ambiguously bittersweet. She points out that, however tragic the melancholic's despair over and identification with the lost object seems, 'there is a certain beauty that remains, even more so, enthralls us'.[55] In incorporating the lost object, the melancholic attests that the lost object is worthy to live for, and makes this object more compelling, as it can never be lost again. In this regard, Kristeva describes melancholy as 'a lavishness of that which no longer is, but which regains for myself a higher meaning because I am able to remake nothingness, better than it was and within an unchanging harmony, here and now and forever'.[56]

Whether regarded as an incapacitating dwelling in the past or as an eternal extravaganza of old times, in both understandings of melancholy, we lose the self (as a present non-object) in favour of (the self as) the lost object. To rehabilitate the self, Freud states in Mourning and Melancholia that the task of the melancholic is

to start mourning, that is, to realise the order dictated by reality, namely that the loved object, in fact, has been lost. In doing so, the melancholic renounces the ties that stubbornly attach her/him/it to the object of love.[57] In his later work *The Ego and the Id*, Freud seems to fully recognise that this demand of mourning over and against the melancholic is excessively difficult and may be impossible.[58] As the melancholic has incorporated the loved object into its sense of self, breaking off ties with this object seems to imply that the melancholic loses itself again, but now as a lost object. Then, the question arises what remains of the self to give meaning to itself. For Freud, the self is only restored when the self's sense of self has been reinvested in a new loved object. As such, Freud's mourning theory—as a process of reality testing, detachment and reattachment—is placed within a long-standing tradition in which the subject neutralises the enduring pain of the realisation of the loss by accepting consolation in the form of a substitute for what has been lost.[59]

Ricoeur, however, poses another theory of how to overcome melancholy through mourning, namely one that does not presuppose a substitution of the lost object but a construction of a new meaning of the lost object through the hermeneutical work of memory. Like Freud, Ricoeur argues that, in mourning, we need to submit to reality testing. This, he contends, 'is an integral part of the work of recollection'.[60] In this memory work, the melancholic compares the memories of the loved object with actual reality, through which she/he/it comes 'step by step, degree by degree'[61] to the conclusion that the past has actually passed and that the lost object no longer exists.[62] This way of remembering should take a specific form to break off ties with the lost object without substituting the lost object. Here, Ricoeur distinguishes between a melancholic memory, which is a factual repetition of the past instigated by a desire to relive it, and an exemplar memory. The exemplary dimension of remembering is directed towards the future of the subject—rather than its past—and takes the form of drawing out a remembered meaning of the loved object that may be part of the construction of the subject's self as also a forward-looking—hoping, expecting and so on—human being.[63] Ricoeur further claims that work on remembering the lost object's exemplar meaning is done through narration. While we define and make sense of ourselves through representing past, present and foreshadowed experiences in our stories, such a narrative construction of the self always involves 'altering, eliminating, or dropping some important events according to the kind of plot we intend to build'.[64] In other words, it is in the attempt to build a plot about ourselves and our lives—an effort that is arguably by definition forward-looking—that the past may take on a different meaning, one that facilitates this plot building. Story-telling, thus, is simultaneously the representation of past experiences and the occasion for manipulating those memories towards a different kind of meaning. As such, it is where what Ricoeur calls *narrative mourning* may begin.[65]

Note that, although Freud, Kristeva and Ricoeur are probably the first to acknowledge that mourning and melancholy, like all lived experiences, are shaped in specific contexts, their accounts of melancholic and mourning experiences still seem to assume a rather universalist understanding.[66–68] That is, these philosophers develop ideas about the meaning of melancholy and mourning *as such*. They do not delve into the various ways melancholy and mourning are experienced across different times, spaces and bodies. Consequently, they cannot account for the issue that melancholy and mourning are coshaped regarding their context. Therefore, appreciating melancholy and mourning in their specific context of infertility treatment allows us to sketch a comprehensive understanding of melancholy and mourning with meaning-structuring embodied, sociocultural, material and dynamic aspects. In doing so, we build on relevant social scientific research in our analysis. As we will see, drawing on studies embedded in critically informed understandings of widely used concepts such as infertility, female embodiment, mothering and parenthood, relationships, and sexuality helps to demonstrate how lived experiences like melancholy and mourning are shaped and coconstituted in relation to various non/normative bodies, shared normative ideas, discourses and practices, and their accompanying materialities and technologies.[69 70–72 73 74 75]

Researching melancholy and mourning in infertility treatment

In our phenomenological investigation of women's melancholy and mourning in infertility treatment, we used a qualitative interpretative research method. This method is especially suitable for uncovering what melancholy and mourning mean for these women because it strives for openness: for describing and interpreting experiences and sense-making processes in their own, detailed, changing and embodied terms within the subject's context.[76–79] In this study, we conducted 10 indepth interviews with Dutch women who are or have been in infertility treatment. Within these interviews, these women were asked to tell about their infertility treatment in general. Even though they were not explicitly asked to talk about experiences of loss, all the interviewed women explicitly narrated such experiences. While all interviewees described losing something or someone in the process of infertility treatment, not all women conveyed experiences of melancholy and mourning in their stories. That is, 8 out of 10 women implicitly or explicitly narrated their melancholy and mourning. Some women referred to themselves as 'melancholic' and/or 'in mourning', while others repeatedly referred to what the authors interpreted as melancholic and mourning experiences, namely intense and desperate longings for what they lost and attempt to come to terms with losing. The women who qualified themselves as melancholic or in mourning and/or displayed melancholy and mourning experiences in their interviews were included in this study.

The recruitment of the interviewees took place through advertisements on public fora: on a site for the so-called 'wish mothers' and on the website of Freya, the Dutch patient association for women in infertility treatment.[80] In this advertisement, we stated that we were interested in women's subjective experiences of infertility treatment and invited women who are or were in such treatment to talk about their experiences on their own terms. At the time of the interview, some women were still in infertility treatment, while others had finished their treatment with or without the outcome of a pregnancy and/or having a baby. These women, moreover, cover a wide variety of medically assisted infertility treatments: some had one or multiple cycles of in vitro fertilisation (IVF). Others had intracytoplasmic sperm injection (ICSI), intrauterine insemination (IUI) or a (serial) combination of these treatments. While these treatments differ in nature, they all include invasive procedures. All the women in this study took hormone medication, had blood tests and underwent transvaginal ultrasound scans. Women who have had IVF or ICSI, moreover, had their eggs collected by way of transvaginal aspiration or abdominal surgery, and got the fertilised egg reinserted in their uterus through a large needle or catheter. Those who had IUI, furthermore, had washed sperm inserted through a catheter. As the success rates of medically assisted reproduction treatments vary between 4% and 50% per treatment cycle, some women in this study ended up having a baby, while others did not (yet). The age of the women in this study

Table 1 Respondents' details

Name (age)	Personal and medical background
Erica (35)	3 IVF attempts, 4 ICSI attempts, currently doing a fifth ICSI attempt. Several pregnancies, one stillbirth at 28 weeks. No (living) children.
Gwen (29)	2 IUI attempts, 2 IVF attempts. Last attempt was successful. Has a daughter.
Fay (44)	4 IVF attempts. Last attempt was successful. Has a daughter.
Leanne (43)	3 ICSI attempts, 5 IUI attempts. Had a miscarriage 11 weeks into her pregnancy. No children.
Roxanne (46)	6 IVF attempts over 17 years, last one successful. Has a son. Cannot have infertility treatment (for a second child) because of medical reasons.
Kate (41)	5 IUI attempts, 13 IVF attempts, 2 of which were successful. Has a son and a daughter.
Emily (45)	3 ICSI attempts, 2 IVF attempts. Had to stop infertility treatment because of age restrictions. No children.
Josephine (33)	3 ICSI attempts. No children.

ICSI, intracytoplasmic sperm injection; IUI, intrauterine insemination; IVF, in vitro fertilisation.

ranged between 29 years and 45 years old, and they were all in a long-term relationship with a male partner.[81] See table 1 for the interviewees' details.

The interviews took place at the interviewees' homes or at another place of their choice. During the interviews, the women were initially encouraged to talk freely about their infertility treatment experiences in general. This resulted in interviews from 1.5 to 2.5 hours, during which the women, among other things, elaborated on bodily treatment experiences, the wish to have children, relationships with partners and experiences of loss. Note that, in these interviews, women did not just *represent* their infertility treatment experiences. While talking to the interviewer, these women also *coconstructed* their experiences again or anew.[82] One woman in this study, for example, even started to remember forgotten details about her stillbirth. All interviews were digitally recorded and transcribed verbatim. On transcription, all interviews were anonymised. In the current article, pseudonyms are used to refer to the interviewees. Only the interviewer—that is, the first author—knows the identity of the interviewees. Quotes from the interviews were translated from Dutch by the first author of this article.

In the analysis phase, the first author closely read the interviews with women about their lived experiences in infertility treatment. Herein, loss, melancholy and mourning appeared to be significant aspects in infertility treatment. In focusing on these women's lived experiences of melancholy and mourning, the first author attributed paper-based descriptive, open codes to excerpts of the interviews that relate to these phenomena. These codes grasped women's melancholy and mourning on a general level. Examples of such codes were 'ritual practices' and 'bittersweet melancholy'. In the process of reading, coding and rereading (already coded) interviews, the first author recoded the interviews and eventually arrived at a set of more specific codes that included the spectrum of women's melancholic and mourning experiences. Examples of these codes were 'longing for a pre-infertility treatment life', 'bittersweet desire for past pregnancy' and 'meaning-making mourning rituals'. Based on these codes, more general storylines involving melancholy and mourning in infertility treatment were drawn out in consultation with the second and the last author of the article. This analysis resulted in a concurring identification of three kinds of melancholic longings: for lost pregnancies, lost love lives and lost futures. Subsequently, this study reveals that some women try to overcome their melancholic longing through narrative and/or ritual mourning.

Three melancholic losses and several mourning practices

Given that most women in our study have been pregnant but do not necessarily bring these pregnancies to term or give birth to a living child, the first of the identified melancholic longings is women's desire for these pregnant times and, by implication, for their lost (potential) children (see the Lost pregnancies section). Second, even though all the interviewed women are in a long-term relationship, several of them speak of losing their partners and/or aspects of their relationships in the process of infertility treatment. These women long to return to a better love life (see the Lost love lives section). Third, many women who have had unsuccessful infertility treatments talk about the longing for lost possible futures in which they are or were able to become mothers (see the Lost futures section).

Although these women's various longings for what they have lost are intense, sometimes, even all-encompassing, some women reveal attempts to release their past and to move on. Through remembering, narrating and renarrating their past, these women try to mourn their losses and bring about new meaning for their lost past and for themselves in relation to this past. Given the difficulty of this meaning-making task, several women adopt additional strategies in their mourning process. Through performing rituals, some celebrate accomplishing the journey of arriving at a new meaning (see the Lost pregnancies section). One woman even intends to enforce the construction of new meaning by performing a ritual (see the Lost futures section).

Lost pregnancies

Although all the women in this study have infertility challenges, most of these women have been pregnant at least once. With two exceptions, these pregnancies were the result of infertility treatments. While some women carry their pregnancies to term and have a baby, others miscarry or have a stillbirth. These latter women typically articulate what the authors interpret as a melancholic desire to return to when they were pregnant. This melancholy can often be traced back to a longing for what a pregnancy foreshadows: the future horizon of having a baby. However, some women also refer to the ways they can give meaning to themselves and their fetus *during* their pregnancy. Erica's story exemplifies this. Having had a stillbirth 28 weeks into her pregnancy, she struggles with the question whether she is a mother. At the beginning of the interview, she reflects on how she felt when she was pregnant:

> I felt like a true woman. Yes, I would give anything to experience that again. (…) The feeling of being a mother, oh, yes, so nice. I've experienced that; I had a son. (…) Or well, a mother, I don't know, am I? (long silence) It's hard. Awful (…) Am I? Are you a mother when you don't have a child? Oh, I don't know…

Erica's words show that she longs for the feeling she had during her pregnancy, when she felt like a "true" woman and, as she hesitantly says a few sentences later, a mother. It may be argued that her longing for these two identities are intimately connected and coshaped through cultural discourses about normative womanhood. Although in Western societies there are increasing, multiple options for women to comply with accepted womanhood, such societies are still very much pronatalist.[83 84] Erica's longing for her pregnancy, then, may be interpreted as being shaped by the joyous experience of culturally approved

womanhood through the feeling of being a mother. As such, her narrated experience shows us that melancholy is not lived and shaped within a mental vacuum—something a major body of psychopathological research assumes—but, rather, is situated within a sociocultural realm.[85 86] In line with Kristeva's understanding of melancholy as 'bittersweet', Erica's account reveals that this normative longing has the double bind of being signified by sadness and by joy.[87] Her melancholy, in other words, is coshaped through her lived happy memory of her pregnancy, in which she complied with normative cultural understandings, in this case, about the inseparable connection between women and motherhood.[88] Simultaneously, Erica's longing for these pregnant times is also a source for severe sadness: with losing her baby, she cannot actually live motherhood. Consequently, she struggles with how to make sense of herself, that is, with answering the question of whether she is a mother. In this sense, Erica's melancholy may be interpreted as a desire for the blissful existential darkness of always having the lived memory of the anticipation to coincide with the norm of being a true woman (as a mother), while having the knowledge that this anticipated life will not be lived.

Later in the interview, Erica returns to the issue of questioning her identity as a mother. By talking about her stillbirth with the interviewer, she remembers forgotten details about the hours just after the delivery, most vividly her lived experience of how she held her son. In the following excerpt of the interview, it becomes clear that, in this renewed lived-through memory, she acquires a new understanding of herself as a mother[89]:

> Erica: "I held him. It's a bit of a blur, sorry. … He was given to me (by the nurse just after the delivery); I know that."
> Interviewer: "Do you remember how? How did that go?"
> Erica: "I don't know… It was in the wrong way. *pauses* It was; it was. His head was all wrong, too low. I… *starts crying*."
> Interviewer: "How wrong? Can you show me?"
> Erica: "I wanted him higher up, here on the bump of my breast. *shows the interviewer the ideal position on her chest* (And) he was here. *shows where he was put on her chest and then pauses to blow her nose* All wrong. I think that (the former position) was the most comfortable for him. (…) I knew it immediately (how to hold him). It felt so natural … so natural … *pauses* I'll be a great mother someday."

Through narrating her story, Erica relives the pain of losing her son and acquires a renewed remembered experience of holding her baby: she remembers how she held her baby and that she immediately knew how to hold him. Through remembering this postdelivery moment, she can conform herself as "a great mother someday." While Erica's acquired memory does not seem to give her an answer to whether she *currently* is a mother, it does enable her to understand herself as *becoming* a great mother. In this sense, we may argue that we see Ricoeur's narrative of mourning in practice.[90] We see how narrating the lost past helps in remembering and, subsequently, how it assists with remembering losses differently, namely in a way a certain exemplary meaning of a memory is narrated that feeds into a forward-looking—instead of only a backward-looking or longing—understanding of oneself. In Erica's case, this means that, while she was preoccupied with the question of whether she has become (and still is) a mother, by narrating and working through her memories of loss, she now understands herself as a future great mother.

Like Erica, Leanne also longs for her pregnancy. As a result of IVF treatment, she was pregnant for 11 weeks. This pregnancy made her feel like she had a child and, by extension, that she was a mother—a feeling that she still longs for today. Interestingly, this way of making sense of herself and her fetus developed in the few weeks before her miscarriage. She narrates her longing as follows:

> I dream of it (being pregnant) every night—how fantastic it was. (…) And when we lost it (the fetus). Horrible, yes, yes … Well, it felt like we lost more than just cells. It was alive, life we created together. (…) The power that comes from the (ultrasound) images of … pff … it could only be a child. (…) I felt like a mother then.

Leanne's words reveal that her way of understanding her fetus as a child and herself as a mother is shaped by a specific meaning of the senses in modern-day pregnancy practices. Nowadays, sonogram technology allows a sensory experience of the fetus early in the pregnancy—and one that can be shared with others—and, we maintain, envisions the fetus so that it may transform the pregnant woman–fetus relationship into a mother–child one. Verbeek argues that the ontological status of the fetus as a child comes about in ultrasound imaging because the fetus is explicitly 'made present as a separate living being',[91] that is, independent from the body in which it is growing and with a 'representation on the screen that makes it appear to have the size of a newborn baby'.[92] For Leanne, then, it seems this specific technological mediation of seeing her fetus in isolation from her body shapes her understanding of her fetus as a child and her (early) pregnant self as a mother. With her miscarriage, she lost this sonogram-induced lived identity of being a mother, and she still longs for it today.

In her interview, Leanne displays a technologically mediated melancholy, and her attempts to overcome it and the various difficulties that accompany it. Like Erica, Leanne mourned her losses through narrating her past to—she says—"make peace with that time (of not maturing her pregnancy)." "It was very hard," she recounted, "because I relived the pain every time I talked about it." For Leanne, narrative mourning was also difficult because her miscarriage stories were not always welcomed—or even tolerated—by her social and work environment. As her friends and family—in her words—"grew tired of the stories," she elected an intense therapy trajectory. Her company's doctor urged her to start working full time again, thereby forcing her to stop her therapy sessions. Leanne's account suggests that she is pressed to comply with what is, apparently, an accepted duration of longing for the past and trying to overcome her longing through story-telling. Thereby, she is given neither the appropriate time nor attention to mourn. Eventually, Leanne says this resulted "[in that] I basically had to deal with it alone. It was difficult, [and] it caused a burnout in the end." Moreover, Leanne states that her mourning process was difficult because mourning's pivotal aspect of talking about losses "does not promise anything." Indeed, story-telling efforts do not guarantee that overcoming one's longing for the past will come about. As such, we argue that Leanne's account shows us that Ricoeur's narrative mourning practice may be understood as a conditional unconditionality: women need to tell their stories to mourn, but the hoped-for result of story-telling—drawing out an exemplar memory that may reconstitute the self as forward-looking—remains an unconditional surplus of these women's story-telling.[93] Narrative mourning, in this sense, adheres to the paradoxical task of complying with mourning's condition of story-telling, even though successful mourning remains unconditional. Leanne seems to deal with this difficult mourning by ritualising her meaning-making process. She says that, when she was finally "at peace" with having miscarried, she needed to

let go of the lost pregnancy. For Leanne, this had a quite literal meaning. When she miscarried, she collected the fluids by sitting in her bathtub, put—what she believed was—the fetus/her child in a jar, and saved it in her nightstand for many years. First, the jar made her feel like "it (her child, the fetus) is still with me," but when she was ready to move on, she recalls that she felt that it needed to be buried. This burial can be interpreted as the performance of a rite of passage in which she, through a spatial reconfiguration of a material memento, symbolically marks the end of her struggles and celebrates her life passage into a new and changed meaning of herself and her life.[94] That is, saving the material remains of the fetus nearby seems to appropriately mark a time when she could not release the fetus, whereas the burial of the jar indicates an effort to let go.

Lost love lives

Infertility treatment is a taxing experience: the interviewed women describe the procedure's physical invasiveness and the emotional rollercoaster that comes with it. These treatment aspects bear on women's relationships. Some women describe a greater sense of intimacy with their partner—reporting that they "do it together" (Leanne) or that their partners have been "their rock" and a "great support" (Roxanne). Conversely, others emphasise the negative consequences of dealing differently with the treatment. They report more fighting with their partner (Josephine and Kate), or they become estranged from one another (Fay). All the participants emphasise the negative impact of infertility treatment on their sex lives. Many of them narrate that conceiving a baby has become an all-consuming quest. Accordingly, their sexual relationships are primarily instrumental, for the purpose of becoming pregnant. Many women in this study also state that their sex lives have changed because of the side effects of hormone medication. They report a decrease in libido, severe mood swings, or other bodily changes like a dry vagina and sensitive breasts. These alterations may be permanent or last long after the hormone treatment has ended. They may result in a less pleasurable sexual experience and/or a decreased frequency of sexual relations—up to the point that two of the interviewed women have not had sex in years.

Most women who report such relationship changes state that they often long to their preinfertility treatment lives, especially to their preinfertility relationships. They describe their wish to go back to a more emotionally stable and harmonious time or when their non-hormone-affected bodies allowed them to have better sex lives. These women's longing, we argue, is coshaped by sheer bodily and emotional discomfort, and by the factor that their post-treatment bodies fall short of the normative concept of a 'good relationship'. That is, these women seem to experience the side effects of their hormone treatment—a decreased libido, mood swings and a dry vagina—as undesirable, uncomfortable and even debilitating as they interfere with what several scholars argue is a modern romantic heterosexual relationship ideal.[95–97] Among other things, this ideal pertains to the idea that stability is the foundation of a love relationship, that partners engage in regular sexual intercourse by way of penetration, that both are regularly aroused by one another, and that such arousal translates into bodily fluids, which allow (painless) penetration. These women's wish to revert to an unaffected, preinfertility treatment life and body seems, at least in part, to be instigated by the experience of not being able to live up to this ideal (anymore).

More than merely expressing this ideal-affirmative melancholic wish, both Josephine and Fay even state that, considering their current changed bodies and lives, they regret opting for infertility treatment. Fay says:

> I've lost a lot. My loving husband, basically, (and) a healthy body. (…) A great, super life. (…) We have lost too much because of it; we lost each other. (…) We're lost.

What is interesting in Fay's account of regret and melancholic longing is that her infertility treatment—unlike Josephine's—was a success, medically speaking: she conceived and had a daughter through IVF. Consequently, her longing for the time before infertility treatment is deeply conflictual. She elaborates:

> So, you're the first person I'm telling this to. (…) Then (before the infertility treatment), I didn't have what I wanted the most (ie, a child). Now I do, and I still want it as bad as I did then, but I would go back in a heartbeat (to her life before her infertility treatment) if I could. (…) But (she would go back) only if I did not know how wonderful she is (her daughter). (…) You cannot say that in real life. It's just that I didn't know what I had, how lucky I was. I was totally preoccupied with that (having a baby). I don't want to sound ungrateful. I am. I mean, so many people helped me with that (having a baby). But well, it's just not that easy.

In her statement, Fay expresses a temporally entangled and complex melancholic experience. While she presently lives what she had longed for before—having a child and being a mother—she now longs to return to the past where this lived present was not (yet) lived. More than that, she longs to revert to a past that she, when she actually lived it, took for granted. She said that, in earlier times, she did not appreciate her luck and was only directed towards her hoped-for future of having a child. In this sense, we may say that she longs for a past that she has never actually lived, that is, for a lost present that never really existed.

Fay's wording, however, seems to contradict that she has never actually lived that particular past. While she merely points to her actually lived present—"it" or "that" as in: (having) a baby—she gives detailed descriptions of what she has lost (but never had) and adds many adjectives—"*loving* husband," "*healthy* body," and superlatives like a "*great, super* life." Yet we may argue that such wording exactly fits her melancholic longing for a non-lived past. After all, the hermeneutical tradition teaches us that, in our stories, we represent our experiences and construct them.[98] By adding lively wording to accounts of our past, these pasts become lived—again or anew—within and through our stories. In this sense, we could interpret Fay's descriptive and detailed account of the past as an attempt to *construct* a lived experience of a past she never actually lived.

What further stands out in Fay's melancholy account is that she begins by saying, "you're the first person I'm telling this to." It may be interpreted that she has not shared this experience with others for two reasons. First, Fay's silence can be connected to her statement that her wish to go back to a life with a happy relationship implies a (preinfertility treatment) life without a child, even though she states that she still wants to have the child she now has. Here, we see that Freud's (1958) asserted decreased meaning of the present in favour of the liveliness of the past may imply a cultural taboo.[99] That is, for Fay, keeping her melancholy to herself seems to be related to the taboo of longing for a past, childless life when one is a mother.[100 101] The fact that Fay's desire only implicitly points to a childless life and, therefore, is rather ambiguous and very indirect, underscores the intensity of this taboo in our culture. Second, Fay's silence also seems to be connected to the idea that she does not want to appear ungrateful because, as she says, "many people helped me with

that (having a baby).” While she does not say to whom she refers, it may be argued that Fay (also) refers to her doctors and other medical professionals. Similar to what Garner documented, then, Fay’s words may hint at the unacceptability of being—or even appearing to be—ungrateful to biomedicine in infertility treatment.[102] Biomedicine is perceived as offering women the privilege of a time-consuming, often expensive opportunity of having a baby. Then, in the situation of being granted the lived reality of infertility corrected by biomedicine, even hints at feeling ambiguous about this lived reality seem unacceptable.

Lost futures

While melancholy is generally seen to refer to a longing for a past, our study shows that it may also include the longing for a certain future.[103] Indeed, the above-described accounts of melancholy over past lives and lost persons also adhere to the loss of a certain kind of future. For example, women adhere to a lost future as a mother within their desire for their lost pregnancy. Alternatively, when referring to a lost love life, they implicitly refer to the loss of a future with a happy relationship. Occasionally, however, women explicitly refer to their lost futures, namely where the primary object of their melancholy is a lost possibility. This is the case for most women for whom their infertility treatment has not been successful and/or for those who had to stop infertility treatment because of age restrictions, health risks or financial reasons. These women long for the lost possibility of being a mother. Emily is one of them. She underwent several, unsuccessful rounds of infertility treatment. On the day she turned 44, she had to stop her treatment since her insurance only covers the treatment up until the age of 43. For Emily, longing for the days in which she was in treatment is intimately connected to her longing for a future in which she is a mother. She elaborates:

> I think back a lot to that period in my life. It (her infertility treatment) was so horrible, yes, with the uncertainty and that you do not know what will happen. But also, well, (that was) better than now. It was still an option (to become pregnant), you know. (…) A sense that you can do something about it (ie, the possibility of becoming pregnant). I had a routine, taking my (hormone medication) shots, exercising, supplementary pills, going to the hospital. The doctors telling you what to do, even. *laughs* It was nice to have that. (…) I am not ready to move on just yet. The possibility, yes, yes, I know, fantasy (of being able to become pregnant) still haunts me. And I like it in some way.

Although Emily experienced her infertility treatment as “horrible,” she still longs for those days. She even mentions liking her longing. The treatment provided her with a possible future of being a mother, something no longer possible. As such, Emily’s melancholy may be characterised as bittersweet, that is, as a vain hope—or “fantasy”—for her presently determinate future to become indeterminate again.[104]

In addition, Emily’s account reveals a chimerical inability to let go of a lost, indeterminate future. It adheres to an inability to relinquish a sense of having control over this future. Her infertility treatment opened up the future of motherhood and provided her with a range of practices—taking shots and supplementary pills, exercising, visiting the hospital and following doctors’ orders—that gave her a sense of control in attempting to transform that possibility of being a mother into an actuality. In the end, the possibility of motherhood turned out to be a “fantasy,” and her sense of control over transforming that possibility was fictional. Despite her best efforts, that possibility did not turn into an actuality. It seems that, for Emily, her possible future of motherhood—and with it, her sense of having control over this possibility—was taken from her because of an institutionalised policy of age-appropriate motherhood. It is argued that this policy is only to a limited extent based on medical knowledge about infertility treatment’s health risks and more so on cultural norms about the age of a ‘good’ mother.[105] Accordingly, while biomedicine seems to provide a sense of control over one’s future, Emily’s account reveals that (not) having this sense of control—and, by implication, longing to having it again—is predominantly based on shared cultural ideas about appropriate motherhood.

Like Emily, Roxanne longs for the lost possibility of becoming a mother through infertility treatment. Two years after Roxanne’s son was born because of IVF treatment, she wanted another child. Unfortunately, another round of IVF treatment was considered too much of a health risk for her. Therefore, Roxanne’s desire to become a mother again has taken the shape of longing for the time in which she could endure infertility treatment. Recently, though, she has tried to mourn her losses and reorient herself to her future again. Besides elaborating on her mourning strategy of talking about her losses, she also details the pursuit of another approach to mourning:

> I’ve been working hard to just be happy with what I have (and) focus on the chapters (of her life) to come. (Therefore,) I really wanted the embryo home: I couldn’t bear that it was just in some (nitrogen) tank in the hospital. (…) Oh, how difficult that was! They (the hospital staff) said (in a patronizing overtone): ‘Madam, you can’t just come and get it. That’s not how it works.’ They wanted me to donate it or something. What a headache case! (…) Now, the embryo is lying here (in straw, at home), waiting for me to do something with it. (…) I think that (doing something with the embryo) will help me to accept that that second (child) will never come. (…) To be honest, I do not yet know what I will do with it. But it will come to me, I think. (…) (Not knowing what to do with it) is difficult. Burn it? Or put it in a box with other memories? (…) Yes, only after that (ritual), will I accept it.

This quote makes clear that, for Roxanne, the embryo is the material representation of the possibility of having another child. As such, overcoming her longing for that child implies letting go of the embryo. She attempts to do so through a ritual—through “do(ing) something with it.” Interestingly, this planned ritual is not a marking of being able to let go of the past, as it is for Leanne. As suggested by the words “only after that (ritual), will I accept it,” Roxanne’s ritual mourning seems to be an attempt to create a new lived meaning of her past, that is, to enforce herself to (be able to) let go. Compared with Leanne, Roxanne’s mourning strategy may be interpreted as a more radical way of dealing with the difficult uncertainty in narrative mourning. While Leanne’s ritual is merely a symbolic and material demarcation of acquiring new meaning making through story-telling, Roxanne attempts to create new meaning within and through her stories, as well as by performing a ritual with the embryo. By finding an alternative way of creating meaning, she seems to (attempt to) sidestep the difficult uncertainty of meaning making in narrative mourning.

In the interview, Roxanne also reveals that meaning-creating ritual mourning comes with its own difficulties. First, Roxanne faces the challenging task of awaiting the moment she knows what to do with the embryo, only after which can she accept that she will not have a second child. She speculates about what she might do with the embryo. Like Leanne, that speculation takes the form of a reconfiguration of materiality: “burn it [the embryo], bury it […], make some art with it”—but she

has to await the moment the appropriate ritual comes to her in a dream. So, although Roxanne's ritual mourning is geared towards enforcing new meaning making, it seems that the ritual that establishes such sense making cannot be enforced and comes as a gift. This means that, while Roxanne's mourning practice may be understood as a way to deal with the hard uncertainty in narrative mourning, her meaning-making effort also turns out to be quite uncertain itself: it depends on an unconditional, gift-like ritual. She must wait until the ritual comes to her. Second, her account shows that her plans to ritually dispose of her embryo go with fierce oppositions from the authorities—telling her "that's not how it works." Although women in the Netherlands are legally entitled to decide how to dispose of their embryos—having the choice between donating the embryo to other couples with fertility challenges, donating it to science, having it destroyed or bringing it home—Roxanne encounters norms that designate inappropriate disposal options—something that "bringing the embryo home" apparently is. Roxanne's account shows that performing her embryo-disposal ritual and coming to terms with the lost possibility of becoming the mother of a second child is a "headache case," because of the difficult nature of ritual mourning and restricting cultural norms.

DISCUSSION

Melancholy and mourning beyond pathology

By taking the philosophies of Freud, Ricoeur and Kristeva and an array of social scientific concepts as a theoretical framework and by drawing on stories of women in infertility treatment, we explored in this article what it actually means as a woman to live with and through melancholy and mourning in infertility treatment. Freud, Ricoeur and Kristeva teach us that melancholy may be understood as a longing for a lost loved object, within which this object is incorporated into one's sense of self. Mourning, then, may be perceived as an attempt to overcome such an identity dwelling in a lost past.[106–108] Then, in tandem with relevant social scientific literature, we demonstrated what such longing—and attempting to overcome it—means for women in infertility treatment. In melancholy, these women derive their sense of self—or rather, their lack thereof—predominantly from a normative interpretation of their lost embodied past. In mourning, they attempt to narratively and materially rework this memory.[109–115] That is, some women long to be the womanhood-affirmative mothers they could have been or even momentarily were. Others long for the ideal lovers they once were, which may implicate a desire never to have become a mother in the first place. Subsequently, this study's mourning women try to escape their dwelling of identity and (re)constitute themselves as (also) forward-looking beings by (re)narrating their pasts and through performing materialised rituals of passage and closure.

Within our analysis, we tried to go beyond a reductive pathological understanding of melancholy and mourning.[116–120] We refrained from assuming that melancholy is by definition a disease, and mourning its cure, and that both are constituted in a predetermined, subjective mental vacuum. Rather, we described women's melancholy and mourning in infertility treatment as coshaped within an embodied, material, technological, sociocultural and constantly changing context. Without attending to these specificities, we argue, we cannot grasp the pivotal aspects of what it actually means to live with melancholy and mourning. We would not see that the object of these women's longing is often an embodied past—such as a lost pregnancy or a lost sex life. Alternatively, women's melancholy and mourning are simultaneously constituted by their current bodily experiences, namely that their present sensory experiences—like looking at a sonogram or the regained memory of holding their baby—play a significant role in how (and if) their melancholy and mourning take shape. Moreover, we would miss that these women's melancholy and mourning are coshaped by artefacts that figure and are refigured as representations or mementoes of their lost, loved objects. We would not see that their melancholy and mourning are interspersed with normative ideas and policies about motherhood and womanhood, biomedicine, embryotic remains, and the nature and duration of melancholy and mourning. We would not comprehend, finally, that both melancholy and mourning are shaped and reshaped while these women's lives unfold: when new events take place in their lives, when they tell new stories and renew old ones, as well as when they dis/connect with others.

However, our intention to explore melancholy and mourning beyond a reductive pathological logic seems to be undermined by the fact that our analysis structures these phenomena in a disease/cure-like dynamic. Indeed, women sketch out their experiences of what seems to be an all-consuming sadness for what (or who) is lost, and a heartbreaking, painful experience. Mourning, in turn, is referred to as a way to overcome this suffering by working through the memories of the lost past. While women depict their melancholy as an ailing experience and mourning as its possible remedy, we avoid the risk of this disease/cure dynamic becoming a reductive template by displaying the ambiguousness inherent in such a binary relationship and by revealing its underlying complex existential lived reality.

We presented, first, that what we understand as melancholy is not just experienced as a disorderly condition and that mourning may entail ailing characteristics. In line with Kristeva's thinking, several women in this study explicitly adhere to their bitter melancholy as a sweet and enjoyable experience.[121] Some women even refer to their melancholy as something that they foster instead of try to overcome. Moreover, unlike descriptions of overcoming melancholy through mourning in various empirical studies[122–125] and by Freud and Ricoeur,[126 127] the women in this study who do try to mourn do not emphasise the healing aspect of it. Instead, they focus on its hardship: the painfulness of telling and retelling their stories, the difficulties of enduring in their narrative and ritual efforts, and the nerve-wracking uncertainty that mourning may never lead to healing. In this sense, our study reveals the melancholy-disease/mourning-cure binary dynamic as thoroughly ambiguous: melancholy may be understood as a joyous painfulness, something that is or is not overcome through the agonising exertion of mourning.

Second, our study reveals that underlying the melancholy and mourning disease/cure dynamic is a pressing and uncontrollable existential reality of not being able to make (sufficient) sense of oneself. While melancholy is commonly understood as a past-oriented shaping of identity, the women in this study show that such sense making of oneself actually signifies a lack of a meaningful self. This becomes most apparent in women's relentless attempts to hold on to a past at the expense of a meaningful present life and self, for example, "I would give anything to experience that (past) again" (Erica) or "I am not ready to move on just yet" (Emily). This is also demonstrated in their bleak descriptions of their current lives, for instance, by using the words "it" or "that," as in having a baby (Fay), or in their persistent hesitation when asked how they see themselves now, that is, "Oh, I don't know…" (Erica), or in their determinate statement about their current loss of self, "We're lost" (Fay), or in repetitively questioning their present identity, "Am I? Am I?" (Erica). The phenomenological tradition helps us understand the workings of this inability to make sense and to appreciate

its existential repercussions. Phenomenology teaches us that, as self-reflective and meaning-making beings, we live within and through various temporal dimensions.[128 129] That is, when answering the question 'Who am I?' we refer to our memories, our present stance in the world, and to our expectations, hopes and dreams for the future. Accordingly, as humans, we do not just live *with* and *in* time, we *are* temporal. Hence, melancholy as a way of sense making of oneself through (predominantly) the past undercuts the basis of our existence. It signifies an inability to constitute oneself as a complete—past, present and future—human being. Understandably, most women in this study experience such melancholic (lack of) sense making as unlivable and as something they need to overcome. These women try to do so through mourning and acquiring a new meaning of their past that (also) facilitates a forward-looking sense of self. This move from melancholy to mourning is understood by Freud, Ricoeur and Kristeva as figuratively and literally *sensible*.[130–132] After all, the difficult task of mourning could provide a new or renewed sense of self and life.

This study reveals the workings of mourning and, by extension, the depth of its difficulties. We disclose that mourning is a conditional unconditionality. This means, in this case, that women must put in various efforts to try to attain a new meaning of their past—telling and retelling their painful stories, creating and performing rituals, and resisting suppressive and detrimental norms and policies—all the while new meaning is—as the term suggests—*given* to you, namely by forces and structures outside of oneself. This study shows that these forces and structures may be others who urge melancholics to move on while they do not listen to the stories that may facilitate overcoming melancholy. These may be institutions and policies that do not allow sufficient assistance in narrative and ritual mourning; ultimately, these may be the unconditional meaning-making surplus of the melancholic's story-telling or ritualising efforts. Our analysis also reveals that melancholics can only control the nature and duration of their dwelling and of their in/ability to overcome such dwelling through mourning to a limited extent. Meanwhile, we revealed that the existential repercussions of this uncontrollability are significant for those who must live with the timeliness of melancholy and mourning: it may construct or destruct them as human beings. In our view, this analysis of mourning does not just lead to a conceptual appreciation of mourning's paradoxical and existential unconditional/conditional modus operandi. It also leads us to question whether Freud, Ricoeur and Kristeva are right to assert that overcoming melancholy through mourning is indeed sensible. After all, our results suggest that mourning may only happen within and through the non-sensical practice of relentlessly trying to overcome melancholy, even though such hopeful efforts essentially do not lead to such overcoming. In this sense, mourning may pertain to a lived existential deadlock: overcoming melancholy and making sense of oneself (again) occur regardless of mourning's imperative and possibly perpetual efforts.

Then, considering these conclusions about melancholy's and mourning's situatedness, their ambiguous relationship, and their underlying difficult lived existential reality, we argue that understanding melancholy and mourning as templates does not do justice to their complexity. Even more, we hold that, without appreciating these phenomena's complexities, we would neither be called on nor enabled to assist women in infertility treatment to overcome their melancholy through mourning. We hold that women's revealed pressing and existential lived reality in melancholy and mourning urges us to be patient with them and to take compassionate measures—an appeal that may also apply to melancholics and mourners in other situations of medicalisation, illness, disability and disfigurement, perhaps even to all melancholics and mourners. Here, we take up and specify Ricoeur's—rather abstract, hesitant and indirect—point that mourning and melancholy require 'time (and) is not unrelated to patience'.[133] That is, we contend that the described inherent situatedness within melancholy and mourning shows us that such compassionate patience needs to take shape, always anew, by attending to the specific context in which these lived phenomena arise. Consequently, whether working in healthcare or in the role as cocitizen, we should offer a listening ear and acknowledge the various contextually shaped pains inherent in experienced losses to facilitate particular mourning strategies and to help overcome the distinct sociocultural obstacles that accompany them. Alternatively, we need to try to understand that overcoming losses takes time, is difficult and, for some, many or even most, never comes at all. Such context-sensitive, compassionate patience does not guarantee that melancholy becomes easier or that it will be overcome. However, only by granting melancholics and mourners—in this case, in infertility treatment—the appropriate time and proper assistance does one help them possibly escape a lived existential deadlock and arrive at a new meaning of their lost past and of themselves in relation to their losses. At the least, such measures prevent the existential struggle of melancholy and mourning from becoming more difficult and meaningless than it already is. Again, note that such an appeal for compassion and patience is addressed to biomedicine and to all of us. Our study of melancholy and mourning in infertility reveals the importance of medical policy makers, medical institutions and (mental) health professionals being sensitive to the pressing existential and contextualised reality of melancholy and mourning experiences. Indeed, these experiences also seem to make an appeal to us as family members, friends, and more generally as fellow human beings.

At the end of this paper, then, we may conclude that the words in its title, 'Beyond pathology', have multiple layers. We started this study with the aim to explore melancholy and mourning beyond a reductive pathological logic. While we succeeded by revealing melancholy and mourning in infertility treatment as a thoroughly embodied, contextualised and constantly changing experience, a binary pathological dynamic between these phenomena was still present in our analysis. The women in this study predominantly understand their melancholy as (similar to) a disease and mourning as a way of healing. However, we refrained from reducing this binary relationship to a pathological template by describing the melancholy/mourning dynamic as inherently ambiguous and by drawing attention to what this binary relationship means on an existential level. Subsequently, in describing melancholy's and mourning's lived existential reality, we lay bare the urgency to be compassionate and patient with those who (must) live in and with this reality. This appeal, then, transcends yet another pathology: it presses medical (mental) health professionals, policy makers and institutions and all of us to deal with melancholy and mourning in an appropriate manner.

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of) the article, the second and last authors substantially contributed by commenting in depth on several drafts of the article. The last author, as the leader of the research project of which this article is part, was responsible for the overall conduct of the study. By implication, the third author was also responsible for obtaining research ethics approval.

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NOTES

1. Nowadays, the terms *melancholy* and *melancholia* are used interchangeably and refer to both a mental disease and normal experiences. In historical texts, however, *melancholia* generally relates to an abnormality, while *melancholy* connotes normality. Since we aim to explore melancholy (or melancholia) beyond its pathological understandings, we will consistently use the term *melancholy* in this article. See Jennifer Radden (2002), *The Nature of Melancholy: From Aristotle to Kristeva* (Oxford University Press, 2002).
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