

ANNIVERSARY COLLECTION – PAPER

Dark Wombs and Broken Pledges

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Over the past ten years, in tandem with greater educational and occupational opportunities, many innovations in the reproductive field have increased the range of choices available to ordinary women. Yet despite this unprecedented revolution, obsolete expectations about motherhood persist. Excessive pressure to comply with impossible prescriptions leads to the breakdown of intimate relationships within small insulated nuclear families. However, little practical assistance and support is available for the powerful upheavals and often contradictory demands of parenting.

It is argued that babycare is predisposed to reactivate deep feelings, due to contagious resonance with archaic experience. Lack of realistic preparation render primary carers (of whatever gender) particularly susceptible to emotional disturbance, which arises in the gap between false beliefs and actual experience. Regardless of sound evidence of the financial cost-effectiveness of investing in the perinatal period and early years to safeguard the future mental health of the nation, over the past decade social provisions have declined, and far from making progress, our essential services are deteriorating.

We live in an extraordinary time for motherhood. Choices prevail as never before, and scientific advances promise to render even our wildest fantasies actualisable in reality. Reproductive technologies continue to transform women's lives, as female-based contraception did in the past. Miraculous conceptions and virgin births happen daily. New techniques allow for preimplantation selection of embryos, gene-editing to eliminate faulty genes, and prenatal surgery on fetuses.

Has there ever been a better time to define what we 'really really' want?

Over the past ten years the number of older single mothers has doubled, as many women choose to consolidate their careers before resorting to in vitro interventions for post-menopausal pregnancy.¹ Some now use their own eggs, frozen years earlier. They may have a male or female partner or decide to go it solo, conceiving asexually through an anonymous sperm donor. Lesbian partners may swap eggs to ensure a biological link to offspring. Conversely, at least one in five Western women choose not to become a mother at all. So, indeed, as this Journal attests, the status, composition, and meaning of motherhood are changing rapidly, socially, politically, economically, technologically, psychosocially.

A revolution is happening. Yet looking back on this past decade, services decline, and obsolete expectations persist.

Here, I want to focus on one of the most tenacious of these – unrealistic beliefs about motherhood. Despite re-examination of fundamental concepts of gender, sexuality and reproduction, we still simultaneously idealise maternity while denigrating mothers. If, as I claim, pregnancy is the most radical form of coexistence of self and other, and the multifaceted complexity of relating to a preverbal infant comes a close second, why does the popular glorifying culture go on ignoring emotional hardships and denying the existence of maternal ambivalence? I argue that reification of intrauterine conditions drives sentimental nostalgia for an imagined 'paradise lost'. *An unconscious expectation prevails: mothers must replicate womb functions by providing never-ending placenta-like mothering.*

¹ The number of women who reach 45 without having had children had now doubled to 18 per cent, from 9 per cent of those in the previous generation.

Regardless of unprecedented technological innovations, one crucial sex-divergence remains: the fetus always resides in a female body. In fact, we carry an indelible reminder of the biological mother's awesome transformative and potentially mal-formative power—the ubiquitous bellybutton: marker of our originary cord-connectedness and severance.

Patriarchally generated theories have focused on male circumcision as a culturally imposed sign of (castrative) autonomy, while studiously ignoring the navel. But we all bear that lifelong scar; the irrefutable evidence of the umbilical link to an archaic mother. It seems to me that mythologising pregnancies as blissful, counterbalances the denied 'dark side of the womb'. Simultaneously, it sustains another false equation: *the female container of pregnancy is unconsciously conflated with the provider of postnatal care.*

Child-bearing and lactation remain sex-specific. But ethological and cross-cultural evidence shows that primary carers can be of either sex or various ages. Today, some three generations of western children have benefitted from 'hands-on' nurturing fathers, which has somewhat lessened the culpability of 'The Mother' as the source of psychogenic faults. The primary 'ruler' against whom we struggle to assert frustrated self-determination no longer need be female (as Dinnerstein predicted in 1976). However, outside of Scandinavia, most parental-leave policies fail to take this into account.

Today's greater educational and occupational opportunities mean that women's professional ambitions are no longer compatible with the needs of babies, which have changed little since we lived in caves. Compartmentalised employment which segregates workplace from baby-care makes breastfeeding impracticable. Career mothers lose their foothold on the promotion ladder if they reduce their work-hours. But women still do the majority of primary care (and housework). So, despite advances, motherhood remains a delicately balanced compromise between contradictory pressures of a woman's age, career status, social forces, demands of other dependents and multiple internal clashes. Unsurprisingly, perinatal distress is rife.

In higher income societies, up to half of mothers (and a quarter of engaged fathers) experience emotional disorders during pregnancy or within the first two

years after having a baby. Around one in five primary carers develop a mental illness ranging from mild to extremely severe. Elsewhere the situation is even worse.² Low social support intensifies adverse factors (e.g. poverty, extreme stress, domestic violence and migration due to natural disasters and conflict situations), increasing the risk for specific disorders. Perinatal conditions include not only the proverbial postnatal depression, but also antenatal disturbances, anxiety and dangerous persecutory conditions such as paranoia, phobias, obsessive-compulsive disorder as well as post-traumatic stress disorder (PTSD) and rarely, postpartum psychosis. These are compounded by breakthrough residues of unprocessed past violations or neglect. Unfavourable childhood experiences result in up to twelve-fold increase in alcoholism, drug dependency and self-harm. *Yet, perinatal mental health services are dwindling.*

In addition, technology's illusory omnipotence can backfire. For instance, as subsidised medical services diminish in the USA, and elective caesareans increase, American women are now twice as likely to die in childbirth compared with their own mothers. Women of colour have a threefold risk, irrespective of income or education.³ That said, over 99% of maternity-related deaths occur in the developing world, even though most of these are caused by conditions that could be treatable with low-cost interventions.

Over the past years, maternal mortality in childbirth has fallen (albeit the UK still ranks 34th behind Slovenia just ahead of Lithuania). As a result, mental illness is now one of the leading causes of perinatal death for new mothers. Suicide may

² Few robust prevalence studies exist in Low and Middle Income (LMI) societies. A WHO meta-analysis of the sparse data available (from only 8% of these societies) suggests that one in four women in South Asian countries, and up to one in three in South Africa is likely to experience clinical depression after childbirth! Low social support intensifies adverse factors (e.g. poverty, extreme stress, domestic, sexual and gender-based violence, drug dependency and migration due to natural disasters and conflict situations) increasing the risk for specific disorders.

³ Maternal mortality has soared in the USA to 26.4 deaths per 100,000 live births while it declines in the rest of the so-called developed world yet with England, Portugal and Germany still around 9 as opposed to Ireland and the Scandinavian countries (about 4 per 100,000). The new NHS funding will be used to reduce the rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20 per cent by the end of 2020/21, and 50% by 2025.

be accompanied by infanticide when bonding is compromised by the impact of a traumatic delivery or a previous perinatal loss, or by the arrival of a less than perfect newborn, or one of the wrong sex. Excessive pressure to comply with an impossible prescription leads to the breakdown of couple-relationships within small insulated nuclear families. A contributing factor to such breakdown is the lack of realistic preparation for the powerful upheavals of parenting that affect intimate relations between partners. Understandably, intensely concentrated feelings of love and hate coexist at this time, and they may explode within the relentless demands of 24/7 baby care. No clocking-off after the exhausting night shift! But in addition to sleep disruption, and the increased financial expenses, and the strain of trying to fathom preverbal communications, baby care also rekindles unresolved emotional issues and old rivalries.

Finally, infant care itself involves contradictory demands. On the one hand, there is the mess and boredom associated with the limited repertoire and inescapable *cyclical tasks* of basic maintenance (recurrent feeding, toileting, cleaning, slumbering), and on the other hand, there is a *perpetual novelty*—both pleasure and threats inherent in constant change. Both these sides of infant care necessitate synchronised adaptations between carer and infant to meet new expectations, or risk obsolescence of outgrown interaction. Crucially, emotional distress is most prevalent when no confidante is available.

Babies are the future of any society. Political recognition that perinatal disturbance can have a long-lasting impact makes it a popular public health issue.⁴ At long last, over the past few years, some politicians began to accept the financial cost-effectiveness of investing in the early years to safeguard future mental health.⁵ In

⁴ For instance, to coincide with International Day of the Midwife 2019, our NHS reinvented an old wheel, pledging £40 million to ensure continuity of midwifery care, thereby aiming to reduce the rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20 per cent by the end of 2020/21, and 50% by 2025. All expectant mothers are to be given a named midwife throughout their pregnancy (as advocated in the 1980s), instead of seeing a different midwife at all nine or ten of her antenatal visits and birth.

⁵ Rigorous long-term studies find a range of returns between £4 and £9 for every pound invested in early intervention for low income families.

2013, a unique Parliament cross-party published a manifesto accepting the 'moral, scientific and economic case' for treating the first 1001 days from conception to two years as a critical period. A Maternal Mental Health Alliance was formed among 60 organisations and professional bodies that purport to represent or provide early care and support to parents and families. Yet, promises are reversible. As we look back on the past decade, it is difficult not to be cynical about lip-service pledges that are subsequently broken or withdrawn.

Far from making progress, our essential services are deteriorating. The flagship programme which provided the necessary support to mothers and aimed to foster social mobility in children is now in decline. Since 2010, around 1000 Sure Start children's centres have been shut down in England (double the official closure-estimates). Further drastic reductions are on the way as local authority budgets continue to shrink (see Sutton Trust report, 2018). Concomitantly, other crucial perinatal provisions are being eroded. There is a shortage of midwives and creches. Since the Health Visitor Implementation Plan ended in 2016, the number of health visitors has fallen drastically in England, with subsequent 22% reductions in planned health visitor training-commissions from the previous year (RCN, 2017).

Inevitably, reproductive decisions are influenced by policy. We saw this with China's one-child strategy, and also with Ceausescu's prohibition on abortion and tax on childlessness to enforce a massive demographic increase in Romania (resulting disastrously in unwanted children ditched in institutions). We are less aware of the unintended consequences of our own policies. For instance, the two-child benefit cap induced a sharp rise in recent years of the proportion of mothers having a termination in the UK, aborting a third, unplanned pregnancy.⁶

Over the past 50 years of my transcultural specialisation in perinatal issues, working professionally with parents and primary health practitioners in over forty

⁶ Over the past decade the rates for women aged 30 to 34 increased from 15.6 per 1,000 women in 2008 to 19.9 in 2018. Now in the UK, 56% of abortions (111,633) were to mothers, up 5% on the 106,550 the previous year. By contrast, ten years ago, 48% of abortions were to women who had already had one or more previous births.

countries on six continents, I realise how many facets of parenting are underpinned by social provisions. Collective cultural imagery generates local shared values and defences to mould the values of future citizens. However, some common factors precipitate perinatal distress, including incompatibility between collective dictates and personal feelings.

Wherever it occurs, intimate baby care is predisposed to reactivate deep feelings. It immerses carers in unavoidable sensuality. In breastfeeding mothers, suckling with its visceral pull renders the unsymbolisable archaic maternal body a lived experience. For parturients, turmoil is exacerbated by hormonal fluctuations and corporeal changes. In addition to the powerful impact of the baby's raw emotions, exposure to voluptuous skin-surfaces and leaking orifices may feel highly threatening. Disruption is intensified in urbanised societies, where many women nurture alone, bereft of intergenerational households, and without the mitigating support of co-carers. In the absence of supportive communities, isolation prevails. Our stratified societies-in-transition allow little experience of young babies, and they lack opportunities for mothers to work-through their own infantile feelings before being handed full responsibility for their own baby.

Moreover, I propose that close contact with the heady cocktail of primal substances, including pee, poop, breastmilk and posset stimulates sub-symbolic feelings in the carer. Baby care triggers archaic reverberations through a process of *contagious resonance*, as I termed it in 2003. Looking after an infant is highly 'infectious'—precisely because sensory stimuli so closely replicate the early context when the carer's own preverbal experience was encoded.

In sum, funding-cuts to maternity and early-years' provision mean that only a fraction of perinatal services that existed a decade ago now operate. Lacking practical assistance and realistic preparation for the inordinate demands of baby care, primary carers (of whatever gender) are particularly susceptible to emotional disturbance, which arises in the gap between false expectations and experience. A new NHS initiative (Five Year Forward View implementation plan, 2016) intends to increase specialist mental health support by 2020. It pledges to promote 'healthy pregnancies

and lifestyles; primary and secondary prevention; early identification and timely provision of quality specialist care'.⁷

But I wonder, having failed to deliver over the past decade, can we do better in the next?

Editor's Note

This contribution to the 10th anniversary issue of *Studies in the Maternal* were invited by the editorial team. As such they were internally reviewed by the journal's editorial team.

Competing Interests

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⁷ The focus is on pregnant women and mothers who have or previously experienced a mental health condition. Promises include increased access to specialist perinatal community teams and additional mother and baby inpatient beds. A Joint Strategic Needs Assessment (JSNA) is planned to measure the level of local need for perinatal physical and mental health education in maternity and primary care services, and to assess how well mental health problems are being identified and responded. However, the plan ignores realistic preparation for the ordeal of baby care, and there is no offer of widespread availability of perinatal psychotherapy, parent-infant therapy, or couple counselling.

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