

PSYCHOLOGICAL PROCESSES OF CHILDBEARING

FOURTH EDITION



Joan Raphael-Leff

ROUTLEDGE

Psychological Processes of Childbearing

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Psychoanalyst and Social Psychologist

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Foreword by **Professor Marshall Klaus**

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Introduction

Childbearing is where the ambitions of human biology and the benefits and constraints of human society meet, where cultural belief about birth and maternity are tested against the facts of life. Science has, so far, made a poor job of understanding how a foetus and its brain, nourished within a mother's responsive body, connected directly to her visceral turbulence, can be born with the mind of a conscious infant, sensitive to the scent and touch of her woman's body, suckling skilfully while holding her hand and gazing at her eyes, knowing her voice, able to engage the expressions of her face, her talk and her gestures, sharing her joy and her depression intimately. Only in recent years has this unique attachment of two intending and aware beings, one ignorant of theories, reasons and language and dependent on the body of the other for support, protection, nourishment and responsive sympathy (not empathy!), the other transformed in her feelings, pride and physiology to give needed and attentions and to share the happiness of play, been given the respectful observation it deserves. The complexity of their innate impulses of intersubjectivity, of Dan Stern's 'attunement', on both sides has surprised medical and psychological researchers who had assumed the baby could feel no pain and had no self-awareness, or capacity for imitative and inviting engagement with a rational adult. Most surprising discoveries have come from brain science. The potent influence of emotions in the making of the neural systems of reason, perception and memory for significant experiences has been proven. Thanks to Jaak Panksepp, Alan Schore and others we see that the affective brain and its capacity for sympathetic attachment takes control in the wedding of mature adult and questing infant. We know the attentive infant's whole brain resonates with images not only of the mother's appearance and movements, but with the quality of motives that generate them. This gives natural sense to the rationalisations and verbalisations of psychoanalysis, vindicating Freud's early hope for a neuroscience of human impulses. And yet, the most important matters remain the real life benefits and hardships of a new mother's partnership with the father, her family, the community she lives in and the state that governs services that affect her.

Joan Raphael-Leff set herself the formidable task of reviewing the trials and tribulations of people bearing children, worldwide. Her book, full of information perceptively and sensitively interpreted against a background of clinical experience has been a success. This new edition swells the data impressively, tackling the dramatic changes of the past decade, of HIV-AIDS in South Africa, of single parenthood, of mothers who escape

loneliness with drugs or alcohol, or who deal with a father's insecurity or violence, or enforced loss of homeland. This is a unique reservoir of factual information and psychodynamic wisdom. Professor Raphael-Leff has created original practical tools for observing the different ways parents meet the presence of a young child with companionship in joy, with distant incomprehension, or with fear and even anger. It offers advice to all those who wish to give therapeutic aid, or simply wish to understand better how being human comes about.

Colwyn Trevarthen, Edinburgh, 23 November, 2004

Selected Reading:

Corrigall, J. and H. Wilkinson, H. (2003). (Eds.) Revolutionary Connections: Psychotherapy and Neuroscience. London/New York: Karnak.

Gomes-Pedro, J., Nugent, K., Young, G. and Brazelton, B., (2002). (Eds.) The Infant and Family in the Twenty-First Century New York/Hove, UK: Brunner-Routledge.

Schore, A. N. (2003). Affect Dysregulation and Disorders of the Self. New York: Norton.

Stern, D. N. (2000) The Interpersonal World of the Infant: A View from Psychoanalysis and Development Psychology. (Second Edition) Basic Books, New York.

Trevarthen, C. (2005) Stepping away from the mirror: Pride and shame in adventures of companionship Reflections on the nature and emotional needs of infant intersubjectivity. In, C.S. Carter, L. Ahnert et al., eds. Attachment and Bonding: A New Synthesis. Dahlem Workshop Report 92. Cambridge, MA: The MIT Press.

Colwyn Trevarthen, 2004
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Chapter 0:

Psychosocial Process of Childbearing Revisited

OVERVIEW:

Childbearing seems eternal, primordial and universal. Yet over the last decades human reproduction is in a state of flux. This book highlights changes that have occurred over the years. Updating it is a challenge, as there have been crucial developments in several relevant fields. These include:

On a global level, increased precariousness, with marked climate changes, widespread terrorism, massive migration, rapid urbanisation, economic instability, and the rapid spread of HIV infection now estimated at 56 million people worldwide. (The latter has crucial implications for maternity and neonatal care as many women, especially in sub-Saharan Africa, learn of their positive status when tested in pregnancy).

On a physiological level knowledge of the human body has changed dramatically with the 2003 completion of the Human Genome Programme which defines the boundaries of heritability, and the complex dialectic between genes and environment. Assisted Reproductive Technology has burgeoned, transforming modes of conception, evolutionary natural selection and patterns of family formation to include childbearing of genetically unrelated offspring. Evolution of the functional MRI has brought major leaps in brain research, revealing the interpersonal nature of brain growth, thereby affecting the ways we think about development in babies.

Finally, *on the psychosocial level*, 21st century life's increasing complexity and instability are accompanied by new challenges to mental health in child-bearing and rearing, with ramifications for maternity and child care policies. There is a growing recognition of the diversity of women's needs, which is the foundation of this book. I argue that each woman's expectations and desires are rooted in both her internal and her external realities, and vary with

age, parity, interval between pregnancies, relationship to her own mother, degree of emotional support in her immediate environment, restrictions in her socioeconomic situation and cultural expectations and previous experience of parenting - all of which determine her current orientation towards pregnancy, motherhood and this baby.

The central theme of this book is *interconnectedness*. Even when alone others are embedded in our minds, and every aspect of our lives is interwoven. This updating section reflects such dynamic reciprocation by addressing four inter-related topics:

1. Maternity care services [see section O.2 below]:

Increasingly over the past years, the emphasis has returned to woman-led midwifery provisions - antenatally, during labour and birth, and in establishing lactation. In the UK, beginning with the 1993 'changing childbirth' report, government policies are now in keeping with the foundational message of this book - *greater awareness of psychological issues and availability of choices* - to cater to personal preferences, special needs and diversity of expectations. Midwives and consumers concur on the importance of midwifery competence, but also stress building a relationship through communication, mutual respect and compassion throughout pregnancy and birthing. However, studies reveal failings in both *continuity* of maternity care and *quality*. Nursing shortages continue with lack of uniformity in antenatal provisions, closure of smaller maternity units and birth centres and a rising rate of caesarean sections. Few specialist mother and baby units exist for women suffering severe mental health problems after the birth and inequalities of access still affect women with disabilities or language problems. This is somewhat remedied by programmes such as Sure Start, encouraging families in disadvantaged areas to access ante-natal and baby clinics, and specialist services exist for children with Special Educational Needs. But lack of data on the socio-economic and ethnic status of pregnant women and mothers impedes maternity service planners and providers in assessing equity of services. A Mental Health National Service Framework [NSF September 15th 2004] advocates multidisciplinary collaboration to safeguard mental health through provisions geared to children, young people and maternity.

2. Perinatal disturbance [see section O.3 below]:

Almost half the population of western new mothers experience mild depression, with over one in ten suffering severe disturbance over the first

postnatal year. Perinatal psychiatric disorder is the leading cause of parental morbidity, and suicide is the leading cause of maternal mortality in the UK, and probably northern Europe. Fathers are not exempt. Emotional distress during the childbearing period is associated with deteriorating family relationships and long-term adverse consequences for the baby. As evidence accumulates of the link between parental disturbance and emotional, social and cognitive difficulties in the offspring, government policy makers hope to combat this damaging intergenerational transmission of distress.

However, while developmental psychology demonstrates the effects of parental mental states on their baby's cognitive and psychosocial development, this book draws attention to current social arrangements which exacerbate the emotional upheaval antenatally, and the little acknowledged postnatal impact of the infant on the parent. I suggest that intense arousal resonates with procedural 'autobiographical' memories relating to the parent's own infancy, which have not been processed due to changes in family structure. These emotional memories are reactivated both by disturbing exposure to the baby's inchoate feelings and through unmediated contact with evocative primary substances (urine, feces, milk...). Some new parents find the primal intimacy overwhelming, and unable to protect themselves from such '*contagious arousal*', succumb to postnatal disturbance – a spectrum of depressive, persecutory, obsessional or anxious reactions. Mechanisms range from anxious overinvolvement and identificatory fusion/confusion with the idealised infant to projection and/or detachment (phobias, paranoia or extreme withdrawal) from denigrated or feared attributes of the infant associated with repudiated aspects of the carer's imagined baby-self).

Recognition of such processes necessitates *changes in training midwives and health visitors* to increase their understanding of perinatal psychological disturbances, and to promote supportive maternity care and prompt referral of troubled women for therapeutic help, ideally during pregnancy.

3. Infant mental health issues [see section O.4 below]:

1990-2000 was 'decade of the brain' and in recent years infant mental health issues have gained recognition due to dissemination of findings about the competence and sensitivity of babies, in the womb and after birth. *The hallmark of this decade is rediscovery of the interactive nature of our innermost beings – and the long-lasting reciprocal influences that make us who we are.* Neonatal research demonstrates how innate capacities for sociability, self-regulation, thought and language can only

be activated through intensely emotional interactions with others. The infant's range of arousal, his/her stress responses and biochemical patterns come to reflect parental handling. Neuroscience reveals influences of caregiver's behaviour not only on the patterns of growth but the very structure of the baby's brain. Geneticists illustrate ways in which genetic endowment is instigated, modified or inhibited by the specific emotional social environment of the child's life. Similarly, within the family system, interactions between parent/s and child/ren are never isolated occurrences, but part of an intricate familial give-and-take, a constantly adapting and changing kaleidoscopic feedback loop.

These realisations have implications for safeguarding healthy family interaction and helping parents and their children when this is derailed. In the wake of the 1989 UK Children Act, changes in practice ensure primacy of child welfare and rights, with *guidelines to prevent, detect and treat emotional, sexual and physical abuse*. The 2004 Children's NSF is similarly committed to sustained improvement in children's mental health through integrated health and social care from gestation to adulthood, and early interventions.

4. Facilitator-Reciprocator-Regulator model [see section O.5 below]:

The framework of this book delineates three basic orientations towards parenting, revealed in different practices that reflect underpinning beliefs and unconscious representations.

- *Facilitators* who relish pregnancy and natural childbirth, and postnatally, adapt devotedly to the baby to gratify his/her perceived needs.
- *Regulators* who strive to control the discomforts of pregnancy, want a 'civilised' birth and aim to regulate the baby so s/he learns to be socialised.
- *Reciprocators*, who can tolerate ambiguity and uncertainty, and neither adapt nor promote adaptation but negotiate each incident as it arises, both in pregnancy and labour, and postnatally.
- Pathological reactions are found at the extremes and in a fourth *conflicted group*, whose internal confusion and inconsistency spills over into the family.

Over the past 15 years, independent researchers have replicated my model with interesting results from large scale and longitudinal research in England and elsewhere. The model is extended to elucidate some of the unconscious representations and anxieties underpinning attachment styles, and prospective research has validated my predictors of postnatal depression. Rather than treating 'women' as a single category,

questionnaires enable differentiation between groups with diverse expectations, needs and symptomatic disturbance (depressive, persecutory, obsessional, anxious reactions).

Research papers in the first three areas run into scores of thousands – so this updating section cites only a fraction, but hopefully representative sample of recent studies, predominantly British but also around the world. As always, findings from other locations must be read in context, questioning whether and how these apply to our own increasingly multicultural and complex (and in some ways, ‘de-developing’) society. I have a dual motivation in providing this mixture of findings: with all the faults of the National Health Service, in the UK we may need reminding of our own highly privileged access to services still unavailable in many other developed, as well as developing, societies. Conversely, worrying trends and research findings from other places highlight gaps and offer a means to re-evaluate and hopefully improve our own provisions. I begin by sketching the background to these issues. [Numbers in brackets refer to references which, unlike the rest of the book, appear at the end of this chapter].

0.1. SOCIO-CULTURAL BACKDROP

0.1.1. New parameters of Childbearing:

Babies are the potential of any society. Their health status predicts the quality of the future. Paradoxically, their needs have changed very little over the millennia. *In societies in transition, this puts babies at risk of being at odds with their parents' rapidly changing lives.* Today half the world's population live in towns and in the more developed regions, Latin America and the Caribbean, this rural to urban shift involves 75% of the inhabitants and is projected to rise still further[1]. Rapid urbanisation has altered family patterns. Geographical mobility and trans-border migration dislocate communities, disconnecting generations and disrupting support networks. Adults tend to develop passionate (often, serial) sexual relations, and/or emotionally intense parent-child twosomes. With dispersal of extended families the family unit becomes a small nuclear unit, often composed of a lone parent and child/ren.

The way western societies are age-stratified means that many adults have had little exposure to young children before becoming parents. This leaves them unprepared for the emotional impact of a baby on their lives, especially one for whom they are totally responsible. *I argue that*

growing up in smaller families reduces opportunities for us to emotionally work through infantile issues triggered by babies (siblings, cousins, etc) in the presence of containing adults, before becoming a parent oneself - thus raising the likelihood of perinatal disturbance [2].

Ninety percent of infants are born in developing or low-income countries. Yet, as safer childbirth and lower child mortality diminish the need to have lots of children to ensure that some will survive, in many societies family size is decreasing. This is largely due to government policies and/or changing social attitudes, with safer abortion and efficient contraception. *Worldwide, women are having fewer babies than their mothers did.* Compared to the late 1980's, in societies where traditionally women had many offspring, now significantly more mothers of two children are saying they want no more – 60% of women in Bangladesh and Egypt; 38% in Guatemala, 33% of Kenyan women and 29% in Zimbabwe [3]. Similarly, in places as diverse as Brazil, Tunisia, Indonesia and Iran, women who had six or seven siblings now only have two children [4]. However, paradoxically, although the number of babies per woman has declined, millions are still added to the world's population annually as the number of women in their childbearing years has increased in most societies, due to high fertility in their mothers' and grandmothers' generations, and greater longevity of this generation. [UN predictions based on 'medium level' expectations state that fertility rates will decline significantly to two children per woman, even in developing nations, thereby stabilising at around 9 billion in three centuries].

However, one important effect of smaller families and scattering of extended families is to increase mutual-reliance within the isolated family and the intensity of interdependent relations in the small unit.

China, India and the United States are the three most populous countries and Africa has faster population growth, higher fertility and sadly, higher mortality than other parts of the world. Although there are still tracts of Africa and the Middle East where women will have three or more babies (and 6 or 7 in Somalia, Niger, Yemen and Uganda), in 2000-2005 in places as diverse as Hong Kong, Singapore, Korea (North and South) and Armenia to central Europe and even Catholic Spain and Italy *the average number of children per woman is just ONE (or none)!* [5]. Even in South Africa, there has been a dramatic fall from 5.75 live births per woman in 1970 to only 2.77 in 2004 – though this is not only due to socio-economic changes, but rural to urban migration and sadly, AIDS [6]. Overall, the patterns of westernised reproduction are shifting to concentrated, later or even negated reproduction. 12-20% of women are

estimated to be childless-by-choice across Europe and birth rates have declined substantially, in some places to fewer than one baby per woman (Latvia has 7.8 births per 1,000 population; Bulgaria 8.6; Russia 9.02 and Greece 9.82). With the lowest birth rate of any region in world history Europe is now also the only region where the death rate exceeds the birth rate.

In western countries educational parity and career prospects delay childbearing, inevitably limiting reproduction. According to the Office for National Statistics in England and Wales birth rates have dropped to a record low of 1.64 births per woman of child-bearing age (this, despite a massive rise in the number of multiple births over the last ten years). Many women postpone starting a family until their thirties or later (the average UK age at maternity was 30.6 years in 2003, and this calculation includes teen age births!). To counterbalance this, an industry of reproductive technology assists waning fertility in older women, and in turn produces new patterns of family formation – new kinship categories, such as surrogates, adopted embryos, lone-by-choice mothers, same-sexed parents, and post-menopausal parturients. With longer life expectancy, fertility treatments (and soon, egg-freezing) extend the upper range and versatility of prime adulthood, which is no longer dedicated to childbearing and rearing. However, despite technological solutions, infertility triggers emotional distress; increasingly bizarre treatments create painful tensions and raise false hopes (only about 15% of couples undergoing fertility treatment do achieve a ‘take-home baby’), and despite the joy they sometimes bring, successful interventions are also accompanied by unprecedented anxieties, doubts and ethical dilemmas while the child is growing up. In addition, this trend towards postponed parenthood and decreasing fecundity increases the likelihood of only-children (or multiple births - twins, triplets or more), and newborns arriving during the turmoil of their parents’ mid-life crises.

Conversely, the lower end of parenthood expands with ever younger mothers. In the UK one in ten babies is born to a teenage mother and infant mortality in this group is twice the average. Social circumstances, eating habits and access to services vary within subgroups and geographically. Low birth-weight, the primary cause of neonatal morbidity and mortality, is a common marker of maternal and child health. According to the WHO, Britain now has the highest western European rate of babies born below normal birth weight (5.5lb). Throughout the world, despite birth-control there are still many unwanted

juvenile pregnancies attributed to earlier sexual activity, ignorance and/or casualness with contraception, and in impoverished communities also due to child-prostitution or child-rape associated with a range of emotional, health and socio-economic problems.

0.1.2 Teenage pregnancies:

Over the last few decades, the western age of menarche has dropped with improved nutrition. We demarcate adolescence as a prolonged transitional period of maturation and learning how to operate in our complex society. Yet, due to various factors including more relaxed social mores and disillusionment with contraception, in 1997 Britain was found to have the highest rate in western Europe for adolescent mothers - triple that of France and Sweden, quadruple that of Italy, six times that of the Netherlands and ten times that of Switzerland! [7]. Sex-education campaigns have been effective and between 1998 and 2001 teenage conceptions in England fell by 9%. Despite a slight rise in 2002 among 14, 15 and 16 year-olds, statistics were still lower than those for 1992, an improvement seemingly related to reaffirmed confidence in the pill (after the 1996 scare). Nonetheless, the number of babies conceived by teenagers in the UK is still very high (90,000 in 2003), and varies geographically - women in poor inner-city areas are six times more likely to become pregnant before age 20 than their counterparts in wealthier areas [8a]. Although half of adolescent pregnancies end in abortion, those who keep the pregnancy now choose to raise their babies (but are less likely to breastfeed). Many are excellent mothers but young parenthood is associated with particular emotional and economic hardships (see Chapter 27). The government aims to halve the teenage birth-rate by 2010 as part of a drive to reduce health inequalities, and to prevent child poverty and social exclusion. Among other proposals, a national media campaign to foster personal responsibility, offering advice and contraception for young people; Sex and Relationship Education (SRE) and Personal, Social and Health Education (PSHE) in schools, along with training teacher and involving parents in prevention of teenage pregnancies. In addition, support for young parents includes hostels and subsidised housing, providing job-training, benefits for co-habiting fathers, and healthcare and crèche facilities are being evaluated, especially for parents under 16 years old [8b]. The Independent Advisory Group for Sexual Health recommended free condoms, 90% of abortions funded by the NHS, and early detection and treatment of sexually transmitted infections [8c]. RESPECT, a recent campaign to end poverty and prejudice faced by

young mums, has published a charter calling for extension of Sure Start, improvements in education, income and affordable, flexible childcare, and support services, including specialised midwives [8d].

In the USA, since teenage pregnancies peaked in 1991 these have fallen overall by 31% in the 15-19 group (and 42% among black women!), possibly related to campaigns for celibacy, delayed sexual activity and use of contraception. Nonetheless, with over 40% of adolescents becoming pregnant before age 20, *the US still has the highest rate of teen pregnancy and births in the western industrialised world*, twice as high as England, France and Canada. Eight of each ten of these US teen-pregnancies are unintended, and as only a third of these girls finish high school, many live in poverty and nearly 80% of them end up on welfare [9] thereby extending the cycle of deprivation, which is found to affect their sons and daughters in turn.

0.1.3. Gender inequality, parental grants and social 'revolution':

Despite our expectations for the improved quality of life depicted by the media depictions and feminist driven socio-political demands, women in the 21st century still suffer inequalities. This is reflected in basic education worldwide (even where it does accept girls, not only do pregnant ones drop out, but pre-teens are expected to miss school to do housework, help with child care or fetch water). Even in the privileged West, there are still disproportionately few female tertiary students. *Employment is still subject to sex discrimination. Earning differential and, segregated work conditions are commonplace, and downward post-maternal occupational mobility affects professionals too.* In the west, women earn 75% of what men do for comparable work, and gender interacts with other axes of social disadvantage such as race and class. In egalitarian Europe equity for parents remains a myth, with mothers striving to fulfil often conflicting domestic and work roles, both in traditional (largely Catholic) south-east European countries (where the fertility rate has now dropped below 1.7 births per woman), and in the more generously state-endowed north-western European countries. Despite growing appreciation of the importance of fathers, outside of Scandinavia paternity leave is meagre or non-existent. Similarly, despite awareness of the needs of young children, maternity leave is short, child-care remains problematic, and in Britain is the most expensive in Europe!

Clearly, the way welfare issues are addressed at governmental level determines the mode and quality of life for families. *The wealthiest 20% of the world's population consume 80% of resources.* Always in the

vanguard, during the last decade of the century the Nordic countries decided to decentralise provisions to safeguard equity and welfare. The very human definition of 'welfare' is 'individual resources to direct the conditions of one's life' [10] - in other words, the means to maintain *a sense of agency or self-determination*. The Nordic changes were introduced as a response to the regional macro-economic crisis, with local recessions, deteriorating work and living condition for the lower income section of the population (usually single mothers and immigrants), and recognition that these increase poor health and raise anxiety, with special risks to babies and children. Sweden and Finland in particular, recognised that relative income poverty had spread with growing socio-economic inequalities despite strategies of even-handedness [11]. Denmark, too, addressed issues of social protection for weaker groups by extending the scope of services for children in the 1990's, improving full-time jobs for mothers and investing in equality-promoting policies of childcare and education [12].

0.1.3.1. Parental leave:

In Iceland, policies to combat the extensive rise in gender and economic inequality included income-tested child benefits and increased expenditure on healthcare. *Fathers' leave* increased from two weeks in 1997 to nine months parental leave [three months for each parent and the remaining three to be utilised by either, with fathers receiving 80% of their regular pay] [13]. Sweden entitled fathers to at least two months parental leave out of the 18 months allocated to both parents [14]. Over the 1990's Norway too, shifted from a policy of universalism aimed to diminish inequality to one of specifically improving welfare for the poorest. Relying on its oil economy to ensure generous benefits, Norway also extended its parental leave period from 28 to 42 weeks at 100% wage compensation, with fathers having a minimum of four weeks spread over the first year [15]. Compare this the recent (2004) British fathers' boost of two weeks to be taken within the first two months! And contrast the Nordic early parental leave policies with figures for maternity leave and pay in the rest of Europe: UK - 6 weeks at 90% of pay, then 20 weeks statutory maternity pay at £102.80 (with up to another 26 weeks unpaid leave); Austria - 16 weeks at 100%; Portugal - 13 weeks at 100%; France - 16-26 weeks at 84% pay; Ireland - 14 weeks at 70%; Switzerland - 8 weeks at 100% [16a]. A hidden drawback remains: as long as sex-based inequalities of pay persist with a payment ceiling for paternity leave, the choice of who takes leave is predetermined among higher earning men, as it makes economic sense for fathers to go back to work. (British fathers on

average earn two-thirds of family incomes and work the longest hours in the European Union – 48 hours a week [16b]). *Furthermore, as the stay-home primary carer's total responsibility for the developing infant increases, with intimate knowledge of needs and wants, the working parent becomes further distanced as secondary and less familiar caregiver.* Nevertheless, in the UK 36% of fathers are the main carers while mothers are working, and many are involved in primary care on weekends.

However, it is not an all or nothing situation. Among working parents in Britain, a recent survey revealed a hidden social revolution taking place in public attitudes towards balancing work and parenting, with 61% saying that parents of young children spend too long at work. Since 2003 the younger workforce has been trying to change the balance of their responsibilities by taking advantage of the Government's 'family friendly' package which gives employees the right to request flexible working hours, to enable them to spend more 'prime' time at home. However, there is a need for further reform of early care, and 66% of all those polled expressed a desire to see families being given a Scandinavian style choice of mothers or fathers sharing parental leave, and 53% want more than the 'mean' current two-week paternity leave to enable fathers to have a chance to take a greater role in caring for babies and bringing up their young children [17a]. Once again, we may think in terms of the three basic orientations towards mothering, differing in behavioural practices that reflect underpinning beliefs and unconscious representations. The '*Facilitator*' mother who believes that pregnancy primes her for a unique and exclusive connection to her baby; the '*Regulator*' who sees mothering as one role among many and the '*Reciprocator*' who negotiates issues as these arise, rather than acting on set beliefs. Clearly, the pressure to return to work too soon affects Facilitators who wish to be sole provider for the baby. Craving adult company and application of their work skills, other mothers (namely Regulators) might be ready to go back well before the maternity leave is up. While Reciprocators may seek a combination. One neat (and cheap) solution that combats both social isolation and second-rate childcare is a PACT [Parent and Children Together] baby and toddler playgroup facility in which Facilitator mums stay with their own baby and in addition, take personal responsibility for the baby of a working Regulator.

However, sadly, for most mothers, decisions are determined not by desires but financial needs, as a family drops abruptly from two incomes to one at the very point of their biggest expenditure. In

competitive professions, career women feel pressured to return to work for fear of losing out. Conversely, with high unemployment, some of those wishing to work may have no job to go back to. And for working mothers living in large cities, breastfeeding remains a problematic issue as long as work places do not provide on-site crèche facilities (see 0.2.9 below).

Once again, it is a matter of implementing policies which provide multiple choices to suit the needs of differing families. Yet far from providing such flexibility of choice, in Britain the current Government has veered from one extreme to another – providing financial incentives to encourage all mothers to go back to work, penalising stay-at-home Mums. Then, conversely, as awareness of the birth-rate falling below the critical replacement level created panic at the looming crisis of an ageing population. The projected soaring number of pensionless older citizens and shrinking work-force in 2050 induced the Trade & Industry Secretary to actually appeal in late 2004 to women's sense of 'national duty' to have more babies so 'crucial for the economic and social success of the country', pledging new family friendly policies [17b]. *This blurring of private and public zones, illustrates the dawning recognition that while reproduction is essential for species and state – for the individual woman, it is now an option.*

0.1.3.2 Mental Health of children and adolescents in Great Britain:

The one consistent precipitant of disturbance in children is parental disorder. As many people experiencing mental health problems go undetected or do not seek help, a series of nation wide surveys were undertaken to establish rates of psychiatric morbidity across Great Britain and England. These household surveys found that 1 in 6 (16%) of the population of adults have mental health problems and symptoms at any one point in time of which a higher proportion are women (in London 22.4% vs. 14%). Men have higher levels of generalised anxiety disorder and depressive episodes, personality disorders, drug and alcohol misuse and suicide, although women are at a higher risk for ongoing depression.

Rates of emotional disorders in children are directly associated with mental health problems in the parents, with a three-fold risk when mothers are disturbed, a two-fold risk in discordant or reconstituted families and in lone parent-families (whether single, widowed, divorced or separated). Apart from severe disorders, childhood disturbance manifests as 5% conduct disorders, 4% emotional disturbance (mainly anxiety and depression) and 1% hyperactivity, with a higher proportion of

boys (11% vs.8%). Rates increase with stressful life events, poverty, geographical location (twice as many children have mental health problems in inner cities and 'striving' as opposed to 'expanding' or 'thriving' areas), linked to parental unemployment and low education [17c]. If this is so in the UK with its National Health Service and all its many resources, this is even more pertinent in less fortunate societies. As noted throughout this book, children are particularly vulnerable during *the early years of life* when the child's self is being constituted through interaction with caregivers [see section 0.4 below]. The detrimental effects of parental postnatal disturbance on their children's emotional, social and cognitive development often persist long after the carer's illness abates. It is crucial therefore to provide parents with resources to prevent disorder and opportunities to work through and resolve disturbance rather than inflicting this on their children.

0.1.4. Life Expectancy, infant mortality and relevant Epidemiological data:

0.1.4.1. Healthy life expectancy at birth has risen dramatically in the west over the past two decades but it varies between rich and poor, both within societies, and across the world - from just 25.9 years in Sierra Leone, and under 30 for many other sub-Saharan countries where it has dropped to medieval figures due to AIDS.

This new method of calculation developed by WHO [HALE or DALE] estimates the expected number of years a baby born today will live in full health. Years lost to disability are substantially higher in poorer countries (14% of life in blindness, paralysis or severe bouts of malaria) than the healthiest regions who lose some 9% to ill health. Healthy life expectancy in war devastated Afghanistan is a mere 33.8 years as opposed to 69.9 in the UK and 73.8 in low heart disease Japan (projected to fall as eating habits deteriorate). Preventable ill-health is still an issue - even Iceland and Norway (amongst the highest life expectancy in the world - 78.1 and 76.4 for men and 82.2 and 81.7 for women respectively) are still losing almost 6 and 9 years respectively on (largely alcohol related) conditions. In addition, an estimated 25% of preventable illnesses worldwide can be attributed to poor environmental quality!

The other top nations are France (73.1); Sweden (73.0); Spain (72.8); Italy (72.7); Greece and Switzerland (72.5). Australia is about to fall from 73.2 due to childhood obesity. USA came 24th, with 72.6 for females and 67.5 for males, largely due to poor minorities, homicides, HIV, obesity, drug and tobacco abuse. *As noted, within societies, health*

disparities can be marked, intrinsically related to income, education and access to health facilities. The infant death rate among African Americans, American Indians and Alaska natives is twice that of whites – attributed to a complex interaction between environmental factors, genetic variations and specific health behaviours. Similarly, **gender disparities** exist within societies. In the early 1990s, the gap between female and male life expectancy was 23 years in richer countries, but by 1999, women live an average of 7-8 years longer (due to better diet and more exercise although recent increased smoking among women will soon translate into higher disability and earlier death). In the UK, the gender breakdown for current HALE figures is 69.1 for males and 72.1 for females with total life expectancy (LEX - uncorrected for years of illness and disability) at 75.8 for males and 80.5 for females born in 2004 (contrasted with 100 years ago when it was 45 and 49 respectively!). The greatest female/male discrepancy is Russia with 66.4 and 56.1 respectively due largely to male alcohol abuse with consequent accidents, violence and cardiovascular disease [18 a, b, c]. In general, differences in life expectancy have widened over the past decade between prosperous and deprived areas (counties and health districts) even within the same society.

0.1.4.2. Infant Mortality:

Medical care, especially targeted at weaker groups, with incentives to utilise antenatal care and early immunization initiatives are seen to pay off. In 1997, Sweden had the lowest recorded rate of infant mortality in history – 3.6 deaths per 1,000 live births. However, by the end of the millennium Iceland achieved an outstanding reduction in infant mortality to 1.2 per 1000 live births! (vs. 2.4-3.1 in the other Nordic countries). Deaths under a year result from extreme prematurity, birth defects and Sudden Infant Death Syndrome. The most recent UK figures put infant mortality rates at 5.5. But figures can be misleading as although similarly based on the number of deaths before the first birthday for every thousand live births, in Britain viability at birth is calculated from 24 weeks of gestation (and the USA at 20 weeks) – so figures may not be comparable to rates elsewhere which figure birth from 34 weeks gestation or later. Similarly, figures are biased as many societies do not register births of under 1,000 grams as opposed to highly industrialised societies with systems of intensive emergency intervention, who do register very low birth weight preterm babies, with an extremely high risk of dying.

A breakdown of UK infant mortality rates delineates: early neonatal

deaths 2.7 (under one week); neonatal deaths 3.6 (per 1,000 babies under 4 weeks), post-neonatal deaths 1.8 (post 28 days but under a year) and 5.3 stillbirths per 1,000 births [19a]. Foetal and neonatal deaths are highly related to socioeconomic deprivation (whether measured by any of three population based indicators of material deprivation - Jarman index, Townsend score and percentage unemployed). One study showed that 30% of perinatal deaths were statistically attributable to social inequality [19b]. Similarly, regional differences in stillbirths and neonatal death rates can help to ascertain weak elements in quality of antenatal, delivery and neonatal clinical care, as studies in Wales and Sweden illustrate [19c,d].

Bearing these qualifications in mind, variations in infant mortality rates serve as a measure of *state health care policies and the socio-economic status of subgroups of a general population*. The USA, with 5% of the world's population consumes 40% of its natural resources. Nevertheless, this richest society in the world has a high infant mortality rate, and America's life expectancy at birth still ranks behind fifteen other nations, all of which spend proportionately far less on health care. In 2001 infant mortality rate reached an historic low of 6.8 deaths per 1,000 live births, but by 2002 it rose to 7.2, backsliding from 21st to 30th place in infant mortality, behind Cuba (at 6.45) with its socialist public health care system [20]. Infants die at a higher rate in America each year than in 29 other industrialized societies, including the Nordic countries, UK, Germany, Portugal, Israel, France, Singapore and Slovenia! The Center for Diseases Control and Prevention attributes the worsening US rate to very young or much older first-time mothers, inclusion of preterm very low birth-weight babies and multiple births rather than poor state health care provisions. However, examination of the figures reveals *large disparities among racial and ethnic groups*, with black infant mortality rates still almost three times greater than that of white infants which continue into the new millennium despite new initiatives of Medicaid and SCHIP (State Children's Health Insurance Program). And according to a 2004 study by the US Center for System Research (n=25,400 families), one in seven Americans – or 20 million families – are struggling to pay for food and shelter because of debt problems from medical care![21]

0.1.4.3. Cultural influences: Infant mortality is also compounded by *social mores*. In Asia, conservative estimates find that 90 million females are missing in societies which favour sons over daughters, practicing discriminatory abortion or female infanticide, especially in India, Japan, and China since the single-child policy. Laws prohibiting abuse of

ultrasound for fetal sex-selection are finally becoming more effective but the social ramifications of the gender gap are enormous.

0.1.4.4. Crisis and conflict: Perinatal mortality also directly reflects *political realities*. The worst rates, like 165 babies of every thousand live births dying under one year in Afghanistan, reflect desperate poverty, poor sanitation and post-war difficulty implementing health programmes, such as immunization. In war-torn Iraq due to a collapse of the water and sewage systems, women are miscarrying and dying from a virulent form of hepatitis E infection particularly dangerous to pregnant women [22a]. Statistics from the Middle East demonstrate a similar story. Israeli figures indicate a steady decline in infant mortality since 1970. The most recent figures show a decrease from 5.5 per 1000 in 2002 to 4.94 in 2003. However, when broken down into ethnic groups, the figure for Jewish babies was 3.3 per 1000 (constituting a 10% drop) while in the Israeli Arab sector it was 8.36 per 1000, reflecting an 8% fall. The discrepancy is attributed to 'inbreeding [between first cousins] and poverty' [22b]. However, figures for Palestinians in the occupied territories (as opposed to Arab citizens of Israel) show a much higher figure despite a recorded fall from 32 in 1990 to 21 per thousand in 2001. Official figures are based on registered infant deaths, and some Palestinian professionals claim that infant mortality in the West Bank and Gaza far exceeds the low 20's (and UNICEF puts it at 23 for 2003). Quite apart from the chronic anxiety, food shortages nightly bombings and violence – curfews and travel restrictions affect antenatal screening and long delays at checkpoints when in labour greatly increase the chances of complications [23].

Throughout the world, in many places the devastating aftermath of wars creates large-scale population upheavals with displacement of refugees. In addition, internally displaced people (IDP), and voluntary or enforced rural to urban and/or trans-border migration have lead to a hundred million homeless worldwide (1,000 million if temporary or poor accommodation is included), with consequent problems of lowered self-confidence, disorientation, lost relatives and possessions, dependency and lack of protection. Starvation, illness, overcrowding and social isolation, mass unemployment, lack of access to medical care, drug addiction and sexually transmitted diseases all contribute to the medley of demographic and socio-economic reasons for a high prevalence of psychological distress, especially affecting parents, young children and vulnerable babies. Thus UNICEF cites 2004 infant mortality figures for Mozambique, a civil-war torn and climactically devastated country, at 197 deaths per 1,000 live births! As noted above, 165 under-one-year olds die

in post-war Afghanistan with under-five mortality rising to 257 per 1,000 live births and over 400,000 displaced people. 129 infants per thousand live births die in the democratic republic of Congo where one of the bloodiest world conflicts rages, with disease, starvation and destruction of homes and hospitals. Conversely, with health and nutrition campaigns, Angola which had one of the world's worst infant mortality rates has now dropped to 154 deaths per thousand babies under one year, (and 260 for under-fives!) but hopes are high since the April 2002 peace accord, despite landmines, rising HIV/AIDS, lack of safe water and devastated health and education services.

0.1.5. Third World privations, AIDS and maternity:

In the relative luxury of our health services, we tend to forget that compared to Europe, the third world gap in life expectation continues to widen. Babies born now are doomed to an early death due to privation, famine, violence and disease, especially AIDS, in addition to poverty, dietary deficiencies and maternal mortality [see 0.2.9. below]. UNAIDS 2003 estimate the global total of HIV/AIDS-related deaths at 3 million, with 37 million adults and 2.5 million children living with HIV - 95% of those in the developing world [24] [This is a shocking 50% higher than the figures projected by WHO in 1991. However, UN predictions are that after an eventual peaking of AIDS deaths, rates of HIV transmission will start to decline from 2010 in the 53 countries most affected]. Antiretroviral treatments increase survivor numbers in high-income countries; however these have not been available in poorer societies, who are now negotiating the use of generic locally made cheaper drugs. As many African males find condoms objectionable, new preventive measures include protective microbicides, and diaphragms or condoms for use by females. Planning also includes a relatively cheap treatment for herpes infection as up to 70% of women in sub-Saharan Africa suffer from genital herpes which increases the risk of contracting AIDS by a factor of four or five [25]. Meanwhile, there are expanding geographical tracts in which the population is 'hour-glass' shaped and toddlers are cared for by grandparents as the mid-range generation of childbearing adults have died off. 14 million AIDS orphans live in slums around the world, joining other child-headed households and street-children who survive by prostitution or scavenging. Unlike women in other regions, African women are 1.2 times more likely than men to be infected [26a]. In many places, women are screened for HIV during pregnancy. This gives an indication of the rapid spread of the disease. In South Africa, HIV

prevalence in antenatal clinics has risen from 0.7% in 1990 to 4.0% in 1993, to 17.0% in 1997 and 26.5% in 2002! [26b]. Throughout Africa between 5% and 40% of pregnant women are affected, with more than one child infected every minute of every day through mother-to-child transmission, occurring before, during or after delivery. A number of pilot projects started by UNICEF, USAID, UNFPA, UNAIDS, WHO, Medecins Sans Frontieres, the Therapeutic Solidarity Fund and other agencies aim to reduce the risk of transmission by lowering maternal viral load (using prophylactic anti-retroviral treatment, boosting the immune system, and reducing the baby's exposure).

My consultations to midwives, therapists and counsellors on different continents, show that wherever she lives, when an expectant mother discovers she is HIV+, the juxtaposition of a life threatening illness with a life-giving pregnancy is an impossible aporia. The diagnosis in the context of pregnancy is accompanied by stages akin to mourning – shock, confusion, denial, abandonment, anger and mixed feelings. Pleasure in the pregnancy mingles with anxiety about her own survival, guilt about bringing an orphan into the world, remorse at possibly infecting her baby, shame about having to break the news to her family (with the social stigma of AIDS still rife) and dread of the uncertain course ahead, including treatment (or its unavailability). In macho societies, many pregnant women are beaten or abandoned by their partners who refuse to be tested themselves. Some are ostracised by family and friends. In addition to being treated as potentially contaminating by maternity staff, a woman has her own fears about pregnancy exacerbating the illness, ambivalence about a C-section, crucial decisions about breastfeeding as fantasies merge with the reality of her body and milk being poisonous. (WHO stresses that forbidding breastfeeding where it is the norm marks the bottle-feeding mother as HIV-infected, and the risk of stigmatisation, possible violence and rejection [27]).

Every new physical twinge is treated with caution and confusion between symptoms due to pregnancy and others of unclear origin. These turbulent emotions often lead to inconsistent treatment of the baby who is both over-invested and envied, repudiated and/or blamed. Counselling is often restricted to only two visits and limited to the physical. The need for ongoing psychological treatment and/or containment usually goes unrecognised, or is regarded as too expensive by perinatal service providers. However, work in Soweto and other HIV+ high-density areas, demonstrate the effectiveness of low maintenance leaderless pre and

postnatal peer-support groups, and many women benefit from this self-help group. Nevertheless, some mothers choose to avoid these, feeling that being reminded of the diagnosis undermines their adaptive denial or need for secrecy.

Mother to child transmission is responsible for at least 50% of child cases. Breastfeeding by HIV+ mothers is usually counter-indicated [28]. However, often it is the only viable choice, as refraining from breastfeeding in areas of famine or polluted water increases the risk of infant mortality (and releases maternal fertility). Studies in Cote d'Ivoire and Burkina Faso of women who breastfed despite the risks, found that the initial benefits of prevention of vertical HIV infection are partly reversed through breastfeeding [29]. Another study in Durban, South Africa, shows that even in the absence of antiretroviral therapy to reduce mother-to-infant transmission, babies who were exclusively breastfed for three months or more by HIV-infected mothers had no excess risk of HIV infection over six months than those never breastfed [30]. Sadly though, exclusive breastfeeding can compound the risks as a cohort study of child survival in Uganda found. In many cases infant mortality associated with maternal death is not due to HIV infection but malnutrition or diarrhoeal disease because of sudden forced weaning [31]. Teasing out the complexities of these various findings is essential in view of the risks of NOT breastfeeding among disadvantaged populations in Sub-Saharan Africa and South Asia where clean water for formula feeding is not readily available. Finally, a new form of HIV infection has been disclosed in some hospital-born babies to parents not infected by the virus (thus unrelated to breastfeeding or sexual transmission). Fourteen such cases have been brought to light recently by parents suing the department of health in the Western Cape and elsewhere [32a]. The source of these infections may be blood transfusions, needle-stick, contaminated medical instruments or possibly, infection by another patient in the same hospital, indicating the need for greater HIV risk management and increased precautions.

Finally, there is no place for western complacency as the total number of people living with HIV continues to rise in high-income countries (now estimated at 1.6 million), largely due to widespread access to antiretroviral treatment, as well as the 80,000 new infections in 2003, due to risk-taking behaviours. Prevention activities are not keeping pace with the rapid and changing spread of HIV and AIDS continues to take its toll, claiming some 18, 000 lives in the past year. And the AIDS epidemic in Eastern Europe and Central Asia shows no signs of declining,

especially in the Russian Federation, Ukraine and the Baltic states with some 230,000 newly infected in 2003 bringing the total number of people living there with the virus to 1.5 million (and 30,000 deaths last year). Similarly, over 1 million people acquired HIV in 2003 in Asia and the Pacific, bringing the estimated total there to 7.4 million. Infection also rose in North Africa and the Middle East. And more than 2 million people in Latin America and the Caribbean are now living with the illness [32b]. Since the 1996 introduction of anti-retroviral drugs, in some European countries, medical policy leans towards assisting HIV affected couples to conceiving safely through sperm washing and IVF, thereby treating it as a containable disease, like diabetes. However, worldwide, early and unprotected sex results in unintended pregnancy, in some cases with terrible repercussions. Over 90% of infected children in the world are babies born to HIV positive mothers who have not received protective drugs. Their care, education campaigns and prevention of HIV must concern us all. In these times of interdependent globalisation, none of us can ethically remain a protected isolate.

Changing parameters of childbearing, infant mortality and healthy life expectancy are indices of the complex interrelatedness of factors which determine any individual's quality of life, anywhere in the world. They indicate the necessity for a combined multidisciplinary effort towards health promotion, appropriate education, reduction in health disparities and improved emotional well-being, to which we can contribute, each in our own way, in our own corner.

KEY POINTS:

*The needs of babies have changed very little over the millennia. In societies in transition, this puts babies at risk of being at odds with their parents' rapidly changing lives.

*Scattering of extended families and eroded community networks increase mutual-reliance and the intensity of interdependent relations in the small nuclear unit.

*Gender inequalities of childcare within the family are fostered by governmental policies on parental leave.

*In western countries educational parity and women's career prospects delay childbearing, and work/home dislocation disrupts parental childcare.

*Conversely, western teenage births have increased, with attendant problems of low birth weight, poverty and parental immaturity.

* Urban stratification and reduced family size decrease access to babies and opportunities for us to emotionally work through infantile issues

before becoming a parent raising the likelihood of perinatal disturbance.

* The detrimental effects of parental disturbance on their children's emotional, social and cognitive development often long after the carer's illness abates. Preventive and therapeutic measures are a necessity.

* Both within and between societies, health disparities are intrinsically related to income, education and access to health facilities, with higher infant mortality and maternal morbidity.

0.2. MATERNITY CARE

0.2.1. Changes in maternity services in the UK:

Over the past few decades, advances have been led by both *provider initiatives* (Health providers in the UK, Association of Radical Midwives and ANACS – the Association of Nurse Advocates for Childbirth Solutions in the USA) and *consumer pressures* (National Childbirth Trust, Maternity Alliance, and AIMS – the Association for Improvement of Maternity Services in the UK and the Maternity Care Coalition in the USA) to improve maternity care. *The emphasis is on woman-led care - antenatally, during labour and birth, and in establishing lactation.* Concerted campaigns from courageous individuals to ensure women's rights [33] have helped to change the climate of opinion. In recent years, British Government policies indicate greater awareness of psychological issues, and advocate availability of options to cater to personal preferences, special needs and diverse cultural expectations. The 1993 'Changing Childbirth' report laid down guidelines for one-to-one midwifery care and 'choice, control and continuity' for women and since devolution, the Scottish Framework evolved 27 principles to improve maternity services [34 a, b]. The Royal College of Midwives, the world's oldest and largest midwifery organisation, published a report entitled 'Vision 2000' for future development of maternity services based on a UK-wide consultation, conducted throughout 1999, of midwives and other key stakeholders in maternity care. The vision called for maternity services to provide high quality, evidence-based, cost-effective care which is responsive to individual needs and preferences, and which promotes and sustains public health according to twelve key principles:

- *User involvement.*
- *Public health* (including targeted support for women with special health and social needs, and measures to reduce inequalities).
- *Community focus*
- *Integration across acute and community sectors*

- *Normality* (an underpinning philosophy of pregnancy and birth as normal, with a commitment to positive reduction in unnecessary medicalisation)
- *Midwifery-led care*
- *Maximised and targeted continuity of carer*
- *One-to-one midwifery care in labour*
- *Family-centred care*
- *Clinical excellence*
- *Midwifery leadership*
- *Partnership* (between Midwives, obstetricians, paediatricians, GPs and health visitors)
- *Opportunities for change* (acknowledging variations in models of maternity care and geographical, demographic and staffing, pointing to the need for continuing flexibility and creativity in service planning and delivery) [35a,b].

Sadly this 'vision' is far from realisation. In fact a national survey investigating the experiences of 2,000 recent mothers (average age 29) published in March 2001 revealed that most respondents were dissatisfied with the care they received during childbirth and less than half felt happy to return to the same hospital to give birth again. Three-quarters said they felt anxious during pregnancy and frightened during labour. Six in ten found the experience of giving birth more shocking than they expected. Four in ten said they were not allowed to move around during labour and take up positions they wanted, and 43% said they did not have the type of birth they sought. Only 8% of women had a completely natural birth, without the need for drugs or surgical interventions. A quarter had a caesarean section. Among those giving birth normally, 35% were induced, 45% had an epidural, 12% had a forceps delivery and 53% needed stitches. Half of all new mothers also said they had received poor postnatal care once they had taken their baby home and 79% said they were in pain after the birth for an average of two weeks. The women were also dissatisfied with their care during pregnancy. And only 4% had the same midwife for all antenatal appointments and delivery. Summed up as 'conveyor-belt birth experience to suit the hospital's agenda', these findings were partly attributed to 'overstretched maternity staff' and a 'lottery' of unevenly distributed resources and variations in standards in units across the country [36]. This situation lowers the morale of midwives who strive to provide good care as well as letting down the women who are entitled to it.

0.2.2. On the coal-front:

How has this situation come about? A National Service Framework (NSF) on maternity services enforced new national standards to ensure that every woman would have '*one-to-one*' *continuous care* by a midwife, dedicated to her throughout labour and the National Institute for Clinical Effectiveness [NICE] provided a review and guidance on Intrapartum Care [37a,b]. And to facilitate improvement the government promised £100 million to maternity services staff and agencies in May 2001. This 'cash injection' was to be supplemented by an extra 2,000 midwives on wards in England by 2005, 500 of whom were promised to be in place by the end of 2003. All 250 NHS maternity units in England were to receive 'extra funds' to refurbish and modernise facilities in a bid to eliminate big variations in the standard of maternity care throughout the UK' [38]. This boost was intended for 'maternity services that give women and families more choice over the care they receive so that every child, regardless of background or circumstance, has the best possible start in life'. Nevertheless, a report by the Commons health committee a year later noted that maternity services were still lacking, with only 2% of babies being born at home (although 20% of mothers would prefer this type of delivery given a choice). Women were limited to bringing only a single birth partner and 'too many women were being given caesareans without having the opportunity to exercise informed choice'. In addition inequalities were still rife and maternal death rate in unemployed families in England was still 20 times higher (!) than among women in the two highest social classes, and a disproportionate number of women from traveller families died in childbirth or shortly afterwards. The Health Committee members concluded that 'the government should address concern that birth was no longer perceived as a normal physiological process'. These MPs also highlighted concerns about the closure of smaller maternity units and birth centres, midwife shortages and a lack of experienced obstetricians, lack of specialist mother and baby units for women suffering severe mental health problems after the birth, and little help for those affected by disabilities or language problems [39]. To date, the UK's midwifery shortfall shows no signs of improving, according to new figures unveiled by the Royal College of Midwives on March 18th 2004. Surveying 240 midwifery units across England, Northern Ireland, Scotland and Wales they found that more than three quarters of the maternity units who responded are still experiencing shortages, rising to 83% of those surveyed in England. In London a massive 18.3% of posts remain unfilled, whilst there has been a decrease in all categories of

midwives joining the service, and no significant improvement on the previous year. In fact, in London and the South East the situation has deteriorated further. Bad conditions and low pay deterred trainee nurses from becoming midwives, and one sorry solution has been to poach qualified midwives from developing countries where they are sorely needed. Conversely, many nurses including midwives are seeking agency jobs or recruited to work in the USA, where flexible work hours and better conditions beckon. It is now estimated that the NHS lacks a further million nurses in 2005! Nevertheless it is not just a matter of numbers. In the debate that followed some adverse maternity incidents, one Director of Midwifery noted that simply increasing staffing levels may not resolve the problem as 'even on a well staffed labour ward there can be moments of crisis...because of the unpredictable nature of the service', especially if personnel are tied up in caesarean sections. She suggested deploying midwives to educate women antenatally to realise the 'cascade of interventions' that follow coming into hospital too early and to motivate doctors and midwives to reduce interventions [40].

0.2.3. Provisions for addressing anxiety - women:

Humans seem to be the only primates who seek assistance during labour. This is attributed to the discrepancy between the large-headed baby and the long axis of the birth canal since humans began to walk upright some five million years ago [41]. We are also the only species who can imagine our own death, and make connections between the aloneness of birthgiving and of dying. Ancient references to midwives and anthropological evidence indicate that provision of assistance was probably not merely physical but included emotional support at a time of pain and anxiety. These needs still exist. However, due to medicalisation, staff shortages and lack of psychological training, the anxieties of pregnant women tend to be overlooked antenatally. Like other research which asks about anxieties, a study of 481 women in western Finland found that 78% of respondents expressed fears relating to pregnancy, childbirth or both and that in some cases desire for a caesarean section was related to negative experiences in previous pregnancies, and a wish to avoid the birth [42]. Similarly, a Swedish study of 100 women with severe anxiety over childbirth found that intense psychological support reduced the rate of C-sections by half [43]. Antenatal classes are the ideal place for emotional support and exploration of anxieties. However, sadly, in the UK fears and fantasies are rarely addressed during pregnancy, and in the

absence of continuous one-to-one midwifery care during labour, women are often left to their own anxieties, which increases the necessity for interventions. Within the NHS antenatal classes tend to focus on the physical aspects of labour and birth, and these lack uniformity, varying regionally, and even within the same hospital. In addition private classes (NCT, Active Birth, Yoga and others) focusing on breathing and relaxation strategies, may not prepare women for the unexpected and/or produce expectations which are at odds with hospital practices.

0.2.3. Provisions for addressing anxiety - midwives:

On the other hand, neither are the **anxieties experienced by midwives** addressed. Working within a cauldron of bubbling and highly disturbing emotions, a midwife is both absorbing the raw feelings of the labouring woman and dealing with life-giving and death-dealing issues in herself. In her daily job, a midwife is exposed to the naked physicality of a stranger, to the tidal contractions and unleashed eruptions of her innermost emotions and bodily fluids. A mid-wife inserts her hand into the stranger's vagina to sweep her membranes, she tidies tendrils of her damp hair, offer her water-sips, blows her nose, rubs her back and holds her hand. In helping the labouring woman, she accepts her leakages - bowel or bladder 'accidents'; vocalisations of pain - screams, curses and expletives; soothes her convulsions of fear and paroxysms of rage, coaches and wheedles the crowning and massages the parturient's trembling legs. Encouraging the birth, she slips her fingers beneath the bulging rim, and as the vernix-covered body slithers out, wipes away the filaments of sac, amnion, meconium and streaks of blood before handing over the glistening squirming bundle into the arms of the spent mother.

Reacting to rudimentary passion in the room through the filter of emotions stirred up inside her from her own unprocessed past experience, the midwife exudes her own anxieties while soaking up those of the woman whose perspiration she mops. She is both fulfilling her professional duty and unconsciously trying to live up to, or taken by surprise by, the labouring woman's unconscious projections of a harsh or protective archaic powerful maternal figure into her (which may or may not coincide with the midwife's own internal mother figure). She may have difficulties negotiating her (at times conflicting) dual identifications with, and envy of, both the mother and her baby during pregnancy, labour and birth. While indispensable she is secondary, a bystander and witness to bare emotional and erotic intimacies between the woman and her partner from which she is excluded, as she was from her parents' sexual

relationship. In an emergency situation, providing psychological support for the labouring woman and her partner is difficult as the midwife confronts immediate dangers she alone can anticipate. Guiding and encouraging the birthing woman to 'pant' or 'push', her feelings wax and wane, aroused and yet resisting arousal by treating as ordinary the miraculous moment of birth. Confronted time and again, night after night, day in and day out by the mystery of origination - a new human being emerging from another (as she herself did, and each and every one of us who rarely have to think about it). And all this while also negotiating issues of control and its loss, authority and unequal power relations; containing the chronic stress and inevitable pain inherent in the job! These are but some of the complexity of feelings experienced by a midwife on the labour ward, but in addition, unlike therapists who are exposed to heightened emotions in their consulting room, she has not had the opportunity of exploring her own hidden feelings [see Chapter 16]

Not surprisingly, the midwife's anxieties and unconscious representations find their way into her practice. For instance, if the labouring woman's body is unconsciously deemed 'open', apprehension about her vulnerability may be formulated as fear that she is susceptible to entry or attack (by germs, bad thoughts, etc) or conversely, to seepages from within (amniotic fluid, loss of blood) leading to urgency about inducing, prepping, stitching, wadding, etc. Similarly, if the labouring woman is perceived as dangerous, a threat either to those around her or the baby, she may be avoided, kept away from others, and/or monitored to prevent her endangering the child. When socially unconscious representations take the form of cultural beliefs, practices become embedded in routine, ritual and unquestioned local customs (also see Chapter 18). These may be charted in **five childbearing configurations** :

IMAGE of WOMAN:		CONDITION:	PRACTICE:
I	Vulnerable	<i>Open</i> ? in ? out	closure, speed protective devices
II	Dangerous	'dark' (supernatural) 'dirty'untouchable 'polluting'	seclusion avoidance purifications
III	Passive	'damaging' <i>inert container</i> 'resistant'	control delivery/caesarean coaxing
IV	Obstructive	'ignorant' 'difficult patient'	coaching punishment
V	Active agent	<i>entitled participant</i>	informed choice

0.2.4. The five 'C's – choice, control and continuity, communication and compassion:

Birth is a highly private and cherished event which many women resent sharing with a stranger. Studies of thousands of women from places as far apart as Melbourne, Australia and Scotland [44a, b] provide evidence that not surprisingly, women desire care from a *known midwife*. However, few services outside of Scandinavia offer overall one-to-one antenatal, intrapartum and postnatal continuity. Nonetheless, although clearly important, there is a danger that focusing research on the issue of 'continuity' of care throughout pregnancy and labour may obscure the importance of *quality* of care, even by an unknown midwife [45].

To the Cumberlege 3C's of a woman being granted '*choice, control and continuity*' during her labour, we may add two more – '*communication and compassion*'. The need for an empathic experience with the midwife is highlighted in studies around the world. For instance two centres in Sweden stress that women's experiences of childbirth are enhanced by creating a trusting relationship between the woman and her midwife, based on the latter's listening skills [46]. Good communication is an asset, but not the whole story as a large survey in Atlanta, Georgia stresses, adding the necessity for pain management and opportunities to discuss the birth postpartum to reduce the traumatic experience of childbirth (especially in women with a history of sexual trauma) [47]. Not only the vulnerable but everyone searches for meaning after a confusing or disturbing experience, especially if it has been traumatic. However, sadly, '*debriefing*' after birth is often separated from the event itself. A national audit of maternity care services in Scotland found that although 62% of women had talked to a professional about what happened during their delivery and labour, in more than half the cases this was not someone who had been present at her labour! [48a]. Feeling powerless and abused, damaged or betrayed, 'overwhelmed', 'mutilated', 'violated' or stigmatised are subjective descriptions of birth experiences. Women who do not have an opportunity to work through what they consider to be negative incidents, continue to mull these over for many years after the event, with all the characteristics of PTSD such as intrusive thoughts, flashbacks, hyper-vigilance, sleep disorders, preoccupation with minutiae of the labour and birth, somatic complaints, suicidal ideation, self-destructive behaviours, sexual dysfunction, marital difficulties, postnatal and ongoing depression [48b].

Researchers comparing maternity-care perceptions of child-bearing women and those of primary health care professionals stress that

development of a '*consumer focused service*' means just that – understanding (rather than underestimating) the importance for women to have confidence in the providers. This includes a need to understand what is happening to them – to receive information about procedures and professionals' roles, and to be given a (personally and medically) appropriate degree of personal involvement in the process of decision making [49] about their own bodies and one of the most important experiences of their lives. Birth plans are a step in that direction, but in many cases these are overridden by hospital protocols. If stress and anxiety are provoked by feeling powerless in an unpredictable and depersonalised situation, *choice* (and realistic preparation) gives people a sense of personal control.

Anecdotal feedback from parturients in the USA and the UK indicate that the childbirth experience in the present context still reflects lack of control, choice, communication and compassion which are far from conducive to emotional well-being [50]. More importantly from the point of view of detecting anxiety and emotional problems during pregnancy, *discontinuous care* and multiple carers have an important side-effect. 'As a woman passes from family doctor to student midwife or to junior obstetricians for subsequent antenatal visits, then meets new faces in the delivery suite and subsequently in the postnatal ward where she must undergo checks from obstetricians and paediatricians before leaving hospital to go back into the care of the community midwives, health visitors and her family doctor, it is not surprising that changes in her mental state may be missed' says a psychiatrist-psychoanalyst [51]. This is compounded by the fact that even when vigorous attempts are made to detect women at risk of developing emotional disturbances, or those already suffering with psychiatric problems antenatally or after the birth, a significant proportion, nearly a third, fail to keep clinic appointments. It is possible that many such non-attenders are also the most needy or distressed; they may be overwhelmed by the problems of coping with other small children without a partner or too depressed or fearful to attend. Women suffering from phobias may find it hard to come to a hospital clinic. Others find the journey too difficult while feeling anxious, exhausted and run down, especially with an infant or toddler in tow. To address these issues, there clearly is a need for a *coordinated policy of care* based upon links between hospital and community primary health care services, Social Services and voluntary agencies. To be effective, such resources must also be capable of being delivered at home and the

contribution of child psychiatrists and parent-infant psychotherapists to the development and shaping of these services seems indispensable.

0.2.5. Complementary and differing perspectives on birth:

In recent years a great deal of research has explored retrospective feelings 'service users' have about the care they receive during this momentous event in their lives. Most findings indicate that labouring women wish to be treated with respect and as individuals. The UK National Birthday Trust Fund's semi-qualitative survey of over 15,000 women named choice as the key factor. Women are satisfied with maternity care, whether at home or in hospital, provided it meets their personal expectations [52]. Studies examining the inter-relationship between women's expectations and their actual experiences of decision making, continuity, choice and control in labour have implications for NHS maternity service policies. Recent findings show a shift in parturients since 1987 towards greater desire for involvement in both non-emergency and emergency decision making (including caesarean section) and choices about pain relief. *Overall, feeling in control during labour was associated with higher satisfaction and better emotional well-being postnatally* [53]. However, as I reiterate throughout this book, 'women' cannot be treated as a unified group. They each differ in their needs and priorities, and hope to have these respected. Thus, a small American study of women with high risk pregnancies (hypertension or threatened preterm delivery) illustrated that these women differed in the degree to which they wanted to be involved in decision-making during this period, but both those wanting active involvement and those who preferred a more passive role were satisfied if health care professionals were congruent with their wishes [54].

In all these studies, the **method of data collection** is most important. A large-scale nation-wide survey of *all* women giving birth in 23 consultant-led maternity units across Scotland over a ten-day period emphasised *the need to compare user and provider views*, using this complementary system of data collection to detect disparities and improve the quality of care [55]. Similarly, the need for comparison was emphasised by a review of all the UK literature relating to women's views on community based care between 1970-1998 concluding that consumer views must reflect different groups of women and their experiences of different care processes [56]. It is also important to recognise that Britain is now a pluralistic society with a diversity of cultural expectations, needs and beliefs. Services must meet the wide variety of needs of the populations they serve locally (see section 0.2.10 below). Evaluation of

the current success of projects within the 'ASQUAM' programme (Achieving Sustainable Quality in Maternity) claim that use of local guidelines, cyclical audit, monthly feedback meetings and training courses have led to significant improvements in clinical effectiveness in many of the 45 standards prioritised. However, they note there has not been the same success in achieving high standards in communication and informed choice [57]. Indeed, this is a recurrent theme, and a prospective study including in-depth interviews to assess women's views in north-east Scotland found that many consumers felt they were given insufficient information about the basics, such as available options of places of birth and pain relief [58].

Even women who try and glean as much knowledge as possible from external sources such as books and the internet, may find themselves caught up in a system where the rationale and implications of procedures are unknown. Clearly, information provision is a complex area, but in the absence of clear understanding, choices may be made by default.

Antenatal screening is a case in point. A review of 98 reports of 74 primary studies in 18 countries found that although ultrasound is attractive to women and their partners, they often lack information about its specific purpose and the technical limitations of the procedure and are therefore unprepared for adverse findings [59]. Indeed, a study of prenatal screening in two Finish towns raises the ethical issue of women being unaware that participation in screening procedures is not routine but a voluntary option [60]. Some tests (e.g. AFP and triple tests) with high false positive rates may cause unnecessary anxiety, followed by a cascade of diagnostic tests, some of which carry a risk of induced abortion and long waits for results. Counseling is rare and information-giving in itself is not always enough – ramifications of findings must be spelled out before a woman undertakes a test. Despite improvement on a previous multi-centre survey, a study in Glasgow similarly commented on women's compliance with antenatal serum-screening despite poor understanding of the nature of tests and their results [61]. Confronted with findings indicating that they have a high risk of a Down's baby, many women may not be aware that they will need further tests to confirm the veracity of the results, or are not even told of the small but real risk of miscarriage or infection amniocentesis holds. More importantly, they may not be informed about probabilities of false-positive maternal serum results, nor have contemplated the consequences of discovering their baby is imperfect, or the degree of abnormality they are willing to accept. A large scale trial in Helsinki reported on the need for written rather than just

verbal information about serum-screening, and possibly a second leaflet for women receiving positive results [62]. Brief counselling would give a couple the chance to bring understanding and emotion together in exploring the options available to them.

Similarly, information, acknowledgement and humane care were the variables cited in a qualitative study of women's needs in response to discovering a '**vanished twin**' through ultrasound [63]. These basic needs are also poignantly illustrated in in-depth case histories which reveal the often overlooked dual impact of technological screening - fostering parental faith in all-powerful medicine and yet also increasing the shattering experience if the familiar baby they have come to know through visualisations on the screen, dies in utero [64] or is born with a defect, despite screening.

Likewise, insufficient information about **the birth process** may lead to choices with unforeseen consequences, such as restricted mobility with drips and fetal monitors (and the latter's unreliability); the rapid acceleration of induced labour; catheterisation, raised uterine temperature, side-effects for the baby, maternal post-birth headache and backache associated with epidurals, and raised likelihood of caesarean, forceps or vacuum assisted deliveries, and possibility of severe perineal lacerations.

0.2.6. Caesarean sections:

In 1985 the WHO proclaimed that no region in the world was justified in having a caesarean rate of more than 10-15%. Despite this and the many medical risks involved for mothers and babies, in the past 20 years, rates in North America have nearly quintupled in the US (to 24%) and quadrupled in Canada - partly due to repeat C-sections, epidural analgesia, private medical insurance, and doctors' fear of litigation. In Britain too, figures have quadrupled over the past 30 years. One in five births in the UK are now by caesarean section - attributed to older primigravidae and a higher incidence of twins and triplets, conceived through IVF. However, caesarean rates also reflect the attitudes of the professionals involved. The doctor's age and gender, too, has been found to affect rates![65]. US studies of low risk cases also find that C-section rates vary between midwifery-led and physicians' wards even in the same hospital, and in free-standing midwives' birth centres rates are significantly lower. In the UK, disillusioned on the 5th anniversary of 'Changing Childbirth', in a 'Midwifery Matters' editorial the Association of Radical Midwives called for a midwife-led birth centre in every neighbourhood [66]. Caesarean section is also related to patient anxiety. A systematic Cochrane review of

randomized controlled trials shows that continuous professional support during labour is associated with a reduced incidence of surgery and instrumental delivery [67]. If one-to-one support in labour reduces risks, yet labour ward midwives are no longer available to provide this (because of overseeing several labours at once), a trained 'doula' birth partner (or female friend) is effective in reducing duration and complications of labour [68].

There are four primary reasons for 85% of C-sections: repeat caesarean (29%), presumed foetal distress (22%), failure to progress (20%) and breech birth (16%). Collecting data on 99% of births in England, Wales and Northern Ireland over a three month period in 2000, a Department of Health audit in 2000 found that only 63% of all caesareans were emergency and 37%, elective [69]. [When my own study in 1985 showed a high proportion of elective caesareans among Regulators, the results were questioned as it seemed unthinkable that women could influence their doctors to conduct major surgery by request]. *The dramatic rise in caesarean rate is now ascribed to a combination of medical, organisational and socio-cultural factors with long-term impact of the mother's health, greater cost to the NHS and as yet unknown effects on babies.* Depression is now a recognised common post-surgical phenomenon. Caesareans are major operations, and not surprisingly, many women experience a deep sense of melancholy, partly related to the body's fallibility and the profound helplessness of having surrendered to being cut open while awake. Breastfeeding is more difficult to establish following a caesarean operation, it is difficult to lift the baby, cough or even laugh. Many women experience a sense of failure, shame and drop in self esteem at not having given birth 'naturally'/vaginally. Some feel embittered, alienated from the baby and or shocked by their scarred ('mutilated') body, and fearful that their fertility has been compromised.

Despite a fall in the mid-90's, worldwide the rate of Caesarean sections has climbed up again in recent years. In 2002 the US average rate rose to its highest ever at 26% (ranging from 31% in Mississippi (where midwifery is still illegal) to 19% in New Mexico where unusually, over 25% of babies are delivered by midwives) [70]. In Brazil it reached an unbelievable average rate of 40% (and over 80% in private hospitals). In the UK the NHS rate is around 20% of which the elective rate is 8.9% - usually attributed to women 'too posh to push'. However, a recent investigation into the rising rates in the UK found on the basis of NHS hospital data for 2001-2 that although women living in deprived areas are significantly less likely to have an elective caesarean, in the other areas

this is not linked to increasing affluence. Nevertheless, this study excludes private hospitals which have very high rates [71]. The reasons for elective Caesars are complex, including a busy schedule and desire for control (by both private obstetricians and the women they serve); avoidance of pain; an intact 'honeymoon fresh' vagina; fear of labour... Financial gain and fear of litigation are among the reasons for compliance by private obstetricians. Accurate information about the postnatal incapacity involved, good birth preparation and timely counseling for women's anxieties may prevent some of these unnecessary operations.

0.2.7. Home births:

In Holland and Denmark, almost one in three children is born at home. In the UK, despite all women's entitlement to a home birth by law, in 1991 when this book was first published almost 98% of births occurred in hospital. However, by 1994, the 'changing childbirth' report indicated that women be referred to a midwife for a home birth on request. The National Birthday Trust conducted a prospective confidential survey of home births, following all women who booked a home birth in the UK in 1994. Results showed that planning a home birth halved the chances of assisted or caesarean births. The researchers concluded that home births would probably increase to 4-5% of all maternities in UK during the next decade, which is indeed the case.

I present these findings in some detail here as they strongly support the hypothesis that social and environmental factors can affect progress of labour and mode of delivery. This study included almost 6000 women at 37 weeks' gestation matched for age, parity and obstetric history by their midwives with a woman in their practice who was booked to deliver in hospital. The overall group profile was low-risk. 84% were expecting second or subsequent children. Mothers who had a previous Caesarean made up 1.4% of the home birth group, and 3% of the hospital group. It was found that despite matching the home-birth group had less incidence of high blood pressure between recruitment for the study, at 37 weeks, and the birth - possibly due to less stressful (midwife) antenatal care. (Alternatively, women who developed high blood pressure before 37 weeks had transferred their booking to the hospital).

	Planned home births *	Planned hospital births
Spontaneous vaginal delivery	94.7%	90.2%
Assisted (forceps, ventouse)	2.4%	5.4%
Caesarean	2.0%	4.1%

*(includes 16% transfers to hospital in late pregnancy or labour)

Home births, including those who transferred to hospital were less likely to involve post-partum haemorrhage. Home birth mothers had fewer episiotomies but more first-degree perineal tears. They were much less likely to use drugs for pain relief, despite availability of Entonox (nitrous oxide and oxygen, 'gas and air'), and Pethidine (called Demerol in the USA). And they were more likely than hospital births to use relaxation techniques, warm water, aromatherapy and homeopathy. At 1 minute, 5.2% of the planned home-birth babies had APGAR scores below 7, compared to 9.3% of the planned hospital babies. At 5 minutes, 0.7% of both groups had scores below 7. Babies planned for home birth were less likely to have bruising or 'resuscitation' interventions (both suctioning, oxygen with a bag and mask, or intubation). Exclusive breastfeeding rates 48 hours after birth were 80% in the home birth group and 58.1% in the planned hospital group; six weeks later, the figures were 65% and 44% respectively [72a]. [The relaxed nature of a home delivery, privacy, security, comfort and the absence of any separation of mother and baby clearly help to establish breastfeeding. However, since breastfeeding rates for the transferred home births were almost identical despite the difficult hospital delivery, perhaps figures reflect specific maternal orientations – Facilitators and Reciprocators – both of whom usually have high level of commitment to breastfeed whatever the circumstances (see Chapter 24, and 0.2.9 below)]. It must be noted that women planning home births have also been found to be highly motivated, better educated and more affluent and hence slightly lower-risk. However, despite the evidence of safety and advantages of home births, there is still a great deal of medical opposition, as a 2004 National Birth Alliance report attests, revealing a range of coercive measures and forcible hospitalisation of Irish would-be-home-birth mothers [72b].

0.2.8. Miscarriage, stillbirth and special care:

Finally, it is when things go wrong that the caregiving relationship is tested to its limits (see Chapter 30). New guidelines have been devised for management of women experiencing **pregnancy loss under 24 weeks**, with implications for provision of information, and improved choice and control by women themselves. Yet explanations are not always forthcoming, as the cause of the miscarriage may be obscure. Many women find the lack of feedback after a spontaneous abortion very distressing. More distressing still, is staff insensitivity. In one appalling incident, lack of foresight and storage facilities resulted in a 14 year old

being given her aborted fetus in a jar and told to take it home and return with it at a later date when a specialist was available [73a]. Organisations like the Miscarriage Association publish guidelines for good practice following pregnancy loss, including study days for professionals to promote more awareness and sensitivity [73b]. Although midwives believe they are ideally placed to provide a holistic approach for women who have suffered a miscarriage [74] the many demands and restrictions of their job make this difficult. Similarly, while diagnostic techniques of antenatal screening are ever more sophisticated, the attention to psychological issues still lags behind. As noted above (section 0.2.5), women may not realise the implications of the seemingly harmless tests, and in the case of suspected abnormalities, they often face a brutal dilemma with little support or guidance. Disenchantment and guilt often follow spontaneous or induced pregnancy losses with a sense that 'the womb is not a safe place' and gestation cannot be taken for granted. A subsequent pregnancy may be filled with trepidation and concern.

0.2.7.1. In the UK, 1 baby in 100 is stillborn or dies within the first 4 weeks of life. Loss so late in the process is particularly poignant and parents are often traumatised and mull over minutiae of the events leading up to the death in years to come, wondering if it could have been forestalled. The institutional approach to **stillbirth or neonatal death** has changed in recent years. There is now greater recognition by maternity staff that perinatal loss is a serious bereavement and parents will experience grief for many months after the loss. The trauma of stillbirth can have long term effects with some 20% of women experiencing prolonged depression [75], and 20% post traumatic stress disorder (PTSD) in the subsequent pregnancy [76]. How it is handled by staff is crucial. Studies show that bereaved mothers report a sense of 'empowerment' from empathic and humane comfort rather than just competent physical care from their health care professionals [77]. Children who have eagerly (and uneasily) anticipated birth of a sibling are deeply affected by the loss (see pages 398-40) and an association has been found between anxiety disorder in adolescence and maternal experience of stillbirth [78]. Infants next-born after stillbirth show a significant increase in disorganisation of attachment behaviour to the mother, mediated not by maternal depression or anxiety, but by a measure of maternal unresolved mourning [79a,b] and the child's fear that s/he too may be doomed. Bereaved parents may not be emotionally available to talk over these painful feelings with the child and referrals for child psychotherapy or family therapy in later years may be necessary to address this unmetabolised family trauma.

Some decades ago, pioneering work in London [80] demonstrated the importance for crisis support to help parents feel less guilty, ashamed and stupefied by the 'non-event' of stillbirth, and less likely to rush in with a replacement pregnancy before resolving their grief. However, the now usual practice of encouraging contact with the dead infant's body which they advocated to facilitate mourning and recovery, was not systematically evaluated. A new study now suggests that for some parents, close contact may be associated with adverse outcome [81]. Once again, this demonstrates differences such as those reflected in parenting orientations, and the need for individuals to follow their own emotional inclinations. Bereavement counselling now also stresses *diverse reactions and gender differences in mourning*. There is often a divergence in expression and duration of grief within the same couple. Most bereaved parents will feel somewhat better 6 to 9 months following a neonatal loss (and the anniversary of original due date, actual birth, burial are crucial events), but it is usually 2-3 years before they are close to full recovery. And even then, anniversaries or other reminders may trigger painful flash backs for years to come. Intense grief, self-blame and guilt have in the past been attributed to maternal ambivalence or unconscious aggression. However, these are now recognised as *a healthy adaptive reaction* to the traumatising helplessness posed by such a loss [82] especially when reproductive technology is accompanied by an illusion of control.

0.2.7.2. Mourning: A review of contemporary bereavement literature in nursing, medical and social science data indicates that a major change is occurring in the understanding of mourning in the United Kingdom and United States of America. This change particularly applies to bereaved parents in the West, where death of a child is seen to be against the natural order. Whereas traditional models of mourning (beginning with Freud) placed emphasis on bereaved people letting go of their emotional relationships with those who have died, *contemporary models accept the need for parents to hold on to their relationship with their dead children*. Therapeutic interventions of health professionals support parents in their grief and encourage them to talk about their loved one and incorporate him or her into their daily life [83a]. The difficulty with stillbirth and very early loss is the brevity of contact and absence of memories, combined with the long build up of now thwarted expectations and hopes invested in the baby. Acknowledged by professionals who knew the woman during her pregnancy is now recognised as a helpful bridge

between past and present, as is the need for counseling or psychotherapeutic help with unmanageable feelings following a perinatal loss. Needless to say, subsequent pregnancies are fraught with misgivings and especially compassionate midwifery care is necessary [83b]. An innovative joint Australian-Canadian study advocates a midwife-managed Special Delivery Service programme and supportive health care services for women who have experienced loss of a baby in a previous pregnancy [84].

Similarly, following **Sudden Infant Death** the shock, confusion, guilt and self-questioning, sleep disturbance and distressing dreams, emotional withdrawal, and long-term grieving process may persist in parents, siblings and grandparents. In some cases, this is exacerbated by accusations and even imprisonment of parents. Despite much research over the past 15 years, the causes of SIDS remain controversial, and although recent guidelines reduce the risk of cot death, they have not prevented it. In this, as in all forms of sudden bereavement, counseling is a necessity.

0.2.7.3 The stresses of **premature births** are exacerbated by lack of preparation for the birth and feelings of shock, abandonment, self-blame and guilt. Uncertainty of outcome and the highly technological and frightening NICU (neonatal intensive care unit) and attendant worries about morbidity, separation and emotional and cognitive effects of incubation all take their toll on new parents. Observations show that staff, too, are challenged in this environment of chronic stress and fatalities, and many find defensive ways of reacting by becoming inappropriately over-involved or callously hardened to their painful tasks [85].

Although the percentage of low birth weight babies is increasing, the borders of viability (24-28 weeks) have hardly changed since 1980, with high mortality rates especially in the first 48 hours, and risk of neurological damage in those who survive. Follow ups reveal that many children have multiple cognitive deficits in later life. Even among low-risk 27-34 week births the maximum survival rate is still 95% and has changed very little over the years [86]. However, a surprising innovation originates in third world countries lacking facilities for incubation. A recent randomised control trial in Southern Africa shows positive effects of immediately placing the baby between the mother's breasts in **skin-to-skin 'kangaroo' care**. This has been found to increase the survival rate even among very low birth-weight babies [87]. In fact the smaller the

baby the more important skin-to-skin care appears to be – as it stabilises the tiny baby more effectively than incubation. Through a fine-tuned process of thermo-synchrony, the mother's body temperature falls as baby's rises (while kangarooing father's tend to overheat the baby). Even six hours of such kangarooing following birth are effective in minimising hyper-arousal and the hyper-metabolic state of premature separation, and is advocated even when incubators are available. Intensive first week skin-to-skin kangaroo care also appears to have a positive effect on some mothers, too, increasing the duration of breastfeeding. For these mothers (namely Facilitators) keeping the baby between their bare breasts provides a continuity of the closeness disrupted by the birth, and possibly may help the grieving process if the baby dies. (This link will be studied in the near future). Regulator mothers find it difficult to have the tiny baby in such constant and intimate contact 24 hours a day, and counselling may be needed to sustain the prolonged skin-to-skin contact. Kangarooing is clearly very important in ill-equipped third world countries or rural districts without electricity, and has been used with good results in Columbia, Ecuador and Zimbabwe.

Finally, many **neonatal units** now encourage parental involvement in the care of premature babies as a means of increasing attachment and reducing parental anxiety. Not surprisingly given the scarcity of paternal leave, findings from a study of the degree of participation in caregiving activities show that mothers visit more frequently than fathers (85% vs. 45%) and for longer, although both parents engage in 'social' interactions such as talking, stroking and holding. A mother's greater involvement in cleaning and feeding activities is linked to the duration of her visits [88]. However, among mothers of incubated babies, too, Facilitator/Regulator orientations towards parenting operate differentially, with the former determined to visit her preemie as much as possible since she regards herself as primed by pregnancy to be the best interpreter of her baby's needs; while the latter (among the 15% who visit infrequently) relies on expert staff to care for the fragile baby until its needs are 'regulated' (see Chapters 6, 21 and 31).

0.2.9. Breastfeeding:

The benefits of breastfeeding are undeniable, and this past decade much effort has been devoted to the best way of encouraging and sustaining it. A Cochrane review of 20 separate controlled trials and observational studies in both developing and developed countries as diverse as Finland, Peru, the Philippines, Senegal and the USA provided evidence that babies

who were exclusively breastfed for six months had less infectious diseases and grew as well as those given other foods [89]. This is particularly important in those many geographical areas where clean water may not be available for preparation of formula or gruel. It is therefore ironic that in many developing countries formula feeding is still being promoted at the very time when Western societies are raising women's awareness of the benefits of breast-feeding. Currently only 35% of babies world wide are exclusively breast fed during the first four months and malnutrition is highest in South Asia where despite the relatively low HIV infection, only 45% of 0-3 months old babies are exclusively breastfed, and in India, only 20% for 6 months [90]. Nonetheless, in some countries trends are being reversed, as in China, where after 20 years of sexual equality expressed in bottle feeding, breastfeeding was reintroduced by the WHO in 1992 and within one week, every parturient was suckling.

In the UK *the incidence of women breastfeeding at birth* rose from 64% in 1990 to 66% in 1995 to 69% in 2000 (most increases occurred in social class I, and in England and Wales), however by six months only 21% still feed and by nine months this drops to 13% [91]. Initial figures can be misleading - in Brisbane Australia, one 2002 study found that although 92% [!] of participants initiated breastfeeding by 4 months almost 40% had discontinued, and only 28% were breastfeeding exclusively, attributed to their sense of 'self-efficacy' [92]. In addition to class variations, there are considerable racial and ethnic disparities even in the same community. For instance, an American study based on data reported by parents in a national survey showed that the proportion of children ever-breastfed was 60% for whites, 26% among non-Hispanic blacks and 54% among Mexican Americans, decreasing by six months to 27%, 9% and 23% correspondingly [93].

Professionals have a great deal of influence for better or for worse. Seeming indifference of health carers and hospital staff is instrumental in influencing breastfeeding failure [94]. Various targeted programmes have been effective in actively encouraging ongoing breastfeeding, with hospital or community health interventions, the latter including home visits [95], and telephone support by peer counsellors or community health nurses, demonstrating that community health interventions induce longer breastfeeding duration, fewer sick visits, offsetting costs of health care and formula [96]. Similarly, a UK study showed that breastfed babies had 15% fewer GP consultations [97].

To successfully promote breastfeeding, health care professionals must understand the emotional intricacies of this intimate exchange. Some

women feel revulsion or anxieties about the erotic experience of breastfeeding while others discover great pride in their capacity, and gain status by their power to make a baby grow. Exclusive breastfeeding can feel depleting – a vital demand on a woman's physical resources, requiring her bodily availability, and drawing on her internal resources. It may interfere with her sexual partnership, her work patterns and relationship with her other children. Some mothers feel endangered by the needy, seemingly insatiable or even 'devouring' baby; indeed, some see breastfeeding as 'cannibalistic'[98]. Conversely, due to her own low self-esteem, a woman may regard her milk as lacking – too 'thin', inferior or even poisonous. The bottle may seem to offer protection and a means of monitoring the baby's intake which feels reassuring to an anxious mother. The fact the amount of milk consumed is measurable is of considerable importance to women who have doubts about adequacy of their own resources or concerns about nourishing the infant - neither starving nor over-stuffing. Indeed, for a mother with eating disorder, or one who dreads her own pathogenic tendencies (reflected in anxieties about the quality of milk), bottle rather than breast feels 'best'. Feeding becomes a rational, shareable, measurable activity. If therapy is not available to the mother, the emotional advantages of bottle feeding outweigh other considerations.

0.2.10. Ethnic minorities, inequalities and disadvantage:

The population of Britain has changed over the past decades. Estimates based on the Labour Force Survey suggest a steep rise in ethnic minorities within the population from 3.9% in 1981, to 5.7% in 1994 to 6.4% in 1997. Since 1991 the Census has included a question of ethnic origins and the latest Census publication 2003 charts the composition of origins of the British ethnic minority population as follows:

28.1% Indian; 16.9% Black Caribbean; 15.4% Pakistani; 7.1% Black African; 6.0% Black other; 5.0% Chinese; 5.5% Bangladeshi; Other Asian 6.5%; Other 9.0%. [99]. Absolute figures have changed, but the geographical distribution of ethnic groups across the country is still as reported previously (pages 22-26).

Circumstances, nutrition and access to services vary within subgroups in each population. For instance, Birmingham Health Authority's 1999 Report cites the babies of women of Pakistani and African Caribbean origin having twice the chance of infant mortality than white European (with poorer material circumstances of income, employment, housing, education and nutrition), and USA figures show

similar discrepancies (see section 0.1.4. above on infant mortality). Recent NICE guidelines aim to reduce NHS variation across the country. However, contact with services does not accurately reflect prevalence, as people may opt out of formal health care, and cultural expectations and concepts of illness vary.

Indeed, a recent parliamentary enquiry found that unfortunately the statistics that are routinely available for maternal and perinatal health care in England are inadequate for measuring the level of access to maternity and neonatal services for groups within the population, including minority ethnic groups and socially disadvantaged groups. Maternity service planners and providers are 'impeded in their work' by lack of data on the socio-economic and ethnic status of pregnant women and mothers, making any comparisons of inequalities in health outcomes along with any assessment of equity of access for vulnerable groups, impossible [100]. Similarly, an important gap in knowledge about inequalities in access to maternity care has been created by the lack of information on women who give birth to their babies without having booked any maternity care at all. A survey showed that at least 4% of women receive no antenatal care whatsoever. One study undertaken in the mid-1990s suggested that on average, women from South Asian backgrounds started maternity care later and made fewer visits than white women. The NPEU also found evidence that South Asian women might be up to 70% less likely to be offered/receive prenatal testing for haemoglobin disorders and Down's Syndrome. Information about differences in access to postnatal and infant care was even more limited although evaluations of new initiatives may increase that [101].

Like Healthy Start in the US, the Sure Start programme was introduced in the UK to ensure families in disadvantaged areas had equal access to services and practical help which enable young children to 'flourish from birth'. This includes help from the first antenatal visit, advice on health in pregnancy and preparation for parenthood.

Sure Start programmes are led by local partnerships with strong parental and community involvement to promote the physical, intellectual, social and emotional development of young children through a range of childcare, preschool education and parent support. The programme offers enhanced childcare, play and early learning opportunities and better access to health services - from ante-natal and baby clinics to specialist services for children with special educational needs. Services are delivered in new 'seamless' ways, by staff working together across health, care and education. It is still too early to assess its effectiveness but

underpinning this programme is a recognition that children's experiences in the earliest years of their life are critical to their subsequent development (see, section 0.4 below) and that psychosocial adversity is damaging. In keeping with this, the Government has also begun a drive to halve child poverty in 10 years and to eradicate it in 20.

0.2.11. Maternal mortality, reproductive rights and safer childbirth:

Finally, a reminder of our own privileged experience in the West. *Every minute a woman dies from complications related to pregnancy and childbirth and 99% of these deaths occur in the developing world.* Globally, only 62% of births are attended by a skilled attendant [102].

A decade has now passed since the UN 4th Conference of Women, in Beijing and the UN International Conference on Population & Development ICPD in Cairo. The latter concluded with a plan of action adopted by 179 countries – a programme for the empowerment of women, which committed nations to work towards guaranteeing access to reproductive health services for all by 2015. This goal included not only improving provisions but educating women about their rights and choices regarding contraception, pregnancy care and postnatal help. Today, there are still many societies where socio-economic conditions, religious injunctions, male dominance and female ignorance of reproductive rights means that women have no access to contraception. Such 'unsafe motherhood' is a function of both poor health systems and societal causes, including women's powerlessness over their reproductive lives, and dependent status. It is ironic that leaders such as George Bush contribute to this powerlessness by stipulating in 2003 that legal abortion clinics be excluded from multimillion dollar grants to combat HIV/AIDS in developing countries. Abortion is often the last desperate resort for women whose lives cannot stretch to accommodate a(nother) baby.

For example, in Kenya, 700 women daily resort to illegal back street abortions, with 5000 dying annually of complications. In addition to unsafe abortion, haemorrhage, infection, eclampsia and obstructed labour account for 70% of maternal deaths, while over 20% of women die as a result of diseases aggravated by pregnancy, such as malaria, anaemia, TB and increasingly, HIV/AIDS. The rate of maternal morbidity in childbirth is still very high in many parts of the third world, particularly sub-Saharan Africa [103]. In Nigeria, for instance, where it is estimated about 8-10 women die per 1,000 live births, a recent National Health Survey showed that only 31% of deliveries are attended by trained personnel. Many Nigerian women forgo hospital births, preferring to have traditional birth

attendants at home, or in a church. Thus, though facilities for obstetric care exist, utilisation of these services during labour is poor. It seems women are deterred by pubic shaving, enema, lithotomy and other restrictive practices. Indeed, systematic reviews highlight potentially harmful hospital birth practices, such as routine episiotomy or ruptured membranes, which possibly increase the risk of HIV transmission to the baby [104]. In societies where women are relatively powerless, hospital nurses may express their own limited autonomy and frustration in punitive behaviour towards their clients. In many places in Africa, 'Better Birth Initiative' (BBI), a collaborative project is now in place as a strategy to improve care, to reduce maternal morbidity and to encourage utilisation of health facilities [105].

The safest countries for delivering babies include Sweden, Iceland, Slovakia and Austria. High maternal mortality countries, in rank order, include Malawi, Angola, Niger, the United Republic of Tanzania, Rwanda, Mali and Somalia. Due to their physical immaturity, very young women are especially vulnerable to maternity complications, some of which are also related to female circumcision and infibulation which is still widely practiced. Recent findings by WHO, UNICEF and the United Nations Population Fund (UNFPA) show that over her lifetime a woman living in sub-Saharan Africa has a 1 in 16 chance of dying in pregnancy or childbirth. This compares with a 1 in 2,800 risk for a woman from a developed region. The next highest maternal mortality rates globally are in south-central Asia. According to the World Health Organisation, the greatest risk for Asian women in childbirth occurs in Sierra Leone and Afghanistan, where one out of every six childbearing women will die from complications related to pregnancy and childbirth. In India alone, 136,000 women die in pregnancy and childbirth every year [106].

Sadly, women need not die in childbearing. The vast majority of maternal deaths could be prevented if women had better nutrition before conceiving, access to, and use of, skilled care during pregnancy, childbirth and the first month after delivery. Newborns, too, die or are disabled because of poor maternal health or lack of perinatal care, and some one million children are left motherless each year as a result of maternal deaths. These children are three to 10 times more likely to die within two years than children who live with both parents.

In conclusion, maternal mortality is a Human Rights and Equity issue. The Millennium Declaration aimed to reduce maternal mortality by $\frac{3}{4}$ by 2015, by training skilled birth attendants, improving family planning

services and strengthening health systems to provide a 'continuum' of care, including maternity services, abortion and post-abortion care. This will be complemented by educational programmes encouraging self-care by individuals, families and communities and fostering collaborative links with other key primary health care programmes. Babies are the future citizens of any nation. In developed as well as developing societies, providing optimal conditions from the start increases long term physical and mental health and quality of life of the nation.

KEY POINTS:

- * Woman-led midwifery provisions - antenatally, during labour and birth, and in establishing lactation involve greater awareness of psychological issues and provision of choice to cater to personal preferences, special needs and diversity of expectations.

- * 'Consumers' emphasise the importance of choice and control, midwifery competence, communication and compassion throughout pregnancy and birthing in addition to continuity in maternity care.

- * Anxieties contribute to increased interventions. Antenatal classes are the ideal place for emotional support and exploration of labour fears and fantasies in expectant parents.

- * Midwives work in situations of chronic anxiety and emotional arousal, including evocation of primal material. Peer supervision and experiential group support can mitigate these.

- * When socially unconscious representations take the form of cultural beliefs, practices become embedded in routine, ritual and unquestioned local customs.

- * The dramatic rise in caesarean rate is ascribed to a combination of organisational defences and socio-cultural pressures with long-term impact of the mother's health, greater cost to the NHS and as yet unknown effects on babies.

- * Social and environmental factors can affect progress of labour, mode of delivery, bonding, and breastfeeding duration yet home births still constitute only 2% of deliveries although desired by 20% of women.

0.3. PERINATAL EMOTIONAL DISTURBANCES:

0.3.1. Partners becoming parents:

Becoming a parent is not easy and rates of perinatal disturbance are high. As this book demonstrates throughout, conception alters the balance in

even the most egalitarian couple's relationship, as she grows their baby in her own body. Pregnancy sets in motion a mass of arousing, often contradictory physical and emotional experiences to which each expectant parent responds differently. These interact with trans-generational narratives of childbearing that each partner brings from their own families, informing their current expectations of parenthood and representations of the unborn baby. Labour and birth then bring about further extraordinary experiences which each parturient (and her partner) interprets in her own way. Some women suffer excruciating contractions and humiliating loss of control while others think in terms of surrender and exaltation. Witnessing her pain, her mate's response may accord with or contradict her own. Then with arrival of the baby, a further avalanche of unexpectedly intense emotions erupt - profusions of sadness and rapture, deep troughs of exhaustion, confusion, rage at the heaviness of responsibility and realization that life has changed irreversibly which affects each partner differently. In addition to sleep deprivation, stress, hormonal fluctuations, and after effects of birth, the breastfeeding mother has specific anxieties about her suckling (see 0.2.9.). She may feel accused by the baby's inconsolability, blaming herself irrationally for any unhappiness, attributing it to the quality of her milk as she deems herself unconditionally accountable to the baby who, having grown inside her, knows her innermost secret ambivalence and shortcomings.

The transition to parenthood transforms the interaction between partners [107]. Childbearing is a particularly stressful period for women, with a threefold increased rate of depression within five weeks of delivery [108]. In the 'first world' half the population of new mothers experience milder forms of perinatal disturbance, and at least one in ten mothers suffer severe depression over the first postnatal year. *Like happiness, disturbance, too, is interactive.* While mood fluctuations are associated with hormonal changes in the early postpartum weeks (especially the sudden drop in prolactin, cortisol and HGG), depression over the next year or two is clearly related to psychosocial factors.

In **traditional societies** new mothers are cosseted for the first month or 40 days, mothered and offered special attention and nourishing foods, while experienced helpers assist with baby care (see Chapter 23 section 23.8). Then again, although formal postpartum support (such as the Chinese *peiyue*) protects the mother from exhaustion and ensures transmission of baby-care lore, the close contact with significant others at this vulnerable time, and particularly conflicts with the mother-in-law, may increase rather than reduce postnatal distress [109a]. A poor

relationship with in-laws is associated with depression in societies where the woman leaves her own parents to live with her husband's family, or comes under their subjugation. In Turkey, for instance, her dependent position increases the likelihood of postnatal disturbance [109b]. (Also see the case of a Zulu woman 0.3.11). Conversely, western mothers who are sent home from hospital after a few days (or even hours) with an expectation that they, and they alone, will take full exclusive care of the newborn, with no-one to care for them, justly feel unsupported, and many receive little practical help from either parents or in-laws. A woman's archaic relationship with her own (generous and supportive or forbidding) 'internal' mother may take on prime importance even (as perhaps, especially) in the absence of her real, live mother.

Thus, a crucial factor in mental ill-health in westernised societies, relates to the *changing patterns of family relationships with few support networks, and high reliance on the sexual partner*. Intimate relationships often take the form of serial cohabitations (or perhaps, serial disillusionments), and separation is common. In Britain, more than one in three children are born to unmarried parents, and over half these births are registered by the mother alone. Social mobility which erodes extended-family and community networks, also produces increased strain on nuclear households. In the absence of other support-systems a couple's relationship is highly interdependent and partners must often be 'best friends' and mutual carers, as well as lovers. However, birth of a baby skews the once equal relationship, as the bulk of intensely demanding baby-care falls on the mother, whose breasts dispense milk and whose salary is usually more dispensable than the father's. Furthermore, it is a circular process. Day-to-day care affords the mother intimate understanding of the baby's needs who then becomes treated as her responsibility even in the presence of a 'hands on' father who is eager to 'help out', yet lacks exact know-how of the minutiae of the baby's experience. Unlike any other job, a primary carer is 'on call' 24 hours a day. The concentrated parent-baby bond, lonely, and unmitigated by other adults, may be both a burden and provide solace to the mother in the absence of her partner (whose 'working for two' now often involves longer hours on the job). Both parents tend to feel overworked and exploited. He often feels ousted from his previous special place in their relationship. She has lost her position as equal partner. Her loss of earnings often subtly affects the balance of her spending power, as their mutual financial assets now become 'his'. And if she wishes to return to

work she must justify doing so by covering costs of child-care, although in the absence of good, reasonably priced day-care, these may swallow up her entire salary. Furthermore, when she does return to work, domestic chores usually remain her domain, as traditional family patterns reassert themselves.

A *Regulator* who resents being demoted from equal 'career woman' to taken-for-granted mother in 'solitary confinement' with her baby, or a *Facilitator* who chooses to stay home, may exercise the only authority remaining to her, by controlling her partner's interaction with the child, allocating tasks or cutting him out - which may suit a *Renouncing* father, but not a *Participator* who wants to be an equal partner in nurturing. Clearly, interactive dynamics vary according the permutations of partners' combined orientation [see Chapters 24 and 25]. The couple relationship is irrevocably changed and where intimate communication ceases, many couples split up in the course of the first two postnatal years as their relations deteriorate [110a,b].

In addition, as noted, few parents have had experience with young children, and many feel unprepared for this most important task. '**Parenting programmes**' have flourished in the UK as in the USA, some with an emphasis on parenting skills or education, while others focus on providing support or help towards some in-depth change. A survey of 38 group-based parenting programmes in the UK found three groups of participants according to types of motivation - those who want to 'do the best for their children'; parents of children with behaviour problems of varying severity; and parents with multiple problems, including depression and extremely low self-esteem (some of the latter projects are described in 0.3.7 below). Some, like PIPPINS, offer a structured preventative educational programme beginning in the fourth month of pregnancy (complementing antenatal classes) and providing 17 sessions and a home visit. Most others are community based and operate only postnatally. Some, like Parent Network, operate informal support groups with periodical follow-up modules. Sadly, few programmes involve fathers or focus on the couple relationship as they become parents. A number of programmes operating in the UK were developed in the United States - Family Nurturing Network, Parent Effectiveness Training (PET), Systematic Training for Effective Parenting (STEP), Webster-Stratton Parents & Children Series. The main difference in approach is that unlike the USA where parent education has developed into a separate profession, in Britain facilitators come from a large number of professional

backgrounds ranging from psychologists, health visitors, midwives, social workers, teachers, counselors and community workers [111]. In general, aims differ from psychodynamic psychotherapeutic groups in focusing on current conflict resolution, problem solving and behaviour changes geared to improving social and relational functioning rather than seeking to address the residue of past experience in unconscious defences and communications.

0.3.2. Antenatal and postnatal disturbances:

New parents are particularly susceptible in societies in transition. A transcultural study in 15 centres found that postnatal depression or commensurate morbid unhappiness after childbirth are consistently attributed to *loneliness, lack of emotional and practical support, poor relationship with one's partner, family conflict, tiredness and problems with the baby* [112]. The 'spiral of demoralization' is further exacerbated by fragmentation of health care, critical attitudes and conflicting advice from midwives in hospital, and health visitor, GP and relatives at home [113], bereavement and loss in people who are prone to develop depression.

Postnatal depression occurs in fathers too [114a], albeit manifesting differently. One study found that new fathers were more troubled by unresolved past events and difficulties in the relationship and its change after the birth of a child; while new mothers primarily felt distressed by perinatal and infant influenced factors [114b]. The important point is that *perinatal disturbance is interactive*. A review of twenty recent studies found that commonly depression in one partner is significantly correlated with depression in the other [115]. *As with antenatal depression, vulnerability to postnatal disturbance is increased under conditions of stress and psychosocial adversity, and is significantly related to couple discord*. There is a substantial overlap between depression and anxiety in the prepartum and postpartum periods [116]. Antenatally, the higher incidence of depressive symptoms in inner cities is also associated with poor emotional support, no partner in second or subsequent pregnancy as well as socio-economic disadvantage – unemployment and lack of educational qualifications [117]. In addition to the distress experienced by the woman and her family, maternal antenatal depression has implications for the unborn child, as it is also associated with poor antenatal clinic attendance, low birth weight and preterm delivery [118] and risk-taking behaviours such as smoking and unhealthy

eating, which may also signify disregard for, or rejection of an unwanted baby.

Yet antenatal depression often goes unrecognised by professionals. Some suggest it may have a higher prevalence than postnatal depression, which it frequently precedes [119]. Its effects may be crucial for the baby. Although as yet no causal connection can be sustained by available evidence [120], there is a growing body of work linking maternal emotional distress in pregnancy and later behavioural problems in the offspring. In addition to direct effects on the gestating fetus of toxins such as alcohol, nicotine and opiates imbibed by the mother, **antenatal maternal stress** and its concomitant high cortisol levels may be transmitted to the fetus, possibly producing a hyper-reactive baby. A longitudinal study of over 10,000 women examined antenatal disturbance separately from postnatal depression, finding that anxiety in late pregnancy posed an independent risk associated with behavioural/emotional problems in the child at 4 years of age [121]. Similarly, maternal antenatal and postpartum stressors are correlated with the temperament of their three year olds [122]. *Clearly, it is essential to identify antenatal stress and distress and to offer counselling or psychotherapy before the baby is born.*

At this time of intensely demanding responsibility yet greater dependency, the drop in a western woman's self confidence is related to lack of preparation for the most challenging job of all, coupled with her isolation, and sudden demotion from a position of seeming equality. Unlike new fathers, there is still an expectation that 'good' mothers stay home with their infants. Yet contradictions abound and sentimentalisation of the mother-infant bond is often accompanied by societal denigration of her role ['Do you work?' new mothers are asked, as if what they do is not] or an assumption that she will drop her emotional concern for the baby when she rejoins the work force.

In addition, throughout this book I suggest that this is a *hypersensitive period*. The enforced intimacy of sharing her body in pregnancy reactivates unresolved emotional issues which continue to reverberate postnatally, and close contact with a young baby is a highly evocative experience, which re-opens old wounds in vulnerable people. Although many depressed women make very good mothers, micro-analysis of videos reveal disrupted patterns of interaction with their infants, featuring maternal withdrawal and reduced emotional availability, or bouts of intrusion and hostility [123]. In other words, depressed

mothers may find it necessary to protect themselves (and/or their babies) from contact that feels too close and endangering. Risks are elevated with personal predisposition - about one third of all women with postpartum depression have a history of previous depression. Continuous responsibility without opportunities for self-replenishment and economic insecurities also contribute to her distress. A depressed mother may be preoccupied with her own sad childhood experiences. If these resonate with the crying baby's misery she may feel too overwhelmed to respond. The unhappy baby provides an ongoing emotional reminder of her own early suffering, and in addition provokes guilt at the suffering she herself inflicts. Feeling that she has been irrevocably failed as a child and is now constantly failing her own child a depressed mother may become suicidal. Only death seems to offer a resolution to her double anguish.

Other mothers manage to maintain their defences yet are threatened by the risk of baby's raw emotions triggering their own. Feeling persecuted rather than depressed, such a mother may resent mothering as exploitative. Regarding her baby as intentionally malevolent, she may retaliate in kind. In extreme cases, punitive interaction towards a 'demanding' baby may escalate into verbal abuse, hitting or even infanticide, with the unconscious aim of ridding herself of the needy, greedy or bad reminder of her own repudiated 'baby-self'. Yet other parents may become self-critical and so anxious about possible loss of control in public, that they become agoraphobic and housebound to avoid exposing themselves to a disapproving world. Another form projection takes is the parent who invests all the badness in others and treats the world as unsafe, reluctant to expose the baby (and the baby-part of themselves) to its dangers.

As noted, in nuclear families, the baby is often alone and totally dependent on the primary carer, who constitutes the medium of emotional and physical growth for better or worse. It is in cases such as all these, that the British tradition of home-visits from health visitors is invaluable.

0.3.3. Generative Identity:

To understand the nature of the emotional 'predisposition' to perinatal disturbances, it is necessary to explore subjective meanings attributed to becoming a parent - and their rootedness in generative identity. Each of us is gendered - a sexed psychic structuring we acquire that is partly defined by the society in which we live, and partly inscribed with our own personal formulations filtered through our caregivers and peers. Gender is

thus a complex identity and I have proposed the concept of 'generative identity' as one of the components of gender formation:

1. *core gender identity* - the mental representation of oneself as anatomically male or female.
2. *gender role* - relating to feminine or masculine cultural roles and psychosocial ideas of the self
3. *sexual partner orientation* which focuses on articulation of hetero/homosexual desires
4. *generative identity* - the psychic construction of oneself as a potential progenitor [124].

Generative identity means recognising one's own reproductive capacities in the context of basic facts of life. I suggest it is consolidated some time between 18-36 months when the child who previously imagined s/he could be 'everything' now has to accommodate four basic restrictions:

- of *sex* (I am only female or male, not the other sex, neither or both)
- of *genesis* (I am not self-made)
- of *generation* (adults have babies; children cannot)
- of *generativity* (females carry/suckle babies, males impregnate).

For a toddler, these restrictions mean facing painful loss of omnipotence. Relinquishing a belief in bi-sexual over-inclusiveness results in acute feelings of jealousy towards adults and 'penis envy' or 'womb envy' of the other sex. In other words, childhood acquisition of generative identity is a struggle. It entails recognising one's limitations - being only one sex (rather than both and unlimited); being pre-potent (rather than omnipotent) and interdependent (half of future procreative coupling rather than autonomous). *In heterosexual two parent families, it also means accepting that they have a sexual and potentially reproductive union from which the child is excluded.* Depending on emotional circumstances at this crucial time, the growing child may come to accept these facts of life creatively, or overreact by stereotypical adherence to, or rebellious refusal of the reality. Some children feel inhibited by the pressure to comply, or depressed by their losses. While others rebel, becoming engrossed in compulsive re-enactments of omnipotence. Clinical experience suggests that disturbances in acquisition of generative identity are more likely to occur when traumatic external events, especially reproductive disasters in the family, severe bodily trauma or sexual abuse coincide with this critical period of demarcation of the child's own generative potentialities. In adulthood, gender disorders and sexual aberrations (such as sex-change or

paedophilia) exemplify denial of, or unresolved issues with one or more of the four fundamental restrictions above.

By contrast, when a child does achieve generative identity several momentous conceptual shifts become possible:

- a shift from being someone else's creature or creation to becoming a potential creator in one's own right
- some children make an imaginative leap, freeing themselves from the biological determinism of sex by utilising psychic cross-gender potentialities. Others adopt formulaic gender identities.
- some children manage a shift from emphasis on physical procreancy of a baby to a more abstract and general notion of creativity. Others persist in treating future reproduction as the height of creativity.

The outcome is that some children grow up with a sense of agency, feeling that irrespective of whether they are male or female, through identification with significant others they can encompass mental characteristics socially attributed to the other sex without having to restrict themselves to being conventionally 'feminine' or 'masculine'. They express their generativity in various non-reproductive ways, rather than having to wait for a baby to fulfil it. In adulthood, comprehensive gratification from their wide-ranging potentialities is such that some people feel no need to embark on parenthood at all. Others do go on to reproduce, with a sense of emotional wellbeing rather than compulsion, but may feel denigrated if confined to a maternal role.

Conversely, when the sense of generative identity remains embedded in procreation, having a child may come to seem to be-all and end-all of adult self-expression. To such a person, diagnosis of infertility can be devastating. Pregnancy when it occurs represents culmination of the precious childhood promise and parenthood is invested with idealised dreams that reality cannot possibly match. Depression commonly follows disappointment with birth of an ordinary (rather than wondrous) baby; or discovery that caregiving is a difficult and demanding occupation (rather than a magical transformative vocation) or when conditions exist that prevent optimal parenting according to their own ideal standards.

To others, having a baby may seem fraught with anxieties relating to fears of usurping their own parents. These may be expressed in an inability to nurture unreservedly, or a strict adherence to the 'rules'. For yet others, parenting may seem antithetical to fulfilment of their own sense of agency and autonomy. Pregnancy is resented, the interdependency of parenthood may feel restrictive. In all these cases, ante or postnatal depression or persecution follow *disillusionment of*

unrealistic expectations, rooted in their long-held unconscious sense of generative identity, within their own particular wider psychosocial context.

0.3.4. Different patterns of perinatal disorders:

Perinatal disorders affect women in many cultures. They manifest both ante- and postnatally. Using standardised diagnostic assessment procedures a multi-centre pilot study across Europe and in the USA found that *antenatal 'caseness'* (including depression and anxiety disorders) averaged at 11.8% across cultures, with diverse rates in different places, ranging from 0% in Vienna to 23.3% in Bordeaux [125]. [Significant differences among the various centres are attributed to between sample differences in terms of demographic characteristics, health care delivery systems and local variables such as attachment types, life events and chronic stresses]. The number of people found to have *major postnatal depression* was 12.3% in this study (overall 6 month period prevalence rate). This is almost identical to the 13% mean prevalence calculated in a meta-analysis of 59 postpartum depression studies conducted in European western and non-western countries over the past 20 years [126].

Puerperal Psychoses are much rarer – about 0.2% of the population. Mothers have a 16-fold risk of developing psychotic illness within three months of the birth as opposed to the rest of their lives with highly disturbing hallucinations, delusions and incongruous feelings. This cannot be merely 'hormonal' as fathers also suffer psychiatric morbidity, including 40% of those whose wives are among the two in a thousand women suffering from puerperal psychoses! [127]. The high rate among partners may be caused by 'assortative mating' (vulnerable people choosing each other), or by the emotional effect of one or each of the partners' illness on the other.

In northern Europe perinatal psychiatric disorder is the leading cause of maternal morbidity, and suicide is the leading cause of maternal mortality in the UK [128]. At risk are not only deluded and acutely depressed women but perfectionistic mothers with good social skills, who often go undetected as they hide their severe disturbance under a façade of bright coping mechanisms. Reluctant to admit defeat or to ask for help, there is a high risk of suicide without warning when their defences fail them.

Perinatal disturbance is characterised by emotional upheavals. The predominant symptom for most new parents is exhaustion caused by

sleep deprivation and the psychologically demanding experience of fathoming and then meeting a (non-verbal) baby's needs. Disturbance may feature extreme concern for or difficulty in expressing love of the baby, depression and excessive crying with low self-esteem, reduced creativity and impaired concentration. For some this is coupled with distressing fluctuations of mood such as bouts of intense anxiety or guilt and panic states. In others, obsessional-compulsive or persecutory syndromes and paranoia predominate, coupled with doubts, irritability, anger, suspicion, thoughts of harming the baby, difficulty concentrating, or a sense of deprivation or exploitation. In a few, delusions, hallucinations or manic states prevail.

As noted, perinatal disturbance is often associated with a relational problem and in many studies, including cross-cultural ones, poor rapport with the partner (along with adversity and negative feelings about the pregnancy) actually predicts perinatal depression [129]. Again, it is unclear to what degree depression aggravates a poor relationship or is aggravated by it, but numerous studies have found that *lack of a confidante* (whether partner or friend) is associated with depression. At a time when there are so many new experiences and turbulent feelings to process, caregivers need a supportive and trustworthy companion in whom they can confide and from whom they can expect some care, while they give out so much of themselves in nurturing the baby. In the absence of such, a professional counsellor or psychotherapist is a necessity.

Following depression, the most frequent adult diagnoses these days is **post-traumatic stress disorder (PTSD)** manifesting in hopelessness, dissociation and/or excessive vigilance, or anxiety disorders, lasting for months and often years following a traumatic event. These symptoms are heightened during the period of expectant and early parenthood, particularly when vulnerability is rooted in childhood privations and deprivations which are then reactivated by taking on responsibility for a child of one's own. Preoccupation with his/her own early suffering makes a troubled parent unlikely to be emotionally available to the baby. Prolonged pain, loss of self-control and harsh treatment by staff during delivery often constitute retraumatising experiences in their own right. Repressed incidents of sexual abuse or rape may be reactivated during labour, triggering flashbacks of unprocessed trauma in either spouse. Sex may become a nightmare experience for the parturient for months after the birth due to internal bruising, painful episiotomy or a caesarean, in addition to changes in body image changes.

Her partner too, may be inhibited by her leaking breasts (no longer erotic but matronly and belonging to the baby) or the memory of having watched her go through the agonies of birth. Traumatized people often feel the need to avoid mental pain by discharging rather than experiencing it. Traumatized parents thereby often inflict similar experiences of emotional, sexual or physical abuse on their offspring as a means of momentarily relieving themselves of internal distress.

A further common disturbance is use of vulnerable body-systems to express psychic complaints through **stress related symptoms/illness** such as headaches, digestive problems, allergies and exhaustion, all of which affect the capacity to fully engage in work, love or play. Pregnancy, with its altered physiological state lends itself to psychosomatic expressions of distress thereby bypassing psychological understanding of painful issues. Increasingly, studies of expectant fathers reveal they too may express distress psychosomatically, often presenting to their GP with pregnancy-like symptoms of nausea or backache.

It is noteworthy that the distribution of emotional disturbance is sex-related. Traditionally depression has been cited as twice as common in women than men. This difference has been accounted for by women worldwide experiencing greater poverty, inferior social roles and sex discrimination, which lead to more negative life events, including violence and abuse [130a]. Put differently, the tendency to depression in women has been linked to their greater experiences of loss, humiliation and family entrapment [130b]. However, based on evidence from studies, the Royal College of Psychiatrists suggests that depression is just as common in men but women are twice as likely to be diagnosed and hence treated [131]. Other disturbances in men tend to take the form of substance abuse, alcoholism, suicide (especially between 15-34) and violent enactments which affect both wives and children. Women are said to experience a higher incidence of anxiety and panic attacks, PTSD and eating disorders. However, women also tend to be better at requesting therapy, and do so for relational issues, low self-esteem, bodily vulnerability and/or unexpressed anger.

0.3.5. Antenatal distress and the 'Placental paradigm':

During pregnancy, the expectant mother provides nutrients and excretes the baby's waste products through the placental connection. I have suggested that for many pregnant women this informs a mental image of

the emotional connection between herself and her tethered baby. Depending on her self-esteem and experience, she may regard herself as an abundant or inadequate nurturer linked to a benign baby or to a parasitic invader. Her self-regard inevitably contains some residues of her own experiences of being mothered, while the image of her unborn baby represents not only a fantasy child, but one unconsciously imbued with aspects of her own (imagined) baby-self.

While most pregnant women experience a variety of mixed feelings fluctuating over the course of a day if not an hour, some take a fixed and intense stance to this continuous placental connection with the baby. A fixed attitude may be composed of one of the perinatal syndromes (section 0.2.6), an exacerbation of her customary tendencies. For instance, a woman who is quite fastidious may intensify her *obsessional type defences* at this point, when her usual means of regulating closeness become threatened by the ultra-intimacy of having two people in one body. *Compulsive actions* fail to ward off the dangers of invasion, and the perfectionist struggle to keep internal good and bad aspects apart is imperilled by the uncontrollable intruder. In addition there is the uncertainty (s/he may be less than perfect), and the threat of revelation, as the baby 'knows' her inside out and when born, will reveal her own hidden faults. *Intrusive thoughts* about controlling or punishing the baby now break through her defences, posing the risk of enacting these antenatally in physical attacks on the fetus, or in postnatal violence or sexual abuse (for clinical examples see 'placental paradigm', [132]). These are not rare conditions as between 20-40% of depressed mothers also report obsessional thoughts about harming the child [133]. For teaching purposes the various positive and negative permutations of these 'fixed' representations on the '**Placental Paradigm**' may be charted as follows:

Self-as-mother	Baby	
+	+	<i>idealisation</i>
-	+	<i>depression</i>
+	-	<i>persecution</i>
-	-	<i>anxiety</i>
+/-	+/-	<i>obsession</i>
+/-	0	<i>detachment</i>

0.3.6. A spectrum of perinatal syndromes:

For some pregnant women, having another (possibly male) growing inside

her body blurs or intensifies distinctions between self and other, female and male, outer and inner, past and future with attendant anxieties and emotional disturbance. Motherhood, too, causes a crisis of identity as a woman finds herself in a state of internal contradictions and external unpredictability, neither able to return to her previous life nor yet to foresee the future priorities. Distress takes many forms. Although development of the popular Edinburgh Postnatal Depression Scale (EPDS) has focused research on postnatal depression, let us not overlook the full spectrum of perinatal disturbance, which occurs with some overlaps between categories. These are based on my own clinical experience or supervision of therapists working with women, both self-referred or sent by clinics:

Depressive disorders

- a range of symptoms, including feelings of despair, emptiness, guilt, inferiority and self-criticism, mainly about being insufficiently nurturing in pregnancy or a 'bad' mother;
- inhibition of thinking; libido and sleep disturbances, eating disorders and psychomotor retardation which may exacerbate the progress of pregnancy or process of caring for a baby.

Persecutory syndromes

- social and other phobias [contamination anxiety; tokophobia (fears about labour and birth);
- feared depletion/exploitation by the fetus or baby; claustrophobia, agoraphobia];
- generalised anxiety disorders and panic states (usually 'free floating anxieties which attach themselves to any 'hook';
- paranoia (irrational fears and projections making others or external events a source of danger).

Schizoid withdrawal

- defensive detachment (avoidance of feelings);
- dread of intimacy (desire for but fear of closeness);
- intellectualisation (replacement of emotion with rationality).

Obsessive-compulsive syndromes

- ruminations (mentally going round in circles);
- ritualistic activities (magical thinking and repetitive deeds to avoid danger);
- intrusive thoughts ('out of the blue' pictures, ideas or instructions).

Psychosomatic and behavioural manifestations

- hyperemesis (extreme nausea/vomiting), compulsive, anorexic and bulimic eating disorders;
- alcohol, nicotine and substance abuse (escape from, or avoidance of, mental pain);
- violence, self-harm and direct attacks on the fetus by the woman or her partner (action as a means of ridding oneself of internal stress).

Manic mood disorders

- idealisation (of pregnancy, motherhood and/or baby);
- grandiosity (a sense of omnipotent capacities or excessive generosity);
- psychomotor excitation (rapid thought, speech, actions).

0.3.7. Specific programmes for mothers at risk:

Not surprisingly, women who are worn down by persistent socio-economic deprivation and chronic oppression are often apathetic, demoralised and powerless, displaying emotional numbness, low self-confidence, depression and insensitivity to, and/or over-reliance on, their children for support. *Increased life stresses and lack of social support raise the incidence of depression.* For instance, the prevalence of postnatal depression in Khayelitsha, a township near Cape Town, is 34.7% [134], almost triple that among the white middle class population. Similarly, in Chile, the rate rose to 36.7% in the lower socioeconomic strata of Santiago [135]. Studies from south Asia demonstrate how severe poverty, social stressors and societal sex-preference act as predisposing causes of perinatal disturbance. A depressed woman's poor nutritional intake affects her baby's development during pregnancy. Postnatally, baby girls are found to be especially at risk of under-nourishment in cultures which favour males, suggesting the need for intervention programmes that focus on improving maternal mental health alongside those targeting infant nutrition [136]. And political stressors and chronic anxiety also contribute to high levels of postnatal distress – for instance, an Israeli study found a prevalence rate of 22.6% [137]. In addition, hidden urban stressors relate to spatial and practical drawbacks and dangers in domestic, community and public spaces – usually planned, designed and implemented by men with little regard for safety, ease of transport, shopping, surveillance of children at play, female camaraderie, use of pushchairs, etc.

In common, all intervention programmes for high risk mothers and traumatised or overburdened families aim to enhance quality of life and reciprocal interaction. Most recognise the intergenerational repetition of unintegrated experiences. Depending on the nature of the problem, treatments may take the form of **brief crisis intervention** or ongoing **case management** of individual families. Some therapeutic projects focus on the immediate interaction between parent and infant, making links with the past and increasing parental awareness of the baby as a sensitive person with feelings and a mind (also see 0.3.11.2 below). This may be achieved by the therapist modelling appropriate receptiveness. In some cases video feedback is used to show-up mismatched sequences of parent-child interaction, and to encourage intrusive carers to tone down their pursuit, or inactive parents to increase their engagement. Similarly **psycho-education** fostering age-appropriate expectations may help carers to relate more realistically. **Psychodynamic approaches** offer the parent an opportunity to have someone listen intently while s/he reflects upon feelings, which is restorative in itself, and, when internalised, enables the parent to similarly listen to their child (see 0.3.2.10-11 below). **Community programmes** such as Sure Start in the UK and CBFRS (Community-based Family Resource Service Programs) in the USA offer a range of collaborative and interdisciplinary community services, some of which are targeted towards families at risk. [Fathers complain that in their hours of operation and activities, these tend to exclude them]. Most **home-based therapeutic interventions** originate in Selma Fraiberg's combination of social-work methods and psychoanalytic understanding [see Chapter 27.3]. Randomised trials of supportive home-based counseling by health visitors or paraprofessionals health care workers show twice as much recovery in the treatment group compared to the control group [138a]. Similarly a Swedish study found that brief training for healthcare workers in non-directive counseling produced excellent results when visiting mothers at home, even for as little as ½ hour over a period of eight weeks [138b]. Some programmes involving home visits may use eclectic practices. For instance the Solihull approach in the Midlands, offers an innovative combination of psychoanalytic and behavioural theories in interventions with disadvantaged families at points of developmental challenges or 'derailments' [138c]. Another 'mixed' example is a UCLA project for high risk mothers offering home visits plus a 'relation-based' therapeutic group which made a significant positive impact on maternal responsiveness and encouragement of autonomy in the child, and after two years of therapy verbally persuasive control replaced

physically coercive methods [138d]. **Family programmes** attempt to 'optimalise' the relationship by helping parents recognise the child's developmental milestones, emotional, linguistic and social needs, either through health visitors in the UK or home visits by child development specialists in the USA [139]. Recent interventions involve training health visitors in running parenting groups using a Webster Stratton programme for 10 weeks. When resources are scarce, home-outreach or individual sessions are often too costly or time consuming, and isolated mothers benefit from community support. **Mother-infant group work** is effective in establishing a support network. These may target hard-to-reach or deprived mothers, or those with personality disorders. Help is usually offered in the context of community based mother-child play groups. Or toddler's stimulation groups while mothers receive community-liason supervised work-rehabilitation. A British project 'Mellow Mothering' set up a community base on a troubled impoverished estate, delivered the programme within the immediate territory, teaching the principles of good interactive childcare and facilitating play (an activity which many mothers had not experienced in childhood). Disturbed women were taught dietary standards, cooked communal meals, and were lent a video camera to film a neighbour at home feeding and hair-washing her baby, and then discussed each others' observed interaction in a small therapeutic group. Evaluation proved positive and all these personality disordered mothers (many of whom had previously had children removed while on the 'at risk' register) kept their babies [140a]. Similarly the Charles St. parent and baby unit and various NEWPIN **drop in centres** are examples of British projects specifically designed for women with postnatal depression offering befrienders, peer group support and 24 hour telephone contact, as well as play facilitation for the babies and a therapeutic support group and personal development programme for the mothers encouraging exploration of underlying problems [140b]. A Swedish **therapeutic centre** 'Maskan' (meaning a 'dropped' stitch in knitting) has also been in existence for over 15 years, utilising a combination of twice weekly three hour groups and individual psycho-educational and psychotherapeutic methods to treat relationship disturbances between mothers and their babies during the first year [140c]. Other examples are of **centres for child development**, such as one in New York, which sees self-referred mothers and their children in small groups, holds psychoanalytically informed discussion groups and provides interventions for self-referred mothers re-experiencing conflicts, deficits or impairments which impinge on the child [141a]. Or another in Cleveland, Ohio which provides a

nursery group and Mother-infant intervention consists of support, education, interpretation and developmental help [141b], and a similar set up at the Anna Freud Centre in London [141c]. The Cassell Hospital in London offers a live-in **Psychotherapeutic Community for the whole family** to deal with issues such as child abuse [142a], while the Marlborough Family Service in London offers evaluation and therapeutic intervention for multiple disturbed families seen simultaneously [142b]. [Psychodynamic forms of psychotherapy will be dealt with below (section 0.3.11)].

It is estimated that 11% of women are substance abusers. **Drug misuse** in pregnancy and early motherhood is a complex problem and care management cannot be constructed in isolation from the social and psychological factors contributing to that lifestyle. Realistically treatment goals hope to focus on harm reduction rather than 'cure' [143]. However, antenatal work can be beneficial. A recent study showed that drug addicted pregnant women who attended even four brief motivational therapy sessions of behavioural reinforcement of drug abstinence gave birth to higher birth-weight babies compared to mothers who did not comply with the full therapy course (attending none to three sessions) [144]. A review of 55 similar multi-component programs for expectant mothers concluded that discriminatingly targeting women with specific risk factors is effective in reducing prevalence of drug abuse, alcohol and tobacco use, with raised birth weight [145]. However, as the early weeks of gestation are the most crucial ones, prevention programmes must find ways of reaching women before they conceive, by using schools and media to address issues of growth deficiencies, and publicising the effects of smoking in pregnancy, or alcohol related neuro-developmental defects and Fetal Alcohol Syndrome (FAS).

Various intervention programmes focus on **psychotic mothers**. For instance, CHILD, an American project includes home visits, stimulation groups for toddlers and preschoolers, community liaison and three times a week 'mother-baby school', in which the focus is on modelling and helping mothers in the group identify their babies' needs and reinforcing effective age appropriate interactions [146]. Other projects like the 'Threshold nurseries' in the US for psychiatrically disturbed mothers living in 'socially disorganised families and chaotic communities', promotes a supervised work-rehabilitation course and quality day-care for their children, aiming to reduce their high (35%) rate of rehospitalisation.

0.3.8. Fathers:

Although her swelling body galvanises interest in the childbearing woman's experience, fathers too are deeply moved by their partner's pregnancy and birth. Nine out of ten fathers in the UK attend the delivery indirectly of their babies and whether resident in the home or absent, have a crucial influence on infant mental health. In non-traditional societies such as our own, fathering, like contemporary mothering, follows subjective choices, with each man's parenting orientation dictated by his own conscious beliefs and unconscious identifications. We may distinguish some approaches to fathering as follows (also see Chapters 11 and 24): drawing on primary identification with his archaic mother a *Participator* father wishes to be fully involved with early child care. The *Renouncer* father would rather wait until the child is older. (This paternal orientation is based on a traditional male/female divide that renounces femininity and regards pregnancy and early nurturing as the province of women). A *Reciprocator* father appears to be a mixture of the other two but unlike them, bases fathering neither on identification with mother or baby, nor emulation of a powerful father and dis-identification with femininity, but on personal assimilation of qualities of all his significant relationships, including both mother and father, siblings, teachers and other caring figures (see Generative Identity, 0.3.3.). His capacity for nurturing draws on sympathy which enables him to switch perspective and reflect on the emotional effect he is having on his loved ones, and they on him. Research findings show that fathers prefer play to caretaking and have a distinctive interactive style of play ('roughhousing' type stimulation vs. maternal containment). However, other findings point to similar styles and degree of attunement. Once again, these conflictual reports do not take account of different parental orientations.

In addition to personal orientations, there are mutual influences and forces within a couple's relationship that shape their respective parental interactions, along with societal demands (see Chapter 24.3). During pregnancy, unlike his pregnant woman for a man taking on the role of Father leaves no physiological traces but entails psychologically assuming his virile manhood within himself. For men who have resolved their basic early conflicts and relinquished untenable desires, parenthood offers a rich opportunity to further their relational capacities. For others, paternity may continue to feel fraught – feeling they are being put to the test or accompanied by guilt and a sense of danger at usurping the archaic father of their own childhood. An expectant father may also experience a

poignant sense of exclusion. Feeling displaced by the twosome inside his partner's body he may try to appropriate the pregnancy. This may reflect his unconscious pervasive longing for the blissful state of 'oneness' that he enviously feels the fetus has achieved. For men who have not satisfactorily consolidated their generative identity, fatherhood may retrigger unresolved envy of the female capacity for childbearing, and in extreme Participators, anger and frustration at being dependent on the pregnant partner to produce (and then breastfeed) the baby, rather than being able to omnipotently do it all himself. Conversely, an extreme Renouncer may feel threatened by the painful or needy feelings the baby arouses in him, and resents the care his partner gives the baby, experiencing it as a risk to his special position (as he may have felt usurped by a younger sibling in childhood). Some fathers may even prohibit the mother from breastfeeding. Fathers who are unable to address these disturbing feelings in themselves may find them reverberating uncontrollably in their ongoing relationships with both mother and child, in some, escalating in envious and violent attacks (see section 0.3.8 below).

At this critical point in their lives, most new fathers experience some confusion, concern for their partner, frustration and helplessness in the face of multiple responsibilities, uncertainty about the future, anger at the many sacrifices and disrupted family, social and leisure activities, not to mention worry about financial problems. Whereas in the early months of fathering a man's relationship to his own parents is vital, later in the first postpartum year the dynamics and functioning of the parental couple are a more significant predictor of depression [147]. In addition, confidence in the reciprocal partnership is important. Men in stepfamilies and partners of single mothers have been found to have higher levels of depressive symptoms than those in traditional families [148], and unskilled occupations and prior poor social functioning have been identified as significant risk factors for depression in new fathers [149].

As noted many men go on to develop postnatal disturbances - a quarter of men with depressed partners develop depression themselves, and this incidence increases significantly when the woman is severely depressed. Up to 50% of the partners of women admitted to psychiatric mother-and-baby units meet diagnostic criteria for psychiatric morbidity, compared with only 4% of men whose partners are not depressed [150]. *Most of these fathers suffer major depressive disorder and generalized anxiety disorders.* Paternal depression is not short lived. Of the 10% of fathers who are depressed when the baby is 6 weeks old, more than half

remain depressed at 6 months [151] and 60% of fathers diagnosed with psychiatric disorder at 2 months postpartum are still symptomatic at 6 month follow-up [152a]. Paternal depression is related to both internalising and externalising psychopathology in adolescents, and maladaptive father-child relationships [152b].

In sum, a new father's postnatal emotional reappraisals, conscious goals, nurturing capacities and immediate priorities are rooted within the context of his own internal world. How he has processed his past will determine how he faces the changing configurations of his intimate relationships, with his parents, the woman and child(ren) in his life. And the external pressures of new social, work and domestic demands, and loss of (usually female) earnings at time of the family's greatest material expenses. Most research focuses on mothers and knowledge of the emotional influence of fathers on their children's development is minimal. However the evidence from two-parent families suggests they do play an important role, especially through play, and interestingly, are better predictors of offspring's adult adjustment than mothers. Further investigations are needed using specifically devised paternal measures rather than those borrowed from exploration of motherhood [152c]. In my view, to increase understanding, research must also differentiate between diverse orientations to fatherhood.

0.3.9. Disturbance and violence in the relationship:

The transition to parenthood involves changes, pressures and role adjustments which crucially affect the couple relationship (see Chapters 13, 14, 15, and 24, 25 and 27). Their lives are irrevocably transformed with the birth but demands escalate and continue to build as the baby grows. *Many studies find that the increase in couple morbidity peaks for both partners at one year, when over half of all new parents are depressed!* As noted, a non-supportive partner increases the likelihood of depression in new mothers (see 0.3.2.-4.). Not surprisingly, the same is true of new fathers. A literature review of twenty research studies found that during the first postpartum year, the incidence of paternal depression ranged from 1.2% to 25.5% in community samples, and from 24% to 50% among men whose partners were themselves experiencing postnatal depression [153]. [This rises to almost 60% when antenatal depression is included]. In other words, a man whose partner is depressed, is unlikely to find her supportive at this time of his own vulnerability, and he in turn

may be unable to provide the support she needs in stressful early motherhood.

Main predictors of **postnatal depression** in both men and women:

- a personal history of depression
- depression in partner, either antenatally or during the early postpartum period
- a dysfunctional couple relationship.

The high prevalence of parental postpartum depression clearly has implications for the well-being of the child. Research has focused on ways in which maternal depression negatively affects mother–infant interaction and child development [154a] (and see 0.4.7 below). A healthy parent can buffer the effects of a depressed one, and infants of depressed mothers are known to have more positive interactions with their non-depressed fathers [154b]. However when both parents experience depressive symptoms during the postpartum period, the interaction between the mother's and father's respective depressions may further the risk to their child's development.

As noted above, women tend to experience more depression, anxiety and panic attacks while in men disturbance tends to take the form of substance abuse, alcoholism, verbal and violent enactments. Recently, in addition to acknowledging ante and postnatal distress in fathers, there is growing recognition of **violence during pregnancy** – 30% of domestic violence either begins or intensifies during pregnancy and is associated with increased rates of miscarriage, low birth weight, premature birth, fetal injury and death. In the UK, a statement by the Public Health Minister in October 2004 promised to introduce routine antenatal clinic enquiry into domestic abuse, and referral for help.

Violence unleashed during pregnancy may be embedded in a culture of male control over women and their bodies. It may be a continuation of a more generalised domestic abuse cycle (*battering? contrition? 'honeymoon'? re-escalation of violence*) or a new phenomenon, in which the man specifically directs his aggression at his pregnant partner's belly. In these latter cases, an expectant father experiences bouts of uncontrollable anger, stemming either from envy of her creative capacity or jealousy of the intimacy of mother and fetus. While etiological pathways vary, the relationship to his own father may have been marked by a real absence or an emotional withdrawal by a man who failed in his paternal role. In such a case, the growing boy's closeness with an over-involved mother may have been aided and abetted by her belittling the father's authority and competence. The expectant father now