1

Mothers' and fathers' orientations: patterns of pregnancy, parenting and the bonding process

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1.1 Introduction

To begin at the very beginning: we were all conceived by union of male and female gametes. However, definitions of 'parents' vary geographically across the world, and at different historical periods.

Over the past decades, eternal facts of life altered dramatically. Due to efficient, female-based contraception methods, 12–20% of European women remain childfree-by-choice. For the first time in world history the death rate exceeds birth rate!

Western family formations now include single, multiple, same-sex, teenage and older parents, while in AIDS-ridden lower-income societies, oldest siblings serve as mother and/or father in child-headed families.

Thus, the concept 'parents' now comprises biological procreators, surrogates, foster and adoptive carers, and new kinship categories formed through reproductive technology as lone, virgin and post-menopausal mothers gestate genetically unrelated babies, asexually conceived by embryo, egg and/or sperm donation. Furthermore,

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with the erosion of traditional customs and dispersed extended families, today's carers evolve parenting patterns shaped by their own subjective beliefs, emotional experience and unconscious desires.

Qualitative/quantitative research of parenting 'orientations' yields several findings[1]:

- In transitional societies, cultural heterogeneity, rapid urbanization and social mobility grant mothers and fathers more latitude, rendering parenting orientations a mixture of collective and personal expectations.
- However, the complex choices involved, and loss of supportive networks increase perinatal stress and anxiety, especially during the first postnatal year when internal conflicts and discordance between nurturing, domestic and work roles are most acute.
- Although it is the child who creates parents of people, bonding patterns are evident and measurable while anticipating parenting. Unless modified, such representations are predictive of parenting 'climate' and praxis.
- The nature of parenting practice is predictable antenatally from representations of self and baby. Infants born into different orientations come to differ significantly in attachment security, feeding and sleep patterns. Maternal orientation at 6 months discriminates among Secure and Insecure infants (predictive of the Strange Situation at one year).
- Mothers differ in responses to risk factors, timing of heightened anxiety and associated protective factors. Precipitants of disturbance vary according to orientation, largely attributable to discrepancies between subjective expectations and postnatal experience.
- Empirical evidence supports details of orientation theory. Replication in large community samples shows that different approaches to mothering cluster, validating clinical findings of underpinning beliefs. Multifarious pathways to work–family satisfaction and perinatal disorders indicate the benefits of subgroup identification.
- Large-scale research confirms psychoanalytic understanding that at times of transition (e.g. childbearing), unresolved/unprocessed issues are reactivated. Parental cognitive experience is accompanied by fantasies and revitalized memories which contribute to incongruous feelings being transferred into the new situation, potentially leading to distorted reactions to parenting and displaced responses to the baby.

[1] Parental orientations were initially formulated by the author on the basis of detailed thrice-weekly observations and longitudinal studies of mothers and fathers within a London community play-centre of 200 families, over an 8-year period, mapping parenting changes in successive cohorts beginning in 1977. This was augmented by focus-group discussions and pre-and postnatal in-depth interviews with purposively selected informants, at 18-month intervals. The findings from my small-scale qualitative studies engendered questionnaires which were subsequently applied by independent researchers in large-scale longitudinal-prospective projects additionally using measures with well-established reliability and validity, conducted with representative samples in various countries, including Israel, Belgium, Australia, Hong Kong, etc. [13, 4, 7, 17]. Understanding the subjective experience of moment-to-moment parenting activities and difficulties is enriched by psychoanalytically informed clinical work with individuals, couples, families and groups within a practice dedicated to issues of reproduction and early parenting over the past 35 years. Finally, to expand from the Eurocentric start-point, the author also conducts consultations, work discussion groups and supervision for midwives, mental health professionals and social service practitioners working with pregnant women, and/or teenage and older parents on six continents; and open-ended exploratory workshops (conducted through interpreters) with parents themselves in many countries, including the Azores, Argentina, Australia, Austria, Belgium, Canada, Chile, China, Crete, Czech Republic, Denmark, Egypt, England, Ethiopia, Finland, France, Greece, Guatemala, Holland, Hong Kong, India, Ireland, Israel, Italy, Japan, Latvia, New Zealand, Norway, Peru, Portugal, Romania, Russia, Scotland, South Africa, Spain, Sweden, Switzerland, Turkey, USA, West Indies, Venezuela.

- While consistent during a particular child's infancy, orientations often change in subsequent gestations, indicating these are neither traits nor personality types – and that parenting constitutes a life-long evolutionary process.

Germane to these findings two models are presented, depicting configurations of bonding with the imaginary baby during pregnancy, and emotional experience and beliefs which generates manifest parental behaviour postnatally.

1.2 Pregnancy and the 'placental paradigm'

Antenatal emotional experience primes postnatal interaction. Pregnancy is a blending of three intertwining systems: biological, psychological and social. The unconscious mind reflects these. An expectant mother's mental construction of the largely unknown fetus consists of her fantasies, wishes and projections, partaking of her imagined baby-self in the eyes of archaic carers, and her own particular mode of engagement with the procreative maternal body and its powers. If gestation is allowed to proceed, the baby growing within the pregnant woman is only viable as part of their symbiotic exchange. For approximately 280 days, floating in the amniotic sea, he or she swallows and excretes, depositing waste products for expulsion by the maternal system, and ingesting nutrients from the plasma filtrate of mother's diet and the hormonal transmissions of her emotional state.

Expectant mothers' subjective interpretations of this bidirectional connectedness are delineated as a *placental paradigm*, illustrating relational representations underpinning variations of antenatal bonding.

Table 1.1 indicates that many women experience flexible fantasies and healthy ambivalence during pregnancy. Ideas about the baby she harbours and herself as mother-to-be

Table 1.1 Placental paradigm

Maternal representations			
	Self-as-mother *(archaic mother)*	***Fantasy baby*** *(baby-self)*	*Manifestation*:
Mixed representations			
1.	+/−	+/−	healthy ambivalence
Fixed representations:			
2.	+	+	idealization
3.	−	+	guilt/depression
4.	+	−	persecution
5.	−	−	anxiety
6.	+/−	+/−	obsession
7.	+/−	**0**	detachment

Note: Given myriad variations of individual and cross-cultural fantasies, an abstract notation is used – 'plus' signs to signify positive feelings and 'minus', negative ones.

Modified from J. Raphael-Leff, procreative process, placental paradigm and perinatal psychotherapy, *Journal of the American Psychoanalyic Association*, Female Psychology supplement, 1997, **44**, 373–99, which includes illustrative clinical examples.

vary in emotional timbre, richness and intensity, fluctuating during the course of an hour, let alone a day. This changeable process, allowing for playful 'practice'-bonding with the unborn baby, contrasts with 'fixed' representations. A woman's unwavering idea of her 'brilliant' pregnancy as perfect communion/fusion between munificent containing mother and 'special' baby is clearly romanticized. Unless she processes this idealized conviction before the birth, she is destined to be sorely disappointed in the ordinary baby she delivers and herself as merely a 'good-enough' mother. Similarly, a pregnant woman who feels insufficient or even full of toxic 'badness' may be consumed by guilt, seeing herself as incapable of nourishing her vulnerable baby. Minor symptoms, ultrasound deviations or complications seem to confirm her sense of failure. Postnatally, inevitable frustrations sadden her greatly, inducing guilt for betraying her desire to provide an idyllic infancy.

Conversely, another woman may experience herself as fine but for the parasite leaching her resources, an invader determined to maul her from within. When this sense of exploitation is overpowering, relief may be sought in an abortion. Persisting acrimonious representations augur badly for bonding with an infant who is envisaged as a demanding persecutor.

Suffering from low self-esteem, another troubled mother may feel that the critical baby inside knows her weaknesses and will expose her shortcomings once born. Nine months of incompatible connectedness can feel intolerable as apprehension erupts in severe panic attacks. Once again, abortion may seem to offer the only respite from chronic anxiety about damaging or being damaged by the baby inside her. If the pregnancy is sustained, this over-anxious conflicted mother feels compelled to constantly check on her baby, envisaged as dangerous and/or in mortal danger.

Pregnancy also weakens obsessional defences that aim to separate good from bad. Breakthrough intrusive thoughts of causing harm to the future baby include graphic visions of molesting or hurting the child, or herself. Fearing madness, these ideas from 'out of the blue' alarm perfectionists who consciously want to be excellent mothers, doing the best for their offspring.

While seeming far-fetched, such disturbances are extremely common. Confusion and tearfulness increase during the transition to parenthood. Domestic violence rises, boding badly for paternal bonding. Borderline tendencies to self-harm, risk-taking behaviours, dissociation and abusive enactments intensify. Numerous studies document poor antenatal clinic attendance, and adverse consequences of untreated depression, persecution, anxiety, post-traumatic stress disorder and childhood abuse, associated with self-neglect, unhealthy eating, smoking, alcohol or substance abuse affecting fetal growth, and resulting in low birth weight, preterm delivery and/or a hyper-reactive baby.

A final hazard is an expectant mother who behaves as if not pregnant, denying her condition or the importance of the changes to come. This portends badly for the future primary relationship, as emotional detachment leads to malattunement and neglect. Early maternal withdrawal is associated with hyper-vigilance in infants and borderline traits in older children.

Meanings she ascribes to their cord-linked interchange are coloured by circumstances of this conception, life events and her current view of maternity, affected by past experiences of being mothered, as well as her anticipation of future mothering.

Thus, no baby is immune to influences across the placental barrier. He or she already feeds on maternal aspirations and emotions, including her (seemingly universal) *primal anxieties* of formation, transformation and sustenance. One prospective study of 10,000

women found that true to folk beliefs, antenatal maternal anxiety indeed affects the offspring – through high cortisol levels, traceable biochemically and evident in behavioural problems even at age seven [1].

Antenatal disorders are commonly under-diagnosed. Strikingly, most treatment literature focuses on post-partum interventions despite prepartum antecedents of equal prevalence. Given the high rates of antenatal emotional disturbance, and great benefits of prophylactic treatment before the interactive process with the baby is affected, it is essential to identify troubled women during pregnancy. Perinatal staff are in a prime position to screen their clientele, and to refer pregnant women with bonding disorders.

Devised with this in mind, the placental paradigm can be easily taught to clinical practitioners (midwives, traditional birth attendants, nurses, obstetricians or paediatricians) as a simple evaluative chart requiring no knowledge of mental disorders but a capacity to listen in an empathic, non-judgemental way. Official guidelines (e.g. National Institute for Health and Clinical Excellence www.nice.org.uk, 45, 2007) advocate 'talking cures' over antidepressants or other medications while pregnant/breastfeeding. Contemporary psychoanalytic psychotherapists recognize pregnancy as a beneficial therapeutic period, aided by greater accessibility of unconscious material, rich fantasy, frequent and vivid dreams, introspective amenability to insight and high motivation to become a 'good' parent [2, 3].

1.3 The model of maternal orientations

This model, depicting parental beliefs and behaviours, interdigitates with the placental paradigm. The diverse orientations help clinicians understand women's subjective approaches to pregnancy, the baby, birth and motherhood, and how different challenges interact with each expectant mother's personal belief system, self-esteem and mental health.

The first of these orientations is that of the *Facilitator* who treats pregnancy as the culmination of her feminine experience. Throwing herself wholeheartedly into the process, she dons maternity clothes early, 'communes' with her baby, revelling in the special attention. She plans as natural a birth as possible, wishing to minimize the traumatic 'caesura' that will reunite her with her familiar baby (see Table 1.2).

This contrasts with the *Regulator* for whom pregnancy is an unavoidable means of getting a (unknown) baby. She resents being treated as an 'incubator', prey to comments by strangers. Childbirth is imagined as a dreaded, exhausting and painful event to be mitigated by medical intervention. Large studies find that Regulators have a higher rate of antenatal depression, anxiety symptoms and specific pregnancy-related fears. Their elevated incidence of elected Caesarean sections indicates preference for predictability and a way of bypassing the potentially humiliating experience of vaginal birth [4, 5, 6].

Facilitators, on the other hand, look forward excitedly to 'birthing'. Studies of expectations find that Facilitators anticipate more intrapartum feelings of fulfilment, marred by assisted delivery [7].

A third group is that of *Reciprocators* – expectant mothers (or fathers) able to tolerate uncertainty and mixed emotions, in themselves and the baby. They manage ambivalence as inevitable in all relationships, accepting occasional resentments as part of the complex experience of caring for a wordless, sleep-interrupting sentient infant, similar to them in having human emotions and needs, but different in being little, dependent and vulnerable.

Table 1.2 Facilitator and Regulator antenatal orientation[2]

Facilitator		Regulator
♀ uniquely privileged		♂ are privileged
Pregnancy enjoyable		'Necessary evil'
Dual identifications		Resists introspection
Natural birth	***labour/birth***	'Civilized' birth
Exciting		Humiliating
'mother'	***identity***	'Person'
Vocation	***mothering***	Skill
Mother and Baby	***primary unit***	Sexual couple

Other mothers are *Conflicted* – torn between an ideal of maternal perfection and rebellion against it. Preoccupied with painful feelings from childhood experiences and unresolved issues with her own mother, this woman feels trapped with a baby who seems not to recognize her. Confused and terrified of breached floodgates she experiences panic attacks. Her life becomes increasingly dominated by avoidant precautions to control intense anxiety, and envy of her baby's care. Meanwhile, the infant seen as needy but impossible to understand fails to thrive, often manifesting persistent crying, sleep or feeding problems, behavioural disruptions and disorganized attachment, both reflecting and contributing to interactive family symptomatology. Differences between these four groups are significant ($p < .001$) [6].

1.4 Mothering

Facilitators treat postnatal nurture as an extension of pregnancy – a 'fourth trimester' of sensually relishing the reunited baby. Enveloped in the maternal body, the infant rediscovers mother's voice, her wake/sleep rhythms, cadences of breathing and kinetic patterns of stillness and movement. Some experiences are new: the feel and fit of mother's fleshy contours, the taste of breast milk and odours of her breath, armpit, vaginal excretions, her bodily warmth, unmuffled immediacy and differing smooth silkiness/rough edges of her caress . . .

Feeling mothering is her vocation, the Facilitator mother adapts herself to her baby, convinced that only she, the biological mother primed by pregnancy, can fathom her infant's needs. Hence as exclusive carer, she maintains close bodily contact, treating every gurgle as a communication that must be responded to (Table 1.3).

By contrast, the Regulator believes that mothering is a 'learned skill', acquirable by others. Since to her neonates do not discriminate between people, she introduces co-carers early on, establishing a *routine* which reduces unpredictability, provides continuity between nurturers, and differentiates between 'valid' crying and ignorable 'noise'.

[2] These tables contrast two of the four orientations. Regarding the others, *Reciprocators* tend to remain open-minded, exploring perinatal experiences and negotiating each episode as it arises rather than holding a preconceived stance. *Conflicted* mothers oscillate between Facilitator and Regulator approaches (and conflicted fathers between a desire to participate fully and defended renunciation).

Table 1.3 Facilitators and Regulators – mothering

Facilitator		Regulator
Mother adapts	***praxis***	Baby adapts
'Baby knows'	***conviction***	'Experts know'
Gratification	***aim***	Socialization
Exclusive	***care***	Shared
Intuitive		'Right way'
Mother's presence	***security***	Routine
Communication	***crying***	'Real' vs. noise
Permissive; frequent	***feeding***	By schedule
Late	***weaning***	Early
Parents' bed	***sleep***	Own room
'Gift'	***feces***	'Mess'

Hence, proximity is not an issue. The main goal is to 'socialize' the asocial, presocial or even antisocial infant and regulate his or her desires. To this end the baby must adapt to the household regime.[3]

Apart from differences of adaptation and feeding, night-waking is elevated in Facilitator babies, associated with maternal separation anxiety. Sleep patterns differ most significantly at 11 months, but at two years Facilitators' babies are still requiring help in the night, as opposed to Regulators, many of whose babies (reportedly) are conditioned to sleep through from 5 weeks. Infants of Conflicted mothers take significantly longer to fall asleep [25 vs. 11 minutes] but sleep later [8].

The specificity of stressful precipitants for each group also makes sense of the inconsistent 'fractionated' findings in the *family-work-stress* literature. To maintain their self-esteem, Regulators need to engage meaningfully with adults outside the home, whereas Facilitators dread separation from the baby. Wishing to provide full-time exclusive care, they return to work reluctantly of economic necessity or job stipulations. Conversely, Regulators resent economic dependence, and the slow 'mommy-track' which penalizes career advancement and salary growth.

Reciprocator couples tend to be dual-career partners. If they can afford loss of earnings they work flexible hours or part-time, alternating in looking after the baby (prevalent in Scandinavian societies, which provide 12–18 months of parental leave at full pay). Otherwise, Reciprocators work from home or employ a helper.

Naturally, low earners are less able to afford either part-time paid jobs or personalized high-quality childminders, having to resort to available day-care. British surveys of the postnatal period indicate that across all social classes, income groups and educational levels (including lone women) 25% of mothers engage in full-time work, 25% stay at home and 50% work part-time [9].

[3] Professionals working with new mothers are of interest here because of their own concordance with the orientation model. For instance, a study of breastfeeding attitudes of health care professionals, found that some practitioners had a positive breastfeeding interest and a trust in the mother-child unit to manage breastfeeding as opposed to practitioners who regulate the mothers, instructing them how to organize their breastfeeding on a routine basis, instead of being sensitive to the child's needs [18].

The current recession is reshaping the financial roles of millions of mothers worldwide, who are becoming sole breadwinners, returning to work or taking on second jobs to compensate for partners' loss of earnings due to predominantly male employment cuts.

1.5 Postnatal disturbances

All primary carers of whatever sex and age find parenting difficult, especially in nuclear families. Being responsible at all times, attentive and attuned to the needs of someone else, is a daunting task. In addition to broken nights, dream-deprivation and exhaustion, birth mothers also contend with hormonal fluctuations and recovery from labour/birth. Breastfeeding mothers experience painful engorgement, frightening orgasmic contractions, cracked nipples or mastitis and sole accountability for the baby's growth. Teenage mothers experience conflicts between parenting demands and adolescent needs.

Not surprisingly, almost half of Westernized new mothers are distressed at some point over the first two postnatal years; 13–20% suffer clinical depression and 20–40% of disturbed mothers report compulsive thoughts or images of harming the child [10]. These preoccupations often remain secret, hidden and untreated. Although most are not acted upon, in severe disturbance, when delusional reasoning includes the baby, there is a serious risk of child abuse or infanticide.

Each mother or father is affected in his or her own way by the highly arousing emotional experience of nurturing a baby. Where new parents are concerned, my research has shown that a Facilitator mother experiences 'primary maternal preoccupation' (in Winnicott's phrase) before and during the months following childbirth. Her identity becomes primarily that of a mother. Holding a distinct mothering philosophy, she strives towards her maternal ideal of devotion, suspending her subjectivity by adapting to the baby, intuitively facilitating, holding and dedicating herself in unconscious identification with both maternal ideal and vicariously gratified baby-self. However, to sustain this orientation any negative feelings must be suppressed. These revert towards herself. Facilitating mothers feel devastated if unable to breastfeed. Desperation over minor lapses of maternal perfection induces irreparable guilt, remorse and anxious over-involvement. Self-reproach for 'ruining' the ideal may escalate to depression, hopelessness and, in extreme cases, even suicide.

Many other women have a different experience I term 'primary maternal persecution'. In-depth exploration of their subjective experience boils down to feeling trapped. If the sense of exploitation (Table 1.1: 4, 5, 7) persists, feeling undermined, and at the mercy of a potentially greedy/spiteful infant, hostility must be managed. Most Regulator mothers do this efficiently. More breastfeed today than in the past – health-education stresses both infantile immunity and maternal benefits of rapid return to pre-pregnancy shapeliness, with reduced risks of diabetes, heart disease, ovarian cancer and stroke.[4] Intake is regulated

[4] Breastfeeding rates, style and duration vary according to orientation. However these also reflect societal policies and local expectations: in Ethiopia (one of the poorest countries in the world) and Norway (one of the richest), breastfeeding approaches 100%, continuing for two-three years and one year respectively, whereas in Britain only 35% of babies are exclusively breastfed at one week! An Israeli study is currently testing the hypothesis that Facilitators show stronger *intrinsic* and Regulators *extrinsic* motivation to breastfeed, on the assumption that maternal orientation moderates the relationship between two developmental axes and this motivation. Facilitators' higher levels of need/lower anxiety regarding attachment vs Regulators' higher need/lower anxiety regarding individuation. Reciprocator mothers are deemed to have a higher need for both attachment and individuation and less anxiety than the Conflicted group, where two competing orientations of 'Facilitator' and 'Regulator' vie (Peleg).

by schedule, and feeding bottles are introduced early to ensure shared care. This allows the mother to replenish herself by spending time in an enriching social world, protecting her from risks of ruptured defences and/or surrendering to 'sentimentality'. However, if adult fulfilment is thwarted by obstacles, due to unemployment or her own inner conflicts, resentment accumulates. Unmitigated mothering of an infant saps her internal resources, threatening her self-discipline. Desperate to get away, she resorts to controlling the baby's sleep-patterns and abhorrent behaviors, but resents being perceived as coercive. Unconsciously the baby represents split-off dependent, ferocious and/or deprived aspects of herself. Persecuted by constant exposure to her repudiated weaknesses, internal pressure mounts to externalize old scenarios. If defensive detachment fails, punitiveness intensifies towards the baby, seen as cause of her problems,[5] (Table 1.4).

Table 1.4 Facilitators and Regulators – beliefs and fantasies

Facilitator		Regulator
Sociable/vulnerable	***newborn***	Pre/asocial. Tyrannical
Innate personality		Becomes person later
Recognizes mother		Undiscriminating
Communicative		Voracious
	Unconscious configuration	
Mother's ideal self	***baby***	Split off weakness
'Fusion'	***ideal***	Autonomy
Glorified	***internal mother***	Denigrated
	Emotional experience	
Primary maternal preoccupation		*Primary maternal persecution*
Insufficiency	***threats***	Competition
Idealization	***defences***	Control
Vicarious gratification		Dissociation/detachment
Fear of hating	***anxiety***	***Fear of loving***

Importantly, these different orientations towards mothering are already measurable during pregnancy and hence cannot be attributed to the baby's personality. The innovation is to treat postnatal distress not as a unified occurrence, but precipitated differentially in these groups by intrapsychic, socio-economic or cultural factors that conspire to prevent each woman from fulfilling her own maternal expectations. With greater involvement in childcare, about 25% of Western fathers also suffer postnatal distress, increasing to 40% if their partners are mentally ill (possibly due to assortative mating).

[5] Such responses are not rare. In various surveys, parents who admit to having smacked their baby, blame the child for doing something dangerous or 'naughty' or justify it as themselves 'letting off steam'. Recent research by the UK Office for National Statistics found that 88% of British people still think parents should have the right to physically discipline their young children despite massive anti-smacking campaigns, and a global initiative to prohibit it. The link between corporal punishment and fatal child abuse is evident in extinction of the latter in Sweden since the ban on physical chastisement was introduced in 1979. However, Sweden also has psychologists in every perinatal clinic and offers all parents 18 months of full economic and social support.

Disturbed parents are unresponsive, less attuned, inconsistent, ineffectual, and/or intrusive, rejecting or hostile, leading to cognitive and developmental deficits in the child, with threefold risk of developing emotional disorders. Chronic marital or socio-economic difficulties also affect parent–infant interaction. Babies of depressed mothers develop hypersensitive stress responses, with greater likelihood of depression in adulthood. Sons of postnatally depressed fathers are prone to conduct disorders, and children of angry parent/s have difficulties controlling their anger, self-soothing and/or understanding emotional states in themselves and others. In many places, therapeutic interventions are not readily accessible but supportive care from self-help groups or non-professionals may improve the quality of the primary relationship.[6]

Retriggering of the past is but one variable of parental perinatal distress. In addition, there are many psychosocial precipitants, of which an important factor is inability to live up to one's own ideal. Independent research confirms my early findings [6, 11, 12] that in each orientation, psychological strain, including perinatal depression, is related to *a discrepancy between personal expectations and fulfilling one's optimal form of mothering.* Statistical evidence reveals that Facilitators are tormented by disappointing birth-interventions. Regulators have increased independent risk during the first six weeks, suffering from a sense of reduced adult competence – confidence loss and self-reported inadequacy and dejection. Reciprocators are resilient. Even those who were distressed antenatally are statistically less likely to develop postnatal depression [6].

Acceptance of sad and angry feelings alongside joyous ones, and flexible reciprocity in meeting emotional needs of *both* parent and infant seems protective, unlike imbalanced emphasis on either baby or carer.

A Facilitator who fails to achieve her mothering ideal tends towards depression. Suffering agonies of self-blame and anxiety, she castigates herself for letting down the vulnerable baby as centre of the world. By contrast, a Regulator mother anticipates mothering 'rationally'. Horrified by her heightened emotions, she dreads becoming 'soppy', or scary. When persecutory feelings escalate, projective experiences of paranoia engender a need to escape or to impose further control. Contending with incompatible tendencies to extreme facilitation and simultaneous regulation, Conflicted mothers feel confusedly martyred or hostile, paralysed by phobias or helplessness (needing the infant's help), or become rejecting, punitive and/or intrusively autocratic.

Notably, *the orientation model is circular* rather than linear: half the circle – namely babies of Reciprocators and those of moderate Facilitators and Regulators – are found to be securely attached. The other half are insecure. Extreme Facilitator mothers tend to be enmeshed (babies ambivalent), extreme Regulator mothers dismissive (babies avoidant), while Conflictual orientations are preoccupied/inconsistent (babies disorganized) [13].

[6] In industrialized nations up to 20% of all mothers suffer from postnatal mental disorders, a figure that rises with poverty, discrimination and adversity. However, scarcity of professional resources means that in low and middle-income countries a high treatment gap exists between disorder and availability of therapeutic interventions, which may also be unevenly distributed and/or inefficient. The World Health Organization advocates a public health policy with 'task shifting' from specialists to training primary health-care workers to recognize distress and deliver cost-effective support and accessible care www.who.int/whr/2001/en. For an example of a randomized control trial of a home-based intervention to improve the quality of mother–infant relationship and attachment in a socio-economically deprived community in South Africa through lay community workers, see the *British Medical Journal* online www.bmj.com/cgi/content/full/338/apr14_2/b974.

1.6 Contagious arousal

Unremitting intimate contact with a newborn triggers formidable emotional forces. One of the first feminists to candidly disclose the arousal of long-buried feelings and her confused sense of maternal 'power and powerlessness' wrote in 1960: 'My children cause me the most exquisite . . . suffering of ambivalence: the murderous alternation between bitter resentment and raw-edged nerves, and blissful gratification and tenderness' [14, p. 21].

The intensity of primary experience resides partly in evocations of the past: bittersweet dual identifications with the baby's neediness, as with one's own mother's protectiveness. A new parent's open receptivity to the infant's 'primitive' communications evokes his or her own implicit processes. Breaking down defences, the infant's helplessness unleashes unresolved 'power/powerlessness' conflicts in the carer, revitalized through *contagious arousal* (as I termed it). Archaic experience is also stirred up through sensual dealings with *primary substances:* the evocative smells and feel of amniotic fluid, lochia, colostrum, breast milk, as well as baby-poo, pee, vomit, navel and other excretions, all unique to infancy. I propose that these retrigger somatic sensations and subsymbolic preverbal memories from the adult's own infancy.

The focus and timing of a mother's or father's arousal reflect the weakest links of his or her infancy/early childhood (as the Conflicted group demonstrate vividly). Conversely, each orientation excels at different developmental phases – Facilitators' exquisite neonatal attunement; Regulators' encouragement of mobility; Reciprocators' negotiation of toddlers' choices . . .

I suggest that perinatal distress is exacerbated by little previous contact with babies and lack of preparation for their emotional impact. Laying oneself open to comprehending preverbal emotions reactivates unprocessed feelings. Surprised by the fierce intensity of their elicited response, many mothers and fathers are deeply shocked by involuntary thoughts about neglecting, harming or even molesting the omnipresent infant.

In the West, the baby handed to parent/s to take home from hospital (with total responsibility for his or her welfare), is usually the first newborn they have ever seen. Furthermore, extended families are scattered. Unfriendly communities tender insufficient emotional and practical support, unrealistically increasing spousal-reliance. Most importantly, in many countries today people live in stratified societies which separate age-groups. Growing up within small isolated nuclear family units offers few opportunities to actively work through loss, grievances and early traumatic experience in the presence of a baby-sibling, -cousin or -neighbour, before caring for one's own infant. Facilitation and regulation (compensation/control) are defensive procedures to reduce the overwhelming aspects of contagious arousal.

In sum: the two-way systemic process of pregnancy continues postnatally. Parents are profoundly affected by emotional interchanges with their offspring, and conversely, a child's internal world is constituted intersubjectively with primary carers. Neuropsychological research reveals that the baby's brain itself is formed interactively, reflecting the degree of stimulation or deprivation, cultivation or pruning of neonatal synaptical connections. Using frame-by-frame microanalysis of filmed interactions, neonatal researchers (Beebe, Lyons-Ruth, Sander, Stern, Trevarthen, Tronick) demonstrate complex bi-directional patterns of mutual regulation and reciprocal influence between carers and infants.

Most importantly, the myth of perfect synchrony is dispelled. In ordinary dialogues between mothers and their babies, around half the communications are mismatched. However, the crucial element for infant mental health is not unadulterated harmony, but a reciprocal *meeting of minds*, and the capacity of both parent and infant to heal impingements and repair miscommunications collaboratively.

The ability to tolerate ambiguity and ambivalence without resorting to foreclosure, guilt or retaliation is something Reciprocators are good at. Aware of the baby's human *sameness* as well as *otherness* (being little, dependent and immature), their primary stance is one of empathy, curiosity and compassion (rather than identification or dis-identification). Although delineated many years before 'mentalization theory' was formulated [15], Reciprocators may be described as utilizing parenthood to enhance their capacity for 'reflective functioning'. Seeing the baby as a separate individual endowed with personal characteristics and changing mental states (feelings, intentions, beliefs, desires) enriches Reciprocators' interactive awareness and self-understanding.

1.7 Paternal orientations

Whereas male Reciprocators share care, striving to evolve a (preoedipal) relationship with the sentient baby, Participator fathers desire total involvement in the pregnancy and sole care of the infant. By contrast, alarmed by the emotional arousal intimate contact entails, Renouncer fathers wish to suspend their paternal role until the infant develops language. Conflicted fathers want both [16]. Clearly, in two-parent families, the interactive combinations of partners is crucial (Table 1.5).

Table 1.5 Parental permutations and precipitants of postnatal distress

Facilitator + Renouncer	**Regulator + Renouncer**
'Conventional' pattern	Dual-career pattern
Primary unit: mother+baby	Primary unit: sexual partners
Non-supportive partner→PND	Conservative partner→PND
Facilitator + Participator	**Regulator + Participator**
Division of care	Shared care
Competitive partner→PND	Role reversal

Note: PND = postnatal depression.

Stable partnerships mitigate psychogenic conflicts. However, Facilitators become distressed by competition over exclusive baby-care or spousal failure to safeguard on-demand breastfeeding against interruptions (by other children, economic needs or household chores). Conversely, Regulators abhor conservative non-egalitarian partners who insist they remain at home. In cultures of male machismo, 'liberated' women may be stigmatized, or subject to partner violence.

Finally, while consistent during the early years of a child's life, orientations often change with subsequent pregnancies, usually due to parental processing of affect. Influential *psychological* variables are the motive for this conception and degree of emotional support (even one confidante is protective). On a *socio-economic* level, issues include the mother's

age, career/employment status, partner, number of children and age-gaps between them, social/economic pressures, cultural expectations and life events. *Physiological* complications of pregnancy, childbirth or baby, hormonal swings and sleep-deprivation all influence future decisions. However, the most important factor in determining a change of orientation is the *emotional experience* of parenting the previous child.

1.8 Conclusion

In Westernized countries, over the decades since the 1960s counter-culture, 'the pill', equal education and higher career expectations, many feminist mothers struggle desperately with *clashes between their own dramatically changed personal aspirations and those of the baby, unchanged since hunter–gatherer times*. This incongruity can lead to high discordance of needs between carer and infant, especially among professional women who wish to be 'good' mothers while pursuing career interests.

Most theoretical expositions depict mothers from the perspective of the child. However, qualitative studies focusing on maternal experience provide greater awareness of flesh-and-blood subjects with their own feelings and independent locus of agency, needs and desire. Nonetheless, painful issues of maternal resentment and anxiety remain under-theorized. In a cultural climate that promotes parenting as blissful, carers as well as mental health professionals are reluctant to acknowledge the depth of parental ambivalence. Accepting that responsiveness to an infant's affective communications inevitably evokes mixed feelings enables these to be voiced and processed rather than either inhibited (by Facilitators), split (by Regulators) or acted upon (by Conflicted parents).

Increased recognition of heterogeneous orientations and awareness of bi-directional psychodynamics engenders greater tolerance for the range of ways parents choose to relate. The emphasis is no longer on a 'correct' form, pathologizing deviations from conventional parenting, but rather helping each parent to develop flexibility and authentic enjoyment within the chosen mode of interaction he or she and this specific infant are comfortable with.

Given Western fragmentation of family and community networks, professionals now fill the gaps – offering developmental guidance and emotional support to both parent and child. And should the need arise, making timely referrals for rewarding perinatal or parent–infant psychotherapy.

1.9 References

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