"Lessons from matriarchs – and what do we still need to learn?"

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> *"Often father and daughter look down on mother (woman) together. They exchange meaningful glances when she misses a point. They agree that she is not bright as they are, cannot reason as they do. This collusion does not save the daughter from the mother's fate."*
> — *Bonnie Burstow, Radical Feminist Therapy: Working in the Context of Violence* (1)

My mother and I, despite my arguments to the contrary as a teenager, are increasingly alike. As happens to many daughters, I have come to the realisation that my mother is, just like me, a person with her own story, strengths, and battles. She is a matriarch in my life, a woman I admire greatly, and the woman I have learnt the most from throughout my life despite my resistance at times. Yet, we both have and do still face similar battles to each other. Why does this seem to happen so often, to so many mothers and daughters?

We all have mothers, and yet 'mother' has a different meaning to each of us. Whilst female political leaders, figures of authority, and those with influence vary across generations and between nations, mothers are universal. Mothers may be of biological, spiritual, adopted, emotional kind, but what all mothers' have in common is that they have given us something. This may be half our genetic material, a lesson of worth, or simply a lesson in what to do when we become sick. The importance of women, their health, and their stories within societal structures is increasingly becoming known to be of paramount importance in determining physical, mental, socioeconomic, educational outcomes – the list could go on (2) (3). Exploring the lessons, both good and bad, that we and our patients may learn from the mother figures in our lives, and the battles that we and our patients continue to face despite, or even as a result of, these lessons is key. Through this I believe we may be able to gain a new perspective of the field of psychiatry, its bidirectional relationship with the world, and what our role is as healthcare professionals.

This essay will begin with an exploration of what a matriarch is, before looking at the lessons matriarchs teach us, and what we, particularly those of us in psychiatry, still need to learn. Mothers are the matriarchs I will focus on. The primary focus will not be on the explicit lessons mothers teach, 'don't touch the oven – it's hot', but cases that I think are more interesting, involving implicit and passive lessons. It will also function on the assumption that mothers are the primary care givers, an acknowledged oversimplification.

<u>Matriarchs and the lessons they teach:</u>

> *"If you want to understand any woman, you must first ask about her mother and then listen carefully. "*
> *— Anita Diamant, The Red Tent* (4)

'Matriarchy', much like 'mother', is a term which brings different thoughts to the minds of different people. Although different fields define 'matriarch' differently, a common thread between theories involves a social system within which a woman or women have power and authority. Through psychology, we now know that we begin learning through observation and experience from the day we are born, potentially even from before birth (5); the first two years of life being a particularly important determinant of future development (6). Thus, even if a woman is within a social context in which she has no 'official' form of social power or authority, her position itself and her actions still teach those around her lessons about who they are, and the world and social structures they are living within. The power this has over a

child and their future is, to me, enough to call any mother a matriarch, and thus in this essay any mother figure within a social system is a matriarch. Therefore, every woman has the power to teach lessons and shape the lives of those around them within their social context implicitly, despite not all women having the authority to teach lessons explicitly.

However, lessons and experiences are not just passed down through observation and teaching. Many conditions and personality traits run in families, including psychiatric disorders. Whether this is through nature, nurture, or a combination of the two is generally unknown as so many factors are involved (7). Studies in epigenetics have shown that the biological impact of trauma on the physical and mental health of descendants of trauma survivors is significant (8). Consequently, mothers and grandmothers do not only pass on experience through what they show or *choose* to tell their children, but also through their genetic material which has been shaped by what they have lived – their *experiences*. Thus, not only can lessons from matriarchs be learnt through observation and active teaching, but experiences can be inherited both passively and actively – through genes and stories. All maternal figures in our lives teach us lessons, but this does not mean that all lessons are good…

Not all lessons are good lessons.

EUPD (emotionally unstable personality disorder) is interesting to think about when exploring the lessons matriarchal figures in our lives teach us. Although there is some degree of genetic heritability, the multifactorial causality of EUPD is still indeterminate (9). One factor that seems to be of particular importance is childhood trauma, and the relationship between mother and child. This is described by a matriarch within psychology, Marsha Linehan, Ph. D., who was once an inpatient in a mental health unit, and who has since developed dialectical behavioural therapy (10). Her biosocial model details how when a child with a naturally emotional temperament grows up and develops within an invalidating environment, they are more likely to develop EUPD-like traits themselves as an adult (11). This may be because a mother (or a father) has EUPD and cannot give them the care, validation, and stability they need due to their own struggles. Children in these environments may learn lessons such as not to trust their inner emotional experiences; that the world is not a safe place or somewhere their needs will be met; and to not be comfortable with consistency, but to find comfort in inconsistency (11).

These lessons heavily shape the relationships, social attainment, and health outcomes of many of these children for the rest of their lives, regardless of whether they themselves go on to develop EUPD (12). This illustrates that we may learn lessons from matriarchal figures in our lives that in fact *lead* to us fighting the same battles as them. Although this is an extreme example, a similar picture can be seen in other situations, such as mothers with post-partum depression or psychosis, anxieties, and OCD, to name but a few. Mothers are not, after all, the perfect humans with no struggles or emotions of their own that we often think when we are younger: no maternal figure is perfect no matter how hard they try. However, there is hope. Mother's do not need to be perfect at all times to generate secure attachments and positive outcomes with their children. It has been shown that even if mothers only respond well 50% of the time, this is 'good enough' (13). What can we do to try to maximise the good and attenuate these difficulties?

The mother's fault?

If children's futures and therefore the future of our societies are so sensitive to the variable nature of a mother's care, it may seem like there is no hope – that the battles will never end. It is important to remember that mothers with EUPD and other mental health disorders such as postpartum depression are often doing their best given the resources available to them. However, there is hope. There are lessons from mothers which we as healthcare professionals and members of society can learn and utilise for the benefit of all. First, it is important to remember that helping mothers and supporting women is beneficial for both males and females (14) – everyone should be invested in helping mothers and improving gender equality within society. Second, the support of a partner has been shown to be the greatest determinant in how successful a mother is seen to be. By teaching young people how to support those around them, and what a healthy family dynamic looks like, we may be able to prevent or reduce the battles that many people face. Third, by trying to break cycles of generational trauma and reducing adverse childhood experiences, particularly through supporting maternal figures in our societies, we may greatly reduce, if not prevent, a vast sum of ill health within our societies (15). Primary prevention is one of the most powerful tools in improving health outcomes (16).

An ethic of care

Today, western society often teaches that men are the rational, scientific, 'not-swayed-by-their-feelings' beings, whereas women are overly emotional, erratic, and sensitive 'things'. In feminist theory there are diverse and rich debates surrounding the ethics of care. However, to simplify this, one of the foundational premises is that an ethic of 'caring' is just as important as one of 'rationality' (17) (18). Outside of the world of academia, many of us likely don't have to look too far to see the outworking's of this – possibly no further than a mental health ward or our own mothers. Many of the mothers in our lives teach us this through their actions towards us, and through what the world expects of them. A mother does not just care about a child's cut knee, but for everything about them – *they* are important, not just their problems. As robots (in my mind, a manifestation of rationality) are increasingly taking over roles once completed by humans (19), most still believe very few people would be happy for a robot to look after their grandmother or their sectioned child.

However, this ethic of caring is often not realised even within medical fields. In medical school we are implicitly taught to see patients as acute problems to which we simply need to find solutions before we can move on. Research is increasingly emphasising the importance and pervasiveness of trauma, adverse childhood experiences, and socioeconomic status on all aspects of life, not least mental health (3) (2). Yet, the focus seems often to be on fitting the symptoms to a diagnosis and then fitting drugs to the diagnosis, instead of understanding the patient and their story, how this may be impacting their current health, holistically. Considering that both we and our patients cannot help but inherit, figuratively and literally, lessons and experiences from our mothers, it may help our therapeutic relationships to remember to act primarily from an ethic of care, instead of an ethic of rationality. By looking at our patients as people, just as mothers look at their children, and not problems to be solved, we can begin to provide the highest quality of care.

Conclusion:

We always learn from our seniors, mothers, and grandmothers. However, this does not exempt us from fighting the same battles, and at times, in fact, is one of the reasons *why*. Through psychology we know that we always learn from those around us, through observation, reprimand, and praise. We learn lessons of both epistemic and experiential nature from all the women in our lives, both good and bad. Importantly, many of these lessons can have a profound impact on the mental health of individuals, and their ability to help both themselves and others. Thus, we need to learn how to support mothers, especially those in the lives of very young children. First in how they view, treat, and support themselves, and secondly how to use this to support the children of all ages around them. Through breaking cycles of generational trauma, and supporting healthy, enriching, and supportive family systems, we may have the biggest positive impact on public health, particularly mental health, especially given the restricted resources available. After all, medicine is *not* an exercise in rationality, but an *art of caring* for the vulnerable – and no one is immune to vulnerability.

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