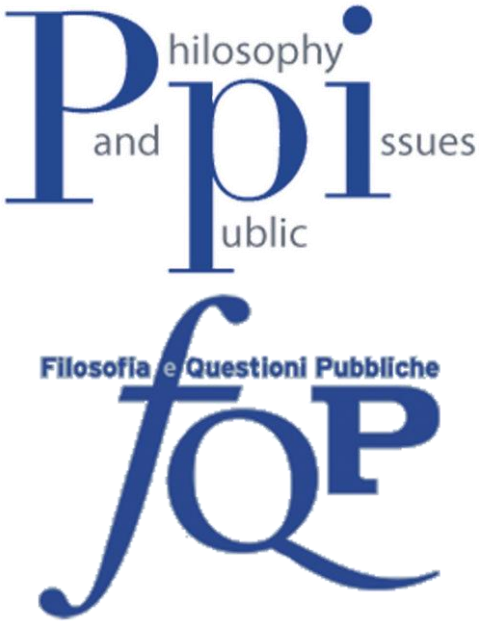

ENHANCING MATERNAL LOVE?

BY

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Andrea Klonschinski and Michael Kühler

Introduction

The attachment bond between mother and child and the concomitant unconditional motherly love[1] for her child (or children) are often regarded as prime examples for intense loving relationships (Earp and Savulescu 2020, 57). Yet, the flow of oxytocin notwithstanding, not all mothers love their children. This may be a temporary situation, as it is the case with the so-called baby blues or postpartum depression (PPD). In the latter case, the mother, indeed, *cannot* love her child (properly). Since the mother suffers in such a situation, medical treatment seems warranted. However, what if the mother does not have a full-blown depression, but still

[1] We use "motherly love" and "maternal love" synonymously.

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does not love or thinks she does not love her child enough? Given the facts that parental love is essential for the child to flourish and that the feeling of not loving one's children enough can seriously diminish one's well-being, would it be apt to recommend the women in question a love drug?[2] Whereas in the case of PPD, taking love drugs can be considered medical treatment, the latter cases would imply using love drugs as enhancement.

We take these cases as prime examples for the use of love drugs and discuss several ethical issues raised by them. Two features make maternal love especially worth considering in the context of love drugs: first, newborns and small children require loving care in order to develop capacities necessary for a flourishing life. In contrast to a partner in a romantic relationship, the child is extremely vulnerable and, at least at the beginning, fully dependent on his or her parents. Therefore, it has even been argued that parents have a duty to love their child (Liao 2015).[3] Yet, the question arises of whether this duty can be accomplished by using love drugs at all if one of the core demands on maternal love, and love more generally, is that it should be *authentic*? Second, maternal love is highly idealized, and the image of the beneficent, nourishing, and selfless mother pervades mythology, theology, and popular culture (Rich 1986, 34; Douglas and Michaels 2004). The ideal is pernicious for women, though, since it confines them to the private realm of care, perpetuates gendered hierarchies, and incorporates social expectations on women that are impossible to meet. In fact, women suffering from PPD or depressive moods often express their anxieties not to be able to live up to the social

[2] We use the singular "child" and the plural "children" interchangeably.

[3] Speaking of a duty to love one's child may even suggest *forcing* parents who do not love their children (enough) to take love drugs. We will not consider this option but follow Earp and Savulescu by presupposing that such drugs should not be used "illegally, coercively, or at home in isolation" (Earp and Savulescu 2020, 12).

expectations surrounding motherhood. Therefore, while both the suffering of mothers who feel that they cannot love their child (enough) and the child's need for motherly love speak in favor of the latter's enhancement, it runs the risk of supporting the unjust background condition of the restrictive "institution of motherhood" (Rich 1986).

In this respect, the issue of enhancing motherly love shows parallels to the use of drugs to suppress homosexuality in Orthodox Jewish yeshiva students discussed by Earp and Savulescu (Earp and Savulescu 2020, 161-170). The religious norms of Orthodox Jews stigmatize homosexuality as a mental disorder, which puts Jews with homosexual desires or behavior into serious conflicts with their community up to the point of becoming depressed. Clearly, what has to change in this situation is not the desires or behaviors of the respective individuals but the religious norms that stigmatize homosexuality. However, changing norms is nothing that can be accomplished rapidly, whereas, due to the existence of certain drugs, the individuals' suffering can be ameliorated on short term. Both "treating" homosexual urges and enhancing motherly love thus pose the following dilemma: "Either we can help the individual and at the same time strengthen the objectionable background norms, or we can resist the norms by refusing to help the individual" (Earp and Savulescu 2020, 168). Our following discussion can thus be read as a follow-up to Earp and Savulescu's considerations in this respect. Just as they do, we believe that matters of applied ethics cannot be solved by establishing any abstract rule or principle alone but requires the careful consideration of the respective contextual factors. In this spirit, we seek to raise and discuss some central ethical issues of enhancing motherly love without defending a clear-cut thesis as to its ethical legitimacy.

In order to do so, we begin by sketching how we understand "love" in general and "maternal love" in particular (section I). After that, we elaborate on the most pressing reasons why there might be a need to enhance motherly love (section II). Against these reasons speaking in favor of using love drugs, we discuss the question of whether doing so might undermine the expected authenticity of motherly love and perpetuate the ethically problematic stereotypical ideal of motherhood and motherly love (section III). We conclude with a cautious skepticism about the use of love drugs to enhance motherly love.

I

Love and maternal love

Maternal love is often considered the prime example of love. To illustrate this, a classical point of reference is Harry G. Frankfurt's seminal account of love as caring (Frankfurt 1999, 166; 2004, 43). Although love, including parental love, is typically considered an emotion, Frankfurt defends a volitional account of love, following up on his general volitional analysis of personhood and autonomy (Frankfurt 1971; 1994; 2004; 2006; for exemplary critical discussions, see Buss and Overton 2002). The details of Frankfurt's multi-level account of the will do not matter for the purpose at hand. The crucial point is that he characterizes love as a kind of *caring* (Frankfurt 1999), and what or whom a person cares about in this sense is, in turn, the defining aspect of the person's *identity*, i.e., *who* the person is. Moreover, Frankfurt argues that we do not have a choice in love. Love is a *volitional necessity*. We are merely able to *discover* what or whom we love and thereby who we *essentially* are (Frankfurt 1994, 138). In loving someone, supporting the beloved to flourish then becomes one of our final ends

(Frankfurt 2004, 55). Consequently, Frankfurt defines love as follows:

> Love is, most centrally, a *disinterested* concern for the existence of what is loved, and for what is good for it. The lover desires that his beloved flourish and not be harmed; and he does not desire this just for the sake of promoting some other goal. […] For the lover, the condition of his beloved is important in itself, apart from any bearing that it may have on other matters. […] This volitional configuration [of love] shapes the dispositions and conduct of the lover with respect to what he loves, by guiding him in the design and ordering of his relevant purposes and priorities (Frankfurt 2004, 42-44).

For our present concern, it is interesting to note that one example Frankfurt gives to describe the notion of love as a volitional necessity deals with a mother who is about to give up her child for adoption. Although the mother has apparently decided to give away her child and has taken all the necessary steps to do so, when the day comes, she finds herself unable to do it. In fact, she is even unable to muster the *will* to do it. Frankfurt describes this phenomenon as the woman encountering her volitional limits, which, in turn, mark the contours of her identity (Frankfurt 1993, 111).[4] Hence, in discovering what we love or what our volitional limits are, we learn something about who we are.

His analysis also leads Frankfurt to defend an account of love according to which there are no reasons *for* love – we do not love for reasons and the beloved does not give us reasons to love him or her. Instead, love is a *source* of reasons, namely reasons *of* love, which directly stem from our very identity as a person (Frankfurt

[4] Note that Frankfurt does not claim that this is necessarily true for *every* mother.

2004, 37-39; for an overview of the debate on love and reasons, see Kroeker and Schaubroeck 2016, Helm 2017). Again, Frankfurt illustrates this idea using the example of parental love:

> Consider the love of parents for their children. I can declare with unequivocal confidence that I do not love my children because I am aware of some value that inheres in them independent of my love for them. The fact is that I loved them even before they were born—before I had any especially relevant information about their personal characteristics or their particular merits and virtues. […] If my children should turn out to be ferociously wicked, or if it should become apparent that loving them somehow threatened my hope of leading a decent life, I might perhaps recognize that my love for them was regrettable. But I suspect that after coming finally to acknowledge this, I would continue to love them anyhow (Frankfurt 2004, 39f.).

Note that Frankfurt discusses *parental* love, which gives the impression that this type of love is gender neutral – which Frankfurt apparently supposes and at least implicitly argues for. As commendable as this may be, neither current social practice nor the stereotypes of maternal and paternal love are nearly as gender neutral as Frankfurt would have it. To see this, it is illuminating to consider the – still prevalent – stereotypical distinction between maternal and paternal love. In his famous book *The Art of Loving*, Erich Fromm describes the distinction as follows:

> He [the infant] learns how to handle people; that mother will smile when I eat; that she will take me in her arms when I cry; that she will praise me when I have a bowel movement. All these experiences become crystallized and integrated in the experience: *I am loved*. I am loved because I am mother's child. […] *I am loved*

> *because I am*. This experience of being loved by mother is a passive one. There is nothing I have to do in order to be loved – mother's love is unconditional (Fromm 1956, 39).

Yet, once the child develops and becomes more and more independent, Fromm observes:

> Motherly love by its very nature is unconditional. […] The relationship to father is quite different. Mother is the home we come from, she is nature, soil, the ocean; father does not represent any such natural home. He has little connection with the child in the first years of its life, and his importance for the child in this early period cannot be compared with that of mother. But while father does not represent the natural world, he represents the other pole of human existence; the world of thought, of man-made things, of law and order, of discipline, of travel and adventure. Father is the one who teaches the child, who shows him the road into the world. […] Fatherly love is conditional love. Its principle is "I love you because you fulfill my expectations, because you do your duty, because you are like me" (Fromm 1956, 41-43).

Note that Fromm explicitly refers to "ideal types" and does not claim that every mother or father in fact loves the way described here (Fromm 1956, 41). To be sure, in particular cases, the typical roles of mother and father can be reversed or be defined totally differently by the persons concerned. However, we take the quotes to neatly express the *stereotypes* of maternal and paternal love without claiming that they are empirically true. We will criticize these stereotypes for their pernicious effects below (see section III.2).

It is striking that Fromm's description of ideal motherly love neatly meshes with Frankfurt's account of love as caring while the image of fatherly love does not do so. In fact, according to Frankfurt, the latter would not count as parental love at all. As mentioned above, he describes love as a volitional necessity and as giving the person decisive reasons to act (reasons *of* love). Conversely, he denies that there are reasons *for* love, which is why love is unconditional. Moreover, when he argues that love is a volitional necessity and the prime source of who a person is, he defends an *essentialist* and *internalist* account of identity. A person's identity, i.e., what or whom she loves, is *internally given* in the sense that the person can merely discover her own internal volitional necessities. This is why one may conclude that motherly love should come *naturally*, stemming from the person's *true self*, when following Frankfurt. In sum, while Frankfurt's account of love as caring appears to be gender neutral, stereotypical social practice may rather expect this type of love from mothers and not or less so from fathers.

II

Why enhance maternal love?

II. 1. Lack of maternal love

Following Frankfurt and Fromm, motherly love can be described as unconditional, natural, caring, and eternal, which raises the question as to why there may be a need to enhance it in the first place. One basic reason consists in the fact that motherly love actually is not as 'natural' as the ideal would have it. In this respect, three cases of – at least a temporal – lack of motherly love can be distinguished: PPD or depressive moods after childbirth, ambivalent feelings of motherhood in general, and a complete lack of maternal love. In the following, we introduce these cases, show

in which respect they may call for love drugs, and differentiate two ways of the latter's application. Note that we deliberately speak of "mothers" and "women" at this point. In doing so, our intention is not to say that only women can care for children or that only biological mothers can occupy the position of the "mothering" person at all.[5] Quite to the contrary, we seek to acknowledge and reveal the currently highly gendered notion and practice of mothering and motherly love (see Ruddick 1989, 45). Considered against this background, speaking of "parents" instead of "mothers" and "women" seems to be gender blind, not gender neutral (Daly 2013, 224f.).

i) PPD and depressive moods

To begin with, some women do not fall in love with their newborn at first sight, but report initial difficulties bonding with their child instead (Nicolson 2001, 6; Stone and Kokanović 2018, 174). According to Paula Nicolson, of the 25 women she talked to about their experiences surrounding nativity, "most wanted to avoid that immediate post-birth time alone with the baby" and the feelings they had for it "ranged from intense hatred, through ambivalence, awe and anxiety about its well-being" (Nicolson 2001, 6).[6] Depressive moods are in fact common within the first year after childbirth. Depending on the severity and the duration of the symptoms, the phenomenon can range from a full-blown

[5] See on mothering and the possibility that men can do so as well (Ruddick 1989, 45).

[6] Note that Nicolson's study is very anecdotal and, as pointed out in a review, it is not clear according to which criteria and how exactly the subjects have been recruited (Tate 2002). Other studies report similar experiences, though (Huppatz 2018; Stone and Kokanović 2018), so that those described by Nicolson do not appear totally uncommon.

PPD, over the so-called "baby blues," up to recurrent depressive moods (Nicolson 2001, 25ff.; Sonnenmoser 2007; Johnson, Adam, and McIntosh 2020).[7] Among these phenomena, only PPD is considered a medical condition warranting treatment (Sonnenmoser 2007). In all cases, though, the women concerned apparently struggle with their transition to motherhood and express the fear of not being able to love their child properly (Rich 1986; Nicolson 2001; Stone and Kokanović 2018; Huppatz 2018, 148; Johnson, Adam, and McIntosh 2020). According to Stone and Kokanović, the "fear that a woman could not cope with mothering or did not even 'want to be a mum'" was implicit in the narratives of the women interviewed for their study and the "fear of being a 'failed mother' is prevalent in the PND [PPD] literature" (Stone and Kokanović 2018, 178). Consequently, some women report that they actually felt relieved when being diagnosed with PPD since this meant that their condition was not their own fault, but a pathological disorder that could (and would) be cured eventually, so that they would come to love their baby after all.

ii) Ambivalence

Even mothers who do not suffer from a full-blown depression frequently describe their feelings towards their children and towards motherhood as ambivalent. In particular, they mourn the loss of their former identity, their freedom, autonomy, time, and control of their lives (Nicolson 2001, 77f.; Donath 2015, 356; Johnson, Adam, and McIntosh 2020, 2f.). Since motherhood is socially equated with happiness and newborns are to be greeted with joy, there is no room for the mothers' grief, so that the women

[7] We put the more extreme cases of postpartum psychosis and post-traumatic stress disorder after giving birth aside here. See on the former (Sonnenmoser 2007, 82) and on the latter (Nicolson 2001, 43).

often feel left alone in a particularly burdensome situation (Nicolson 2001, 38f.). A similar taboo is put on admitting that childcare may not be as joyful as previously expected. By contrast, it can be "a spectacularly ghastly activity. We're not supposed to admit it," a female journalist quoted by Nicolson nevertheless confesses (Nicolson 2001, 75). Some mothers even state that they regret having had children in the first place, as the following woman cited by Moore and Abetz does: "I would turn back the clock in a heartbeat. I find parenthood and specifically motherhood unfulfilling and intellectually demeaning. … I often feel like I'm talking to people with monointerests or a monolife where there is no moment of their life not filled [with] their kid(s)" (Moore and Abetz 2019, 404).[8] Mothers (or fathers) who admit regretting having children usually strictly separate between the love for their children on the one hand and the experience of being a mother (or parent) on the other (Donath 2015, 355; Moore and Abetz 2019, 405). That is to say, the women's reasons for regretting motherhood do not consist in a lack of motherly love, but in the rejection of the mother role.[9] Hence, both in case of PPD, depressive moods, and ambivalent feelings, hatred or the 'failure' to bond with the child are depicted as temporal phases.[10]

iii) Lack of love

Possibly due to the fact that the notion of natural and unconditional maternal love is such a strong normative imperative,

[8] For further examples see (Donath 2015; Moore and Abetz 2019).

[9] See also (Nicolson 2001, 7).

[10] Interestingly, Stone and Kokanović point out that their subjects exhibited a tendency "to structure their narratives [of PPD] in a confessional mode […] that started with scenes of inattentive, uncaring mothers, to the 'penance' of medical treatment and ending with depictions of 'übermothers' harmoniously in tune with their offspring" (Stone and Kokanović 2018, 178).

we did not come across empirical studies in which women explicitly stated that they do not and never have loved their child. Yet, as Sara Protasi carved out, it is certainly imaginable that perfectly sane mothers do not love their children. Consider her following example:

> Ali finds herself pregnant [… and] wants to give the baby up for adoption, but her family prevents her from doing so. They reassure her she will love her child at first sight. At the moment, she hates her state and does not feel any connection with the fetus, which she thinks of as an alien, invasive creature. She hopes this will change when the baby is born. However, after birth the baby looks ugly to her, and she has a hard time breastfeeding him. She lacks adequate medical and familial support, and is left alone dealing with this still-alien-looking creature who cries all the time and who does not seem to like her at all. Ali is exhausted and resentful, dreaming of the life she could have had without him. After a few weeks, she leaves him outside an ER, well covered, wearing bright colors, and in plain sight. She cuts ties with her previous life, and never comes to regret her deed" (Protasi 2018, 38 [italics removed]).

As Protasi points out, there is nothing "psychologically abnormal" about Ali (*ibid.*). The example is evocative of Frankfurt's abovementioned case of the mother who wants to give up her child for adoption but cannot bring herself to do so. Whereas, in that case, the mother reached the limits of her volition, Ali's decision to leave her baby resonates with her volitional identity. A lack of motherly love is thus imaginable and in line with Frankfurt's account of love, albeit not with the ideal of motherly love depicted by Fromm.

II. 2. The potential need for love drugs

In which respect do the three cases illustrated call for the use of love drugs, then? This question can be answered with reference to the women's and the child's well-being, respectively. As the previous considerations showed, mothers who feel that they do not love their children or do not love them enough seriously suffer from this sensation. The numbers given in the literature vary, but at least up to 50% of mothers seem to endure depressive moods within the first weeks after giving birth (Sonnenmoser 2007, 82); Nicolson even reports that up to 90% experience "weepiness, anxiety and feeling down" within the first months after nativity. PPD, by contrast, is diagnosed for 10 to 15% of mothers, who are treated with psychotherapy and tricyclic antidepressants or selective serotonin reuptake inhibitors (SSRIs). In severe cases, hospital admission is required. This raises the question as to why the significant part of women suffering from less severe depressive episodes should not also be given the possibility to take the mentioned drugs – in combination with therapy – in order to alleviate their suffering. After all, the demarcation between a clinical depression and 'mere' depressive moods may be blurry and, as said above, women diagnosed with PPD often feel relieved.[11] Medication could take the edge off the difficult transition to motherhood, lessen the women's anxiety and, in doing so, might help them to build a "sense of maternal competence – a sense that they can and will care for their children" (Ruddick 1989, 29). Beyond that, drugs making women calmer and more patient might also help to even out the felt ambiguities towards the child and the role as mothers. In cases of strong ambiguities, it might be the case that oxytocin helps the women to strengthen the attachment to

[11] This argument resembles Earp and Savulescu's claim that physicians should not "have to […] make up a raft" of disorders in order to provide the persons concerned with proper help (Earp and Savulescu 2020, 6).

their child at the expense of more negative feelings. In sum, enhancing motherly love by means of SSRIs and oxytocin may improve the women's well-being by reducing anxiety, sadness, and negative feelings towards their children. It would also probably make it easier for them to care for their children and to accept their new role as mothers. In doing so, maternal love drugs also have the potential of improving familial and partner relationships.[12]

When the mother suffers, the child is likely to suffer as well. The second reason to consider motherly love drugs thus consists in the particularly vulnerable position of newborns and small children (Gheaus 2011, 502f.) and the resulting importance of love and care for the child's flourishing and his or her identity (Alstott 2004, 4-7; Liao 2015, ch. 3; Protasi 2018, 36; Wonderly 2018). At this point, it is illuminating to continue the description of motherly love by Fromm given above:

> But there is a negative side, too, to the unconditional quality of mother's love. Not only does it not need to be deserved – it also cannot be acquired, produced, controlled. If it is there, it is like a blessing; if it is not there, it is as if all beauty had gone out of life – and there is nothing I can do to create it" (Fromm 1956, 39).

The vividly described horror of a child who is not loved may be the reason for the strong normative ideal of motherly love in the first place, as Protasi surmises: "we realize how crucial it is, for our development as functional human beings, to be loved and nurtured

[12] Johnson et al. write: "Often, the negative effects of the postpartum depression experience included influences on familial and partner relationships, feelings of being dismissed, inability to share feelings openly, and deterioration of relationships" (Johnson, Adam, and McIntosh 2020, 5).

by our parents, and therefore uphold the belief that anything short of unconditional parental love is psychologically abnormal and morally impermissible" (Protasi 2018, 36).[13] While it is beyond the scope of this paper to tackle the question of what exactly (small) children need for their "development as functional human beings",[14] it seems safe to say that they need to be cared for and, at least within the first year of life, need to form a bond of attachment with their primary caregiver (Alstott 2004, 4; Gheaus 2011, 495; Wonderly 2018, 24).

Coming back to the three cases of the lack of motherly love depicted above, it can be said that women suffering from longer episodes of depression will struggle to provide their child with the necessary care. If they are not suffering from an extreme version of PPD, though, they may be left to their own, so that a maternal love drug might foster not only the mother's but also the child's well-being. When it comes to ambivalence, the danger for the child's well-being seems not to be grave, for, as said, the women in question usually report that they love their children but struggle with the role of motherhood. Finally, what about women like Ali? It is clear that she does not love her baby and once she has made the decision to leave him or her, she has no regrets. Also, her action seems to be at least morally permissible, for she makes sure that the baby will be taken care of. It might be objected, though, that the well-being of the child is compromised nevertheless, for once he or she learns that his or her mother left her, he or she might develop a sense of inferiority. It would therefore be better for all if Ali made herself to love the baby and keep it. Then again, it seems questionable whether love can be induced by a drug from scratch in such a situation (Earp and Savulescu 2020, 113). And even if it

[13] A similar explanation is presented by (Hollway 2006, 76).

[14] For a rejection of Liao's arguments that children need love (Liao 2015) see (Cowden 2012).

was possible, especially cases like Ali's raise the question of whether enhanced motherly love could still be considered authentic, for it is arguably *authentic* motherly love that is required by the corresponding stereotype. We now turn to a critical discussion of this and other ethical issues associated with enhancing motherly love.

III

Enhancing maternal love: exploring ethical implications

III. 1 Maternal love and the question of authenticity

A common worry when it comes to mood enhancement techniques, of which love drugs would be an instance, is that resulting changes may be deemed *inauthentic* (for an overview see Juengst and Moseley 2019, section 4). It is argued that the outcome of these *externally* induced changes would not reflect the person's *true* self, which is why such changes and resulting choices and behavior can neither be considered authentic nor autonomous. The underlying idea of the worry about *authentic* love is thus that it must stem from *natural* or *internal* sources, namely the person's true self. Call this the *authenticity as internal prerequisite worry* or, in relation to autonomy, the requirement of *input authenticity* – autonomous choices and actions need to stem from authentic desires etc. This worry plays an important role in the case of love drugs as well, for the resulting love would arguably seem less "true," autonomous, or valuable if it could not be considered authentic.

To address this worry, essentially three counterarguments have been formulated. A first counterargument consists in an attempt to sidestep the distinction between internal and external means of inducing love altogether by equaling their role. Notably, this argument has been formulated by S. Matthew Liao. In a nutshell,

it reads as follows (Liao 2011, 492; cp. also Wasserman and Liao 2008, 179-86):

> (1) Non-pharmaceutical means to induce or enhance parental love (as, for instance, by putting us into situations in which we are likely to have a positive attitude to a child) are not considered endangering the authenticity of parental love.
>
> (2) Non-pharmaceutical and pharmaceutical means ultimately have the same neurochemical effects.
>
> (3) Hence, enhancing parental love by pharmaceutical means does not threaten its authenticity.

However, even if internal, non-pharmaceutical and external, pharmaceutical means have the same neurochemical effects, it is not at all clear that we consider them both authentic, as, for instance, the debate on doping in sports shows. If so, the argument is question-begging and it is still up for debate which conditions must be fulfilled to consider maternal love authentic.

The second counterargument accepts the requirement of input authenticity but claims that love drugs and mood enhancements in general may actually help a person in being their true self in the first place. This is backed up by patients who report that they only feel truly themselves or authentic when taking mood enhancing drugs (Kramer 1993; DeGrazia 2000). Call this the argument of *correcting input authenticity by external means*. Earp and Savulescu use this argument and claim that drugs like MDMA do not compromise a person's true self but rather help the person in bringing it out; at any rate, they do not change who the person *truly* is (Earp and Savulescu 2020, 91-100). However, it should be noted that this makes mood enhancement drugs, including love drugs, necessarily a kind of treatment, as the argument needs to presuppose that there is something internally wrong with the

person to begin with, which can then be corrected by external means.

The third counterargument rejects the worry outright and claims that persons may autonomously choose to take mood enhancing or love drugs precisely because they seek to alter their mood or personality (DeGrazia 2000). If so, the resulting change, even when induced by external means, should be deemed authentic. Accordingly, instead of requiring input authenticity for autonomy, the argument reverses the relation between the two. Call this idea *resulting* or *output authenticity*. Also note that this argument allows for treatment as well as enhancement as long as the underlying choice for taking love drugs can be deemed autonomous. This is certainly the most promising counterargument and Earp and Savulescu use it as well when they emphasize that persons and couples need to decide autonomously on the use of love drugs (Earp and Savulescu 2020, 118-20).

Now, the question for the purpose at hand is how especially the latter two counterarguments fare in the case of enhancing the stereotypical notion of maternal love, i.e., of being unconditional and occurring naturally. Sven Nyholm has spelled out a more specific version of the *authenticity as internal prerequisite worry* in a succinct way, albeit with regard to romantic love (Nyholm 2014):

> [T]he following features seem to be part of what we intrinsically desire in seeking love. We desire: (i) that somebody is firmly and robustly disposed to care for us across various different contingencies; (ii) that this disposition depends on various internal factors within the lover; (iii) that this disposition tracks us in our specific particularity; and (iv) that, in other words, we ourselves have a sort of internal power or ability to call forth, and sustain, the said disposition in our lover that disposes him or her to robustly give us his or her loving care. This means that if it is

> necessary to introduce an external agent – such as gene-therapy or hormone-altering drugs – in order to secure and sustain the attachment and the disposition to provide care, then there is a lack or absence of the complex intrinsic good that we seek in intrinsically desiring the good of love. This in turn should mean that what it is that we create when we use attachment-enhancements is not really the good that we seek in intrinsically desiring love (Nyholm 2014, 197).

When adapted to motherly love, the upshot is that authenticity would require that it be the children who induce the mother's love to its full extent, and not something else like love drugs. "Love is, in this way, a sort of confirmation that we are, as we might put it, 'lovable' in the sense of being able to inspire or call forth such dispositions in another (namely, the lover)" (Nyholm 2014, 196). However, for this point to be consistent with maternal love's definition of being unconditional, children's lovability must not depend on their specific personal characteristics. Still, one formal condition applies, namely the relational condition of being the mother's child – while this need not be understood in a biological sense exclusively but in terms of the social role of the mother. The point is simply that children should inspire love in their mother just because they are *her* children.

Against this particular point, Liao has argued together with David Wasserman that it need *not* be the object of an emotion that directly brings the latter about (Wasserman and Liao 2008, 179f.). However, their argument presupposes that we already have reasons for wanting to have the emotion in question, which is why they conclude that only pharmaceutically induced emotions that are consistent with a person's other emotional makeup may count as authentic (Wasserman and Liao 2008, 182). Interestingly, since this premise is stronger, their argument is actually weaker than the

third counterargument of *output authenticity*, according to which *any* pharmaceutically induced emotion may count as authentic as long as the person autonomously chooses to take the drug. Moreover, one might still bite the bullet and reject Wasserman and Liao's argument on the ground that any emotion brought about by external means, including everyday means like caffeine or alcohol, suffers from being inauthentic. For instance, a person could complain: "if you can only love me when you are drunk, then you do not really love me at all!" Assuming that such a complaint is plausible at least to some degree, this would also put into question the second counterargument of *correcting input authenticity by external means*. If so, the third counterargument of *output authenticity* remains to be the strongest contestant for arguing convincingly that pharmaceutically induced emotions may be deemed authentic.

However, the question of authenticity in motherly love also needs to be addressed from the child's perspective. Assuming that the child is old enough to understand that her mother takes love drugs in order to treat a lack of motherly love or to enhance it, what would be the likely implications? Following Nyholm's argument, children might consider themselves not (fully) capable of inducing their mother's love, and that is in light of only the weak relational condition of being the mother's child. Arguably, children might come to think of themselves as not (fully) loveable. Hence, even if they are actually loved because of the use of a love drug, this shortcoming might still have detrimental effects on the children's well-being and flourishing. If so, using love drugs in the case of motherly love may turn out to be a double-edged sword.

Ultimately, one could even argue that the very idea of enhancing motherly love is self-defeating. For, if the stereotypical notion of motherly love includes the idea that it has to be authentic in the sense of having to emerge as a natural reaction to the child, the very idea of inducing it artificially by pharmaceutical means would

be nonsensical to begin with. Taking love drugs would by definition undermine the very purpose for which they are supposed to be taken. In any case, the situation is more complicated.

To begin with, it needs to be clarified what exactly love drugs are supposed to enhance: maternal love as such or certain capabilities conducive to showing loving behavior, e.g. being more attentive or patient (Earp and Savulescu 2020, 59-65). Beyond that, as the introduction of the child's perspective above has hinted at, when it comes to taking into account the effects on the child's well-being and flourishing, it may make a difference if the child is already capable of understanding that the mother takes love drugs. Consequently, the worry about enhanced motherly love being inauthentic will be more or less severe and the corresponding argument against the use of love drugs will be more or less powerful.

First, consider the case of infants and small children who are not yet capable of understanding that, say due to a PPD, the mother is taking love drugs. Given that the well-being and flourishing of infants and small children crucially hinges on being lovingly cared for (see Liao 2015), this may well be considered to outweigh the worry about authenticity, especially if the mother autonomously decides to take love drugs precisely to be (better) capable of loving and taking care of her child.[15]

Second, imagine older children who are able to understand that their mother takes love drugs and assume that, while the mother is

[15] Following the third counterargument of *output authenticity* at this point, the resulting love would in fact be authentic due to the autonomous choice. Still, it is by no means clear that the child's well-being and flourishing *always* outweigh the mother's possibly conflicting interests. It can merely be argued that it carries *considerable* weight in the type of case described because of the crucial impact on the child's well-being and flourishing.

perfectly capable of taking care of her children's everyday needs, she lacks motherly love due to the fact that she has adopted the children and has not been able to build a deep loving relationship with them. Arguably, this case makes it not only less urgent or important that the mother should try to induce motherly love, but it may also warrant the criticism about the induced motherly love being inauthentic if she did, including possible negative side-effects for the children mentioned above.

Finally, think of a mother who loves her prepubescent child and takes care of all of his or her crucial everyday needs but is convinced that she should love her child even more and should also enhance her capabilities of expressing this love in everyday caring behavior, for instance by being more attentive to her child's interests and life and play an even more supporting role in it. While the worry about her love being inauthentic may carry less weight – after all, it is explicitly stated that she loves her child – the case raises the question of why she would come up with the idea of enhancing her love and capabilities of showing caring behavior even more, likely to the detriment of her other legitimate interests in life. One of the reasons for considering this option at all seems to be the still influential and by definition unattainable stereotype of *perfect* motherhood, much to the disadvantage of recognizing and realizing mothers' other legitimate interests in life.[16]

[16] An anonymous reviewer pointed out that a mother may also believe that she loves her child (enough), but in fact does not do so, and raised the question of whether the respective mother should be nudged or even forced to take love drugs. This is certainly an interesting case, but we put it aside for two reasons. First, as we stated in footnote 3, we take it that love drugs should never be used coercively and, second, we assume that due to the pervasive and strong ideal of the good mother and her unconditional love, it is rather unlikely that the case depicted here occurs in reality frequently.

III. 2. The ideal of motherhood and the problem of complicity

The notion of the mother is strongly symbolically charged and has been playing a central role in mythology and religion since human recollection.[17] The modern ideal of "the good mother" and the concomitant institution of motherhood is much younger, though, and can be traced back to the 19th century, when the industrial revolution separated "work" from "home" and, in doing so, constituted the latter as the women's sphere (Rich 1986, 46-52; Arendell 2000, 1192). Henceforth, caring for and enhancing the welfare of men and children advanced to women's "true mission" (Rich 1986, 49), and mothering became "presumed to be a primary identity for most adult women" (Arendell 2000, 1192). This gendered division of labor is simultaneously reinforced by and mirrored in gender stereotypes and gender essentialism, which considers women as naturally more fitting for care work due to their warm, caring, emotional, and communal character.[18] In virtue of these traits, she is also assumed to provide the child with "absolute, unconditional, self-effacing, and eternal" love—"'forever and for always'" (Protasi 2018, 35).[19] Anything falling short of this instinctive, unconditional love is regarded as either pathological (Hollway 2006, 76; Protasi 2018, 36) or as a moral failure on the part of the woman:[20]

[17] See (Miles 2001, ch. 2) and the references given there.

[18] On the myth of a maternal instinct see (Nicolson 2001, 110ff.; Douglas and Michaels 2004, 25f., 151).

[19] Recall Fromm's definition of maternal love quoted above.

[20] These norms are obviously contradicting: maternal love is supposed to be natural, but nevertheless an achievement (Nicolson 2001, 107), while the lack of love is pathological, but also a sign of individual failure.

> [L]ove toward […] one's children […] is considered sacred and regarded as a feminine moral test. […] [E]xpressing one's love is structured as representing an achievement in terms of one's *feminine moral identity* and social position as a good mother […]. Failing to emphasize the emotion of love toward one's children might be regarded as immoral and unfeminine (Donath 2015, 360).

This quote shows how intricately connected the ideals of the feminine and the mother are; in fact, a good woman is nothing but a good mother – a bad mother has failed not only in her role of a mother, but as a woman as such (Arendell 2000, 1192; Nicolson 2001, 107ff.; Donath 2015, 347; Huppatz 2018, 146).

It becomes increasingly impossible for women to live up to the ideal of the good mother, though. According to the modern paradigm of intensive mothering (Arendell 2000, 1194; Douglas and Michaels 2004, 5), mothering is defined "as a consuming identity requiring sacrifices of health, pleasure, and ambitions unnecessary for the well-being of children" (Ruddick 1989, 29).[21] Within this paradigm, the notion of self-sacrifice for the sake of the child looms large. Beyond that, three recent developments intensify the pressure exerted on mothers. First, the current professionalization of motherhood is unprecedent, as Rebecca Asher points out: "Motherhood is no longer a state of being, it's a project" (Asher 2012, 62), which requires research on any parenting or consumption choice concerning the child (see also Douglas and Michaels 2004; Daly 2013, 227; Huppatz 2018, 150). Second, modern motherhood is highly idealized and romanticized, in so far as it is regarded essential for a good and meaningful life, up to the point of becoming conflated with happiness (Huppatz 2018, 148, 158). Third, and closely connected, the phenomenon of

[21] See also (Arendell 2000, 1194; Gheaus 2011, 489).

"celebrity moms" in the media, advertisement, and, more recently, social media, set the standards for the aesthetics of a good mother (Douglas and Michaels 2004, ch. 4; Huppatz 2018, 145). Note the contradiction implied here: although she is supposed to be focused exclusively on her offspring, the modern good mother does not "let herself go" and remains slim, fit, and sexy both during and after pregnancy (Huppatz 2018, 152; Asher 2012, 63).

These unrealistically high – and in part contradictory – norms put a high pressure on mothers when it comes to childrearing. Since the social expectations on fathers are way easier to meet (Asher 2012, 121f.), the stereotype of the good mother can be considered a major impediment to gender justice (Gheaus and Robeyns 2011, 175; Gheaus 2012). Considered against this background, it becomes apparent that some women's anxieties, depressive moods, and feelings of being overwhelmed by the demands of motherhood depicted above can be traced back to the high expectations that the ideal of the good mother, the concomitant notion of unconditional and eternal maternal love, and the institution of motherhood as such place on them. This is not to say that all women are forced against their will to take up the role of the primary caregiver, accept setbacks in their career, and so on. Yet, the fact that they choose to do so voluntarily does not imply that these choices are not subject to problematic gender norms and unjust background conditions (Asher 2012, ch. 6), as Margaret Olivia Little points out: "One of the insidious ways sexism works is by gradually constricting the options that women imaginatively conceive for themselves" (Little 1998, 174).

These considerations suggest that while motherly love drugs may ameliorate the suffering of women and ease their transition into motherhood in the short run, they tend to strengthen the problematic ideal of the self-sacrificing super-mother and thus contribute to maintaining an unjust, sexist system in the long run.

To speak with Asher, the "mental strain experienced by so many new mothers is a social problem not a medical one – it requires collective changes, not just individual treatment" (Asher 2012, 81). Love drugs therefore pose the danger of "medicating away" symptoms that point towards structural issues, so that endorsing, promoting, or unduly benefitting from the pharmacological enhancement of motherly love would make one complicitous in upholding an unjust social structure (Little 1998, 170). The issue of whether to enhance motherly love by drugs thus leads into the very dilemma between helping particular individuals on the one hand and strengthening objectionable background conditions on the other, which Earp and Savulescu themselves envisage (Earp and Savulescu 2020, 168-70, 185).

One possible route for escaping this dilemma presents itself once we consider the fact that Earp and Savulescu stress numerous times throughout their book that love has two sides, a biological and a psychosocial, and that both need to be taken into account when it comes to measures of improving a person's well-being (Earp and Savulescu 2020, 22f.). Accordingly, they emphasize that love drugs should be administered in the context of couple-counseling or psychotherapy. Therefore, it could be argued that if the use of maternal love drugs were accompanied by therapy, this could be the place to address and critically reflect upon the norms of motherhood and the gendered distinction of labor. Then again, this approach faces two challenges. For one thing, in virtue of the fact that a lack of motherly love is often considered pathological even by therapists,[22] psychotherapy seems more likely to reinforce

[22] To see this, just search for "lack of motherly love" or "I don't love my child" on the internet and you will probably be led to advice on how to tackle your own unresolved psychological issues and to information on PPD. A prime example is the post by psychologist Gail Gross: "Why don't I love my child?" (Gross 2014).

a problematic image of mothers than to dismantle it. For another, psychotherapy is usually focused on the individual and his or her particular problems and does not tackle the social dimension of the unjust burden placed on women when it comes to mothering. At this point, we come back to the suffering of mothers depicted in section II.1. One crucial factor fostering this suffering seems to consist in the lack of an open discourse on the downsides and ambiguities of motherhood, for this lacuna in combination with the notion of "motherhood equals happiness and self-fulfillment" is precisely what makes the women concerned interpret their issues as personal failures instead of perfectly normal reactions – "normal" both in the sense of "widely shared" and in terms of "reasonable in the face of the surrounding conditions." Therefore, Little's argument as to cosmetic surgery and problematic norms of appearance can be directly translated to the issue of motherly love as follows:

> [I]t is important for women to have access to studies and narratives that bring to life the various real-life experiences women have […] [with respect to pregnancy, giving birth, and motherhood,] and society's reaction to them, not only that benefits [of motherhood] are portrayed more realistically, but that the […] [downsides, the pain, the feeling of loss, anxiety, and sometimes even hate] are understood (Little 1998, 174).

This open discussion would be only one but nonetheless a necessary step in dismantling the gendered division of childcare and the concomitant injustices.[23]

[23] In this respect, we are experiencing a regrettable backlash in comparison to the 1970s, as Douglas and Michaels point out (Douglas and Michaels 2004, ch. 1).

Other essential steps include a re-interpretation of the role of fathers. As the quote by Fromm in section I shows, fatherly love is generally considered to be conditional and even dispensable. In fact, fathers who are completely absent from their child's life are not uncommon and though they may be morally criticized for their behavior, the judgment is not nearly as annihilating as it is for absent mothers (Protasi 2018, 37). These gendered expectations towards mothers and fathers probably root in biologistic notions that mothers, not least due to their hormones, are "naturally" more apt to care for children and fathers are "naturally" more hands-off. Yet, as we saw above, neither does giving birth to a child guarantee that a loving bond is formed between mother and child, nor do women any more than men have a natural capacity to care for a baby (Protasi 2018, 38; Asher 2012, 135). As to hormones, they cannot be considered simple internal urges that determine behavior, but are subject to external influences themselves (Fine 2010, 87). Correspondingly, it seems to be the case that not only women's hormones change when they become mothers, but the fathers' do so as well; it has even been demonstrated that the level of oxytocin in grandparents jumps up when they first meet their baby grandchild (Gibbens 2018), although this process is slower in men than in women. If fathers spend an equal time with their infants as mothers do, though, an equally strong bond can be formed (Fine 2010, 87). Consequently, institutional and cultural changes are called for that both make more men willing to spend an equal amount of time with their offspring as women do and make this practice widely socially accepted.[24] When it comes to

[24] For a depiction of the institutions and cultural assumptions which exempt fathers from childcare, see Asher 2012 (ch. 7). Note that during the current corona-pandemic the tendency to regard pregnancy, birth, and child-care predominantly as women's responsibility is reinforced by hygienic rules to contain the spread of the coronavirus. These rules prohibit, for instance, that

fathers and love drugs, there would be no dilemma between individual needs and social justice, but a synergy: providing fathers with the motherly love drug oxytocin might not only accelerate and strengthen their bonding with the child, but, in doing so, also contribute to gender justice and ultimately more well-being for all parties concerned.

Finally, what about mothers who are aware of the social pressures and seek to use a drug that makes them love her children *less* instead of more, so that they do not feel guilty when they get back to work and worry less about the children?[25] Since there is evidence that nonparental care after their first year may be beneficial for children (Gheaus 2011, 485), a love drug diminishing an overwhelming maternal love may actually enhance the child's well-being. By definition, it also fosters the mother's welfare, since the drug eradicates her bad conscience and lets her achieve her professional ambitions far more easily. Also, diminishing maternal love does not strengthen a problematic stereotype of the good mother, but runs counter to it. Especially in combination with administering a love drug to fathers and parent counselling, this anti-maternal-love drug seems to mesh well with our argument. However, if it is true that a lot of the conflicts mothers are facing nowadays, including their bad conscience when getting back to work, stems from an unrealistic ideal of maternal love instead of their emotional inability to separate from their children, an anti-maternal-love drug is unlikely to solve the problem to begin with.

fathers be present at prenatal classes or during delivery. See (Bathke 2020; Höppner 2020).

[25] We thank an anonymous reviewer for raising this case.

Conclusion

A lack of motherly love appears to be a prime example for the use of love drugs in order to enhance not only the mother's but also the child's well-being. While there may be cases in which the use of motherly love drugs might plausibly be called for, we have argued that using love drugs presents a challenge for the idea of *authentic* motherly love, but that this idea and the whole issue mostly stems from a stereotypical and unjust ideal of motherhood to begin with. Consequently, we conclude that the use of love drugs to enhance motherly love should be seen with a cautious eye and be accompanied with a critical take on still prevalent and unjust social norms about gender roles.

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