# Childlessness and the Cry No One Hears: A Pastoral Counselling Perspective

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## Abstract

Involuntary childlessness is more than a reproductive or medical concern. For many women and couples, particularly within African societies where parenthood is closely associated with marital fulfilment, lineage, identity, social acceptance, and religious blessing, infertility can become a profound psychological, relational, cultural, and spiritual burden. This article examines childlessness from a pastoral counselling perspective, using a reported incident involving the alleged theft of a newborn baby in Mamprobi, Ghana, as a point of departure for considering the hidden emotional pressures that may accompany infertility and delayed childbearing. The discussion does not seek to excuse criminal conduct; rather, it explores the psychological distress, stigma, marital tension, social rejection, and cultural expectations that may contribute to desperation in vulnerable individuals. Drawing on literature concerning infertility-related distress and African experiences of involuntary childlessness, the article highlights depression, anxiety, shame, diminished self-worth, marital instability, and social withdrawal as important concerns. It also considers the contrasting problem of child abandonment and the psychosocial pressures experienced by vulnerable mothers. From a pastoral counselling standpoint, the article advocates compassionate listening, couple-centred counselling, mental-health assessment, responsible faith integration, stronger hospital safeguarding, community education, and collaboration among churches, health professionals, counsellors, social services, and the justice system. The biblical narrative of Hannah is employed as a pastoral resource for understanding grief without equating a woman's dignity with biological motherhood. The article concludes that society must learn to hear the silent cry behind involuntary childlessness while maintaining the protection and dignity of every child.

**Keywords:** Infertility; Involuntary Childlessness; Pastoral Counselling; Psychological Distress; Marital Health; Ghana

## Introduction

A troubling story recently drew public attention in Ghana: a woman was reportedly apprehended in connection with the alleged theft of a newborn baby from a hospital in Mamprobi. Understandably, public reaction was dominated by shock, anger, fear, and condemnation. The protection of newborn children is a fundamental moral and legal responsibility, and any suspected abduction must be investigated thoroughly and addressed within the law.

Yet beyond the immediate legal question lies another question that deserves careful pastoral and psychological reflection:

**What kind of emotional, relational, or social desperation might bring a person to such an extreme point?**

Asking this question does not justify baby theft. Compassion must never become an excuse for wrongdoing, and psychological explanation must not be confused with legal exoneration. Nevertheless, responsible counselling seeks to understand behaviour as well as respond to it.

Behind extreme actions may lie long histories of pain that the public never sees.

For some women, involuntary childlessness becomes one such hidden history.

The pastoral counselling room often reveals struggles that remain concealed in public. Women may endure years of medical examinations, unsuccessful treatments, repeated prayers, miscarriages, family questions, marital pressure, social comparison, spiritual confusion, and private grief. Some describe feeling incomplete. Others fear rejection by husbands or in-laws. Still others gradually withdraw from family gatherings, naming ceremonies, children's celebrations, or Mother's Day services because these occasions have become painful reminders of what they desperately desire but have not experienced.

Infertility is therefore not simply a biological condition. It can become a deeply personal and relational experience involving identity, marriage, sexuality, family expectations, culture, spirituality, and mental health.

Research has long demonstrated that infertility may be accompanied by significant psychological distress, including anxiety, depression, social isolation, diminished self-esteem, and relational strain (Cousineau & Domar, 2007; Greil et al., 2010). Within African settings, these difficulties can become especially intense where childbearing is closely linked to social recognition and marital security (Dyer, 2007; Dyer et al., 2005).

This article examines childlessness through a pastoral counselling lens, with particular attention to the Ghanaian cultural context. Its purpose is neither to pathologise childless women nor to suggest that infertility ordinarily leads to criminal behaviour. Rather, it seeks to make visible a form of suffering that often remains unheard until distress reaches crisis point.

**Childlessness Within the Ghanaian Cultural Context**

Children occupy an honoured place within Ghanaian family and community life.

The birth of a child is rarely treated as a purely private event. It may represent continuity of lineage, extension of the family, fulfilment of marital expectations, preservation of inheritance, and confirmation of generational identity. Naming ceremonies, church dedications, thanksgiving services, family gatherings, and community celebrations demonstrate the significance attached to childbirth.

Across several African societies, children have historically been understood not only as members of individual households but as important participants in wider networks of family and community life (Dyer, 2007; Inhorn & van Balen, 2002).

The difficulty arises when a valuable cultural celebration becomes an instrument of pressure.

For newly married couples, questions concerning pregnancy may begin almost immediately:

*"When are we hearing the good news?"*

*"When will you give us grandchildren?"*

*"What are you waiting for?"*

Such comments are sometimes offered playfully and without malicious intent. Yet for a couple already struggling to conceive, they may reopen a wound repeatedly.

What sounds like a casual family question may be experienced as accusation.

A church testimony about childbirth may become painful rather than celebratory.

A family naming ceremony may evoke both genuine joy for others and private grief.

An invitation to a child's birthday party may stir feelings of inadequacy that the woman feels ashamed to acknowledge.

Pastoral counsellors must understand this emotional complexity.

**The Unequal Burden Placed on Women**

One of the most troubling aspects of infertility within many societies is the disproportionate burden placed upon women.

Medical evidence clearly establishes that infertility may arise from female factors, male factors, combined factors, or causes that remain unexplained. Infertility is therefore a couple's reproductive concern rather than automatically a woman's failure.

Yet social assumptions frequently blame the woman first.

She may be labelled "barren," "unfruitful," or spiritually deficient. She may be subjected to intrusive questions, repeated advice, traditional interventions, prophetic pronouncements, or pressure from extended family members.

In extreme situations, she may be warned that her husband will find another partner who can produce children.

The emotional message is devastating:

**Your place in this marriage depends upon your ability to give birth.**

Such attitudes can erode self-esteem and transform infertility from a medical difficulty into an existential crisis.

The woman no longer asks only, *"Why am I not conceiving?"*

She may begin asking:

*"Am I still a complete woman?"*

*"Does my husband still value me?"*

*"Will this marriage survive?"*

*"Has God rejected me?"*

*"What will people say about me?"*

These questions reveal why infertility must be approached psychologically, relationally, spiritually, and medically.

**The Psychological Burden of Involuntary Childlessness**

Infertility can generate a distinctive cycle of hope and disappointment.

A new menstrual cycle may bring renewed expectation.

A medical appointment may awaken hope.

A treatment may appear promising.

A prayer meeting may produce fresh spiritual confidence.

Then another negative test arrives.

Hope collapses.

The process begins again.

Over months or years, repeated disappointment can contribute to emotional exhaustion.

Greil et al. (2010) describe infertility as a significant psychosocial experience rather than merely a medical diagnosis. Cousineau and Domar (2007) similarly highlight substantial psychological consequences associated with fertility difficulties.

Common emotional responses may include:

- grief;
- anxiety;
- depressive symptoms;

- anger;
- shame;
- self-blame;
- reduced self-esteem;
- feelings of inadequacy;
- envy followed by guilt;
- spiritual questioning;
- social withdrawal; and
- fear about the future.

These reactions should not automatically be regarded as psychiatric illness. Many represent understandable responses to prolonged loss and uncertainty.

However, when distress becomes persistent or severely affects sleep, appetite, work, marriage, social functioning, safety, or daily life, professional mental-health assessment becomes important.

**Infertility as a Form of Ambiguous Grief**

One useful pastoral way of understanding infertility is as a form of recurring or ambiguous grief.

Unlike bereavement following the death of a loved one, infertility may involve grief over something deeply desired but not yet possessed.

The woman may grieve:

the child she imagined;

the pregnancy she expected;

the family life she anticipated;

the names she had selected;

the experience of motherhood she assumed would naturally follow marriage.

Because there may be no funeral, no public ritual, and no socially recognised period of mourning, this grief can remain invisible.

People may tell her:

*"Stop worrying."*

*"Your time will come."*

*"Just have faith."*

*"Don't think about it too much."*

Although such statements may be intended to encourage, they can unintentionally minimise pain.

Pastoral counselling offers something different: permission to grieve without surrendering hope.

**Marital Consequences of Childlessness**

Infertility does not occur to an isolated individual. When it occurs within marriage, both partners are affected.

Sexual intimacy may gradually become associated with reproduction rather than affection. Spontaneous intimacy may be replaced by fertility schedules, medical instructions, anxiety, and performance pressure.

Financial strain may arise from repeated investigations or treatment.

One spouse may want to discuss the problem constantly while the other copes through silence.

The wife may interpret the husband's quietness as indifference.

The husband may believe he is protecting her by avoiding the subject.

Both may be hurting while neither understands how the other is grieving.

Extended-family pressure can intensify the problem.

Dyer et al. (2005) documented significant social and marital consequences among African women experiencing involuntary childlessness. These experiences highlight the importance of treating infertility as a couple and family-system concern where appropriate.

Pastoral counselling should therefore resist assigning blame.

The healthier question is not:

**"Whose fault is this?"**

but:

**"How can this couple face this experience together?"**

The difference is profound.

**When Desperation Becomes Dangerous**

Baby theft is rare, and most women experiencing infertility will never engage in such behaviour. It would therefore be both inaccurate and unjust to associate infertility generally with child abduction.

Nevertheless, highly distressed individuals may sometimes engage in irrational, impulsive, deceptive, or dangerous behaviour.

Where infertility is accompanied by severe psychological distress, marital insecurity, social humiliation, fear of abandonment, and obsessive preoccupation with obtaining a child, clinical attention may be necessary.

Understanding potential emotional motivations is not equivalent to excusing unlawful actions.

A society committed to justice can hold two truths simultaneously:

**A child must be protected, and a psychologically distressed adult may also require treatment.**

Pastoral counselling contributes by helping communities move beyond condemnation alone toward prevention, assessment, rehabilitation, and appropriate accountability.

**The Other Side of the Tragedy: Child Abandonment**

There is a painful irony in society.

While some women endure enormous anguish because they cannot have children, other women find themselves overwhelmed by pregnancies they feel unable to manage.

Cases of newborn abandonment expose another kind of silent suffering.

A young mother may face:

poverty;

rejection;

an unplanned pregnancy;

absence of the child's father;

family shame;

housing insecurity;

violence;

lack of social support;

or severe emotional distress after childbirth.

Maternal mental-health difficulties during pregnancy and the postpartum period deserve particular attention.

A woman experiencing severe depression, psychosis, intense anxiety, confusion, or suicidal thinking after childbirth requires urgent professional care.

Again, condemnation alone is insufficient.

Child protection must remain paramount, but prevention requires society to ask why some vulnerable women reach a state in which abandoning a child appears to them to be the only possible choice.

**The Experience of Husbands**

Public discussions about infertility often focus understandably on women, but husbands should not be ignored.

Men may also experience grief, shame, anxiety, disappointment, and pressure concerning fertility.

In societies where masculinity is strongly associated with fatherhood and continuation of the family line, male infertility may become especially difficult to disclose.

Some men respond by withdrawing.

Others become defensive.

Some may blame their wives rather than confront the possibility of male-factor infertility.

Others genuinely want to support their spouses but do not know how to communicate their own emotions.

Pastoral counselling should therefore invite men into the healing process.

A husband should not stand outside the problem as judge.

He is part of the couple facing it.

Marriage becomes more resilient when the language changes from **"your infertility"** to **"our journey."**

**A Pastoral Counselling Response**

The first pastoral response to involuntary childlessness should be neither explanation nor advice.

It should be **presence**.

People in pain need someone who can remain with them without immediately trying to solve the problem.

Compassionate listening communicates:

*Your pain matters.*

*You do not have to pretend before me.*

*You are more than your reproductive struggle.*

*Your dignity remains intact.*

Pastoral counselling should also help individuals separate **human worth from reproductive capacity**.

A woman is not valuable because she has given birth.

A man is not complete simply because he has fathered children.

Parenthood is precious, but human dignity precedes parenthood.

This distinction is particularly important within Christian pastoral care, where every person is understood as bearing the image of God.

**Faith as a Resource Without Spiritual Pressure**

Faith can be a profound source of resilience for couples experiencing infertility.

Prayer may provide comfort.

Scripture may offer language for lament and hope.

Christian community may reduce isolation.

Worship may create space for grief.

Pastoral companionship may help people sustain meaning during uncertainty.

But faith must be used responsibly.

Statements such as:

*"You have not prayed enough,"*

*“There must be sin somewhere,”*

or

*“If your faith were stronger, you would already be pregnant”*

can inflict spiritual injury.

Such explanations oversimplify complex medical realities and can burden already distressed individuals with unnecessary guilt.

Responsible pastoral counselling does not promise outcomes that God has not promised.

It accompanies people faithfully through uncertainty.

**Hannah: A Biblical Narrative of Pain and Dignity**

The story of Hannah in 1 Samuel 1 provides one of Scripture's most powerful portraits of the emotional pain associated with childlessness.

Hannah's suffering was intensified by Peninnah's provocation. Scripture describes her grief so vividly that she wept and struggled to eat.

Her distress was therefore emotional, relational, social, and spiritual.

Yet the narrative does not portray Hannah as worthless.

Her pain is seen.

Her prayer is heard.

Her humanity is respected.

The pastoral value of Hannah's story should not be reduced to the simplistic message that every woman who prays sufficiently will eventually conceive.

That would misuse the text and deepen the wounds of those whose stories unfold differently.

A more responsible pastoral lesson is this:

**God is not indifferent to hidden grief.**

Hannah reminds the church to see those who are suffering quietly.

## Implications for the Church

Churches can either relieve the burden of infertility or intensify it.

Pastors and church leaders should therefore examine the language used around fertility.

Testimonies about childbirth should be celebrated without implying that childless couples are forgotten by God.

Mother's Day and Father's Day services should be handled sensitively.

Public prayers for infertile couples should not expose people who have not consented to such attention.

Preachers should reject language that equates childlessness with spiritual failure.

Churches should also create confidential pastoral-care systems and referral relationships with qualified counsellors and medical professionals.

Congregations can become communities where people are supported without being interrogated.

## Implications for Hospitals and Fertility Services

Healthcare institutions should treat infertility as involving psychological as well as reproductive health.

Where resources permit, fertility services should incorporate counselling before, during, and following significant treatment processes.

Healthcare workers should communicate sensitively, particularly following unsuccessful fertility interventions.

Hospitals and maternity facilities must also maintain rigorous newborn safeguarding procedures, including reliable identification systems, controlled access, staff vigilance, and clear security protocols.

Compassion for distressed adults must never weaken the protection of children.

## Implications for Professional Counsellors

Counsellors working with involuntary childlessness should assess more than sadness.

Attention should be given to:

marital functioning;

depression and anxiety;

self-esteem;

social withdrawal;

suicidal thinking;

family pressure;

domestic abuse;

spiritual distress;

obsessive preoccupation with pregnancy;

financial strain;

sexual functioning;

and coping resources.

Couple counselling may be particularly valuable where blame and communication difficulties are emerging.

Where serious psychiatric symptoms are suspected, referral to appropriate mental-health professionals is essential.

Pastoral counsellors should recognise the limits of their competence and collaborate with psychologists, psychiatrists, physicians, fertility specialists, and social workers where necessary.

**Implications for the Justice System**

The justice system has an uncompromising responsibility to protect children.

However, legal accountability and psychological assessment need not be mutually exclusive.

Where serious offences arise in the context of apparent mental distress, appropriate psychological or psychiatric evaluation can help courts understand relevant factors and determine suitable rehabilitative needs within the limits of the law.

Punishment alone may address an offence without addressing the conditions that contributed to it.

A humane justice system protects victims while also recognising opportunities for treatment, rehabilitation, and prevention.

## Toward Support Communities for Childless Couples

Ghana may also benefit from structured peer-support communities for individuals and couples experiencing infertility.

Support groups can reduce isolation by allowing participants to meet others who understand the experience without lengthy explanation.

Such groups should not become places where unverified treatments, spiritual accusations, or medical misinformation circulate.

Ideally, they should operate with trained facilitation and links to professional counselling, reproductive-health services, and pastoral support.

The broader principle is simple:

**People carry suffering better when they do not carry it alone.**

Churches, hospitals, counselling institutions, community organisations, and non-governmental organisations could collaborate in developing such programmes.

## Discussion

The experience of involuntary childlessness reveals the intersection of biology, culture, psychology, marriage, spirituality, and social identity.

No single explanation is therefore sufficient.

A purely medical response may treat reproductive difficulties while overlooking emotional suffering.

A purely spiritual response may provide prayer while missing depression, marital breakdown, or trauma.

A purely cultural response may reinforce expectations that are themselves contributing to distress.

Pastoral counselling occupies an important meeting point.

It can affirm faith without denying medicine.

It can value family without surrendering individual dignity.

It can promote hope without making false promises.

It can insist upon accountability while still asking what pain lies beneath troubling behaviour.

This is the pastoral task: **to see the person without losing sight of the behaviour, and to address the behaviour without losing sight of the person.**

**Conclusion**

The public may hear about a woman only when she does something shocking.

The counsellor often encounters her much earlier—in the years of unanswered questions, failed treatments, difficult anniversaries, private tears, marital tension, and prayers offered when no one else is listening.

This is the cry that society often fails to hear.

The reported Mamprobi incident should therefore provoke more than outrage. It should provoke deeper reflection on child protection, infertility-related distress, women's mental health, marital pressure, cultural expectations, and the need for accessible counselling.

Understanding suffering does not excuse wrongdoing.

Compassion does not cancel accountability.

But justice without understanding may fail to prevent the next tragedy.

Churches must become safer places for childless couples.

Families must learn when questions become wounds.

Husbands and wives must face infertility as partners rather than opponents.

Healthcare facilities must integrate psychological support with reproductive care.

Counsellors must attend to both emotional and spiritual distress.

The justice system must protect children firmly while remaining open to appropriate psychological assessment and rehabilitation.

And society must recover a simple but essential truth:

**A woman's worth is greater than her womb, a man's worth is greater than his ability to father a child, and a marriage's dignity cannot be measured solely by whether children have been born into it.**

The pastoral response to childlessness must therefore be one of truth, compassion, competent care, and hope.

There are cries that never reach the microphone, the pulpit, or the public square.

They are nevertheless real.

And sometimes healing begins when someone finally hears them.

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