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THE CHILD "AFTER": BETWEEN MATERNAL DEPRESSION AND TRANSMISSION OF THE TRAUMATISM

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SUMMARY
Born a little time after the death of his sister, our patient, Antoine, 13 years old, was suffering from severe obsessional compulsive disorders, which needed care in the hospital and adapted treatment. We tried to know if what we were led to observe by this adolescent could be explained by works and thoughts around the notion of substitute child.

Building our thought on various theoretical approaches, including neurosciences, we tried to think the psychopathological signs of this patient by two ways. One is about the birth and the growth in the presence of depressed parents, and this since the pregnancy. The other one is about the necessity to deal with the traumatic story of the family, met by the parents, who are still facing it, that leads to the question of the transmission of the traumatism from the mother to the baby.

Using the notion of maternal primary care, we proposed the term 'the child after', which appeared to us more able to represent the dynamic and the place really given to these children. This term could mean the question of an undone grief, a traumatism without temporality, and a relation between the mother and the child which seems to be uncertain because of the investment of the child as an impossible reparation of an unscarred loss.

Key words: *the child after - traumatism mother-baby - maternal depression - obsessional compulsive disorders - maternal primary care*

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INTRODUCTION

The Meeting with Antoine

Antoine is 13 years old, when he consults for the first time in the psychiatric unit for children and adolescents. He's suffering from severe obsessional compulsive disorders (American Psychiatric Association 2014, Organisation mondiale de la santé 1993*)*.

A little time before this demand of care, appeared indeed a lot of rituals and repetitive behaviours which affect him. Washing his hands more and more, spending hours and hours under the shower, never knowing if he's really clean, being unable to stand a little touching because of the fear of becoming dirty. Antoine is suffering from thinking and phobic obsessions. These thoughts are forcing him, and lead him to an everlasting fighting. Most part of the time, he experiences ideas around the cleanness, irrational thoughts of being or getting dirty.

Antoine seems to be in a worrying situation, with a psychic exhausting and a depressive collapse. He will sometimes be able to talk about suicidal thoughts, to 'stop all of this'. He's always anxious, and progressively begins to express his suffering of always being exposed to these intrusions, increased by the unbearable look of his mother, always aware of the slightest of his moves.

Antoine was born a little time after the death of a small sister, in dramatic conditions, during a car accident, when his father was driving and his mother not here. His mother learnt the accident by his father, who was responsible of this drama.

This traumatic announce stayed in a silent which was blocking any possible psychic dynamic, and any acknowledgement of the psychic suffering and the depression of the both parents. Antoine grew up without knowing the exact circumstances of this story, until recently, until the moment he experienced his obsessions and compulsions about cleanness. So, Antoine was not only a substitute child, as his mother said during the first consultation. But also a 'child after', as we propose to say. A child who came after this traumatic familial story. A child who built himself under the look of depressed parents, in a suffering they never allowed themselves to recognize.

SUBJECTS AND METHODS

Depression and psychic processes of loss in the primary childhood: comparative approaches between neurosciences and psychoanalysis

Antoine is meeting a depressed mother, still in the grief, who gives birth to this child, when she's still tearing for his daughter, who is always in her mind. A pregnancy to fill the lack, to hide the loss, to substitute to avoid the unbearable loss. This baby has to build himself in front of this mother, who massively denies all of this, but who is feeling deep in herself the terrible suffering of the loss of a child, an unbearable loss, impossible to elaborate. But he's building himself also with a depressed father, collapsed, who tries since several months to overcome his feelings, his guiltiness, his physical and psychic suffering. A father considered as responsible, he was driving the car, he saw his child dying.

Since Winnicott (1975), we know the importance of what a baby sees when he's looking at the face of his mother: 'generally, what he sees is himself. In other terms, the mother looks at the baby, and what her face expresses is directly linked with what she sees'. The depressed mother has difficulties to accord herself with her child. She can misunderstand the signs of this one, monopolized by her attention to her own needs. Her maternal care can become unsuitable. With A. Green (1993) and his metaphor of the 'complex of the dead mother', we understand that the depressive feelings can happen 'in the presence of the object himself, absorbed by a grief'. This can be a mother who just lost a close person, a child, a relative, and who becomes completely involved in this grief and for this reason goes away from her child (Levret).

More recently, works about neurobiology of emotional development showed the direct link between maternal care behaviour, endocrine changes, and neurocognitive development (Schore 1994). Children who experienced secure relation parents-children learn that, when they have to face a stress, they can feel distress, communicate their negative feelings, find help from the care givers (Delvenne 2014). Studies demonstrated that the presence of a sensitive and reactive care giver can prevent the increase of cortisol by the child himself, even if he's anxious tempered (Quevedo et al. 2012). This secure function, which is the kind care that the parent gives to the child, is playing a real role of decreasing on the activity of the hypothalamus-hypophysis-surrenal system (HHS) of the child, in other words a role of protection of his brain from the stress, and helps him to overcome stressful events.

In this way, maternal care behaviour leads to endocrine changes which directly influence the growth of the brain of the child. The perception by the child of the facial positive emotional expression of the mother leads to an increase of opioid peptides, and these endorphins physiologically active dopamine neurones, which manage the development of the orbital-frontal cortex of the child, place of development of executive functions, of the ability to think at his actions and to become conscious of them. On the opposite, an unavailable mother, rejecting or insensitive, will not answer in a suitable way to the emotional needs of her child. In this case, we will notice by the child difficulties of self-control, and a vulnerability to interpersonal situations which need mentalisation abilities. An increase of cortisol basic rate, or a more important or disorganised reactivity to stress, were found by children who experienced an insecure attachment relation, by children educated in socially underprivileged families, by children of depressed mothers, or by abandoned or mistreated children.

On another hand, we know that the environment affects the moment and the way of expression of the genes. So, precocious experiences can activate or not genetic expression (Meaney 2012, Szyf 2009). So, researchers demonstrated a decrease of mRNA (genetic expression) of glucosteroids of the hippocampus by mothers who experienced infantile abuses and who suicided (McGowan et al. 2009). There is in the same way a link between maternal depression and the methylation of the gene of glucosteroid receptor (NR3C1) by the baby and his reaction to the stress (Oberlander et al. 2008).

Transmission of the traumatism, traumatic traces by the babies: comparative approaches between neurosciences and psychoanalysis

Antoine experienced pulsional overflows of his mother, without the ability for her to incarnate a care function, enough useful to protect him.

Children and babies directly and indirectly feel the traumatisms. Main part of topical studies, concerning the mechanisms of psychic intrusion, the fright and its effects on the development (Baubet et al. 2013), the language and the preverbal, the procedural memories, or the memories which allow inscription, representations or precocious representations by very small children or even foetus, demonstrate that.

We know that very small babies are able to recognize stimuli associated to a situation experienced as traumatic, and might express corporal reactions of distress linked with these stimuli (Moro et al. 2014). In neuro sciences, we also know that the development of a psychopathologic disorder will depend on the one hand on biologic, psychologic, familial, social and cultural factors of risk, acting in synergy, and on the other hand on the period of development when they are acting.

The genetic question can't be separated from the environmental aspect. Precocious relational traumatisms, active or passive, lead to a chronic stress and an increase of the production of cortisol secretion, which is depending on the length of the traumatism and its precocity. These traumatisms can stop the physical, biological and psychological development, and can lead to a late development and changes in anatomy (Lachal 2000) and physiology of the brain, with a decrease of the total cerebral volume and a decrease of grey and white substance (De Bellis et al. 1999, De Bellis et al. 1999). These changes are probably due to an activation of neuronal circuits of stress, which are particularly removable during the period of small childhood. Antenatal and perinatal period seems to be a moment of extreme sensitivity to stress for the cerebral development, especially concerning the possibility to develop a neurobiological reminding, able to influence the entire life of the person.

In case of persisting stress or too frequent activation by the small child, a long term increase of cortisol leads to damages in the working of several neuronal systems, and to changes in the architecture of the brain (Lupien et al. 2005, McEwen et al. 1995). Severe and during precocious toxic stress (PTS) by small rats leads to an increase of cerebral cortisol, which has an on/off action on genes, in some specific periods of development and in some cerebral places, causing in a long term way an exaggerated answer to the stress and changes in cerebral architecture, which is essential for learning and memory. It also causes an inhibition of neurogenesis, trouble in neuronal plasticity, neurotoxicity, and an abnormal synaptic connectivity. These genetic prints can be temporary or permanent, and cause different genetic expressions. Some epigenetic changes that happen during foetal life can also be transmitted through generations (Champagne et al. 2009).

RESULTS AND DISCUSSION

The 'children after'

So, Antoine is not only a child born after a deceased child, a substitute child according to the definition usually done to this concept: "a child born after the death of an older one is a substitute child when he is invested by the same expectations and phantasms than the deceased child, projected on him by the parents" (Porot 1993, Sabbadini 1989). He is a child who built himself and grew up with depressed and traumatised parents.

Antoine, when he becomes adolescent, shows so disturbing psychiatric troubles that they have to worry his parents. So, during a familial consultation, the mother of Antoine will explain to us that she has so much concern about the health of her son, she's so afraid of imagining a suicidal attempt, that she forgets to think at her daughter. She's then unable to tell us since how much time this one died, however she was before counting days and months and was still living in this everlasting past.

So, through his psychopathological troubles and his so important psychic suffering, Antoine succeeded in replacing and becoming this substitute child. Antoine couldn't be this child before, because there was no place to replace, there was any possible place, whatever this place could be.

This term of substitute child, now common, was not fitting to a much more complex psychic reality.

So this unappropriated term couldn't fit to the situations that these children had to face and to manage to grow up.

By observing the impossibility to leave this new person a place, at least in the maternal psychics and care (Winnicott 1969), we were led to propose to name these children the 'children after'.

These 'children after' don't replace the child.

They replace a moment of the relation between mother and child, in a locked temporality, as:

- Support of the interaction mother-child;
- Fusion which is impossible to grieve;
- Scene of identification and projections where the Self is building;
- Scene shared by the new child, who takes this place to the older one, can't be subject as the older one, and has only this moment to be like him and build his Self.

These different elements are related to the impossible meeting which the mother and the child can't leave, and which is the substrate used to build the 'child after'.

Antoine and his symptoms, 15 years after, caused enough 'preoccupation' to his mother, to allow this one to 'let something go of'. To allow her to finally abandon a little bit her daughter, to abandon her defences, to begin to put her away, to begin a grieving work.

Antoine came to replace primary maternal care, which was still completely open and dedicated to the little deceased girl. Becoming at last 'substitute child', and no more the 'child after', many years after his birth, replacing in this way the primary maternal care, he was becoming subject and was going away from his pain.

CONCLUSION

From the clinical observation of an adolescent patient suffering from obsessional compulsive disorders, we were led to examine the circumstances of his birth, which happened after the death of a first child.

The singular moment of birth, after a pregnancy which took place in a context of untreated grief, birth of a baby 'hold' by a depressed mother, who was sharing with the father of her baby traumatic unelaborated feelings. Context which is today known, thanks to studies in neurosciences, to have a possible impact on the child.

So, using the notion of primary maternal care, theoretical bringing which seemed to be the most linked to our work, we proposed the term of 'child after', which appeared more fitted with the dynamic and the place really left to these children.

This term can signify the question of an undone grief, a traumatism no printed in a temporality, a relation between the mother and the child which became uncertain because of the investment of the child as an impossible reparation of an unscarred loss.

Through this term, it seemed important to us to allow these children to begin to be something else than a semblance of 'the other', even if they only were the print of a temporality, the print of something 'after'.

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