

## A HASTY CONCEPTION AFTER PERINATAL LOSS: THE SALVE FOR MATERNAL GRIEF OR PERPETUATION OF ANXIETY FOR MOTHER AND CHILD?

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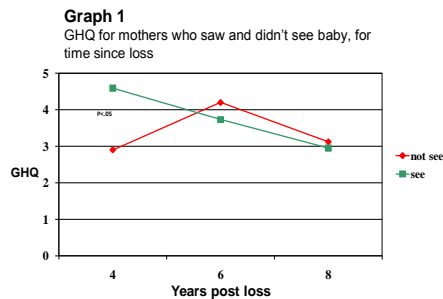
The pregnancy and postnatal period following perinatal loss is typically fraught with anxiety related to fears that 'this baby will die too', often entailing maternal depression and guilt. The notion of a *replacement child syndrome*, when a hastily conceived new baby distorts or delays mourning (Poznanski, 1972), and a *vulnerable child syndrome* (Davis, Stewart & Harmon, 1989), where over-protection or unrealistic expectations of the infant due to the fear of forgetting the previous child and/or of losing this child, have been described. Hughes et al. (2001) suggested that the experience of perinatal loss can trigger a past-learned insecure or disorganised coping style in the mother impacting on the relationship with the new baby - a mechanism of inter-generational transmission of emotional problems. Little empirical research has been reported on these subsequent child syndromes beyond descriptive, qualitative studies. Hughes et al (1999), however, undertaking one of the first comparison studies, found that mothers whose subsequent pregnancy was conceived less than 12 months after a stillbirth had higher levels of anxiety and depression at one year post delivery than mothers who had conceived after 12 months. They concluded (Hughes et al., 2001) that infants next-born after a stillbirth may be at greater risk of increased psychological problems in later childhood as a result of maternal unresolved grief. This paper describes two case study examples of girls conceived quickly after a perinatal loss where anxiety impacted, unrecognised, on their educational experience, and concludes with a plea for further well designed research in this area.

### Grief after perinatal loss?

The death of a baby around the time of birth is now, over the last 30 years, well documented to result in a significant grief response for parents, and radical changes have resulted in postnatal care practices over this time. No longer does an unwell newborn die alone in the nursery or is a stillborn baby whisked away – the rugby pass of the labour room (Lewis, 1979) - unseen by the mother. No longer is mothers' grief unrecognised and considered out of place during her postnatal recovery - the mothers quickly sent home with recommendations to 'forget this baby and have another'; and no longer are the babies buried in unmarked communal graves, no funeral or marker of their life or existence, on the premise that what the eye did not see the heart need not grieve for. As contact with these babies is now almost universal, so too is the satisfaction with this care (Brabin, 2004). However, this support of parents' experience of grief has been linked to research findings of increased anxiety and depression in mothers in the months following the loss, sparking a controversy regarding the value of this contact (Hughes, Turton, Hopper & Evans, 2002). Concerned with these findings, Brabin (2004) reported data supporting the notion that the grief facilitated by contact with a stillborn infant was being measured as impacting on emotional health of mothers (higher GHQ scores - a widely used measure of General Emotional Health, Goldberg, 1978). Of greater concern was that she reported data suggesting that at *six years post loss* this situation was reversed. While the emotional health of mothers who had contact with their babies had improved - see Graph 1 – the emotional health of mothers who had *no contact* had deteriorated (higher GHQ scores). This was suggested to reflect emerging distress related to regret about the past lack of contact with the baby in some 50% of these parents whose average GHQ scores were 5.4, greater distress than for the contact group. It was also suggested that attempts to minimise the

reality of the baby are now more difficult after having seen the growing baby in utero through ultrasound typical now in early and mid pregnancy.

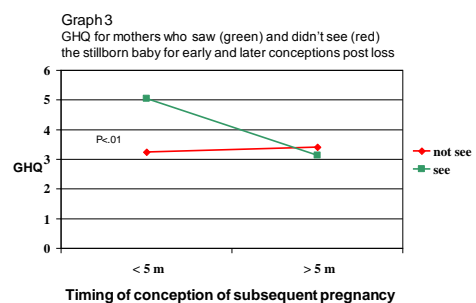
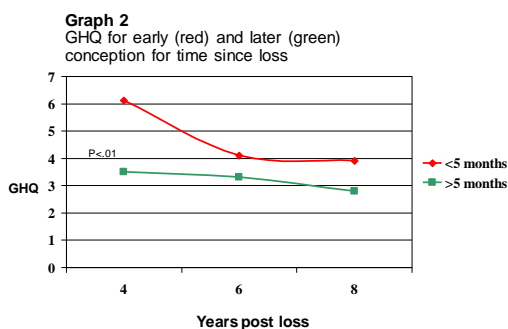
The task of mourning, however, takes time. Research that fails to consider this fact and confuses the natural sequelae of grief with disorders of mental health, reinforces confusion



of these paradigms in general medical practice, as evidenced by the increasing prescription of antidepressant medication after the experience of loss. The strong tendency for humans to try to avoid the pain of grief is well recognised in grief support circles - to distract from it through work or keeping busy; to minimise its depth as in the past practice to imply that a baby was not a real person, thus, the grief not a real experience; or to minimise its extent – *I should be over it now after 3 weeks.*

### The role of having another baby?

Virtually every mother after a perinatal loss wants to get on with finishing the process begun, to bring home a baby. This often also reflects a subconscious process to deflect from the pain of loss, also often reinforced by kindly-intended others: *you'll feel better when you're pregnant and have another, it will help you forget, move on, look to the future.* Other factors are called in to reinforce this – *I'm old or I have to have IVF, so we can't wait.* Yet, other common themes are conveyed – *You'll know when you're ready* – that fail to recognise the common reactions of desperation, sense of failure and self-blame that promote a need to get on with the process begun. The wise advice to *allow yourself to grieve for this baby before embarking on the next pregnancy*, as recommended through research and common sense indicating that some six months usually is adequate, going unheeded.



### Having a hasty next pregnancy aids maternal grief?

Hughes, Turton and Evans (1999), undertaking one of the first comparison group studies in this area of research, found that mothers whose subsequent pregnancy was conceived less than 12 months after a stillbirth had higher levels of anxiety and depression in the third trimester and at one year post delivery than control mothers who had not had a prior stillbirth or those who had conceived after 12 months post loss. Data from Brabin (2004) provides support for these findings that a hasty next pregnancy not only fails to provide a long-term salve for maternal grief but perpetuates the trauma of the experience. Mothers

who conceived the next baby within five months after a stillbirth had poorer on-going emotional health outcomes, significantly different at four years, than mothers who conceived later – see Graph 2. This situation is highlighted when grief expression is reinforced through contact with the baby - see Graph 3.

### Managing the next pregnancy?

The core issue for all parents in the pregnancy/pregnancies after a perinatal loss is the fear that this baby will die too. Cognitively this anxiety can be expressed: *if this baby dies we will never cope*. This increased salience of the threat, magnifies a realistic appraisal of a repeat likelihood - a theme common to the trauma aspect of perinatal loss. Delaying the experience of a subsequent pregnancy allows parents to have moved further through the grief experience and to have learned that the impact does begin to subside reducing the need to get pregnant to attempt to achieve this goal.

### Prenatal maternal anxiety impacts on baby?

An expanding body of research is indicating that prenatal maternal stress and anxiety, particularly in the later weeks of pregnancy, impact negatively on the developing fetus. Talge, Neal and Glover (2007) suggest that activity of the stress-responsive hypothalamic-pituitary-adrenal (HPA) axis and its hormonal end-product cortisol, which crosses the placenta, impact both mother and growing baby. Prenatal maternal stress, has been linked with:

- attention and temperament problems in infancy, externalizing problems in childhood, and psychopathology and chronic illness in adulthood (Field & Diego, 2008);
- greater maternal report of infant negative reactivity and infant temperament at two months of age (Davis, Glynn et al, 2007);
- increased infants' stress-induced salivary cortisol reactivity at seven months of age (Grant, McMahon et al, 2009);
- depressive symptoms in post- pubertal female adolescent offspring (Van den Bergh, Van Calster, Smits, Van Huffel & Lagae, 2008);
- behavioral abnormalities including increased anxiety and shorter attention span at four years of age (Glover and O'Connor, 2005);
- increased emotional or cognitive problems, including an increased risk of attentional deficit/hyperactivity, anxiety, and language delay (Talge, Neal & Glover, 2007).

### Impact of post-natal practices on the baby?

The notion of a *replacement child syndrome*, when the new baby is conceived quickly and the distorted and delayed mourning process impacts on the attachment relationship, was described by Poznanski (1972). The expectations held for the dead child, suggest Legg and Sherick (1976), are transferred to a live one whose self-identity, in the shadow of another identity, is projected onto them via the family myth. A related variant, the *vulnerable child syndrome*, (Davis, Stewart & Harmon, 1989), is characterised by parents being over-protective of the subsequent child with unrealistic expectations of the infant due to the fear of forgetting their previous child and/or the fear of losing this child. Little empirical research has since been reported relating these subsequent child syndromes to perinatal loss, beyond descriptive, qualitative studies.

The UK researchers (Hughes, Turton, Hopper, McGauley and Fonagy (2001), found that infants next-born after a stillbirth showed significantly increased disorganised attachment to the mother compared with control infants assessed at 12 months and concluded that they may be at greater risk of increased psychological and behavioural problems in later childhood. This difference was strongly predicted by maternal unresolved grief with respect to the previous loss.

#### Case examples: two girls subsequent to a perinatal loss

Ms G was initially referred for anxiety and coping with Year 12 and had seen counsellors during her schooling. Her mother was a child subsequent to stillborn twins and Ms G was the middle of three girls born 12 months after her stillborn brother was delivered in 1982. No connections with this experience had been made for Ms G who was clearly more anxious than her sisters who she reported to be confident and academically capable. She indicated that *she wouldn't have been born if he were alive*, and that her mother was unable to talk about him and could not recall Ms G as a baby. Her history indicated a profile of behavioural inhibition at preschool and her early learning issues characterised by poor concentration and distractibility, intelligence testing indicating an average IQ reflecting an asynchrony between her verbal and lower performance subscale. Her friends were all academically competent girls. Over the last eight years Ms G has done well out of the competitive school environment in an event management role and has since developed a special relationship with her mother through their connection with her brother.

Ms A's parents were referred for grief support after the death of her first-born brother who died three days after a difficult delivery in 1994. Her mother was struggling with guilt related to a past history of sexual abuse and attachment difficulties with her own mother, blaming the baby's death as a result of a gastro attack she suffered in the days preceding his birth. Despite advice to the contrary they conceived quickly, arguing *this was right for them*, and Ms A was born 11 months after her brother's death, her mother indicating she had hoped to deliver another boy. Feeding problems occurred immediately, resulting in referral to a neonatal psychiatrist. Ms A was a difficult unsettled baby, tense and rigid, difficult to comfort and required a regular routine. As a toddler she was highly distractible, active and emotionally labile. At school she was highly academically competent with perfectionist demands on her performance but was socially shy and reticent to engage in the playground. On assessment she displayed verbal comprehension difficulties and enjoyed routine mathematical tasks and in drawing her family, her deceased brother was included as a large baby lying above her in the sky. At home she was ordered and neat and at 5 when the home was burgled she suffered severe trauma symptoms obsessing about the burglar returning. Her 2-years younger sister and 8-years younger brother are both highly able children but do not demonstrate the anxieties evident in Ms A.

Both these girls are aware of their place following a deceased baby sibling, perhaps as replacement children. Their anxieties reflected attention disorders, behavioural inhibition (a validated psychological trait marker of anxiety - Dadds, Heard & Rapee, 1991) in the social context and restricted capacity to manage stressors, that could reflect *vulnerable child* experiences not evident in their siblings. While early parenting experiences, with little doubt, have impacted on their emotional development prenatal origins may have also played an initial priming role.

## Professional support in the next pregnancy?

Added to the need for more research in this area, medical care typically focuses on keeping the baby healthy and delivered alive. This reassurance is essential but it is not therapy. Effective therapy for maternal anxiety management needs to address the *coping skills* related to the typically unlikely but with exaggerated salience – *what if this baby dies too!* This process is rarely considered as we tiptoe around this ‘unmentionable’ constant for parents. However, without this care the focus stays on the live delivery rather than freeing parents to plan the future with the baby, beginning with enjoying the pregnancy.

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