ON REPLACING A CHILD

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An occasional occurrence in child guidance clinics is the case of a disturbed child who was conceived shortly after the death of another child, his parents' specific intention being to have this child as a replacement or substitute for their child who died. It is with such children this article deals—with the circumstances of their conception, the constellation of parental attitudes that may cloud the child's upbringing, and the potentially severe pathological consequences of these influences upon the child's emotional development.

The circumstances of the birth of these children were as follows. A child, generally of latency age or early adolescence tragically died, the cause either illness or accident: in our cases, malignancies, severe infection, automobile accident, and choking on a piece of bread. The parents mourned deeply and openly. Yet they—one or

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both[1] of them—could not adequately work through their intense anguish and grief over the loss of their child. We cannot say with certainty what determined their, and most particularly the mother's, inability to meaningfully resolve their mourning, for we came to know some of them only briefly, some through closed files, and all of them at least seven or eight years after the actual death of their child. But two major factors seemed prominent: first, the guilt-ridden, generally depressive, phobic, or compulsive premorbid personalities of the mothers, who themselves had suffered a surprising number of family losses in their own childhood. They were known for multiple phobias and for sporadic depressions long before the loss of their child—and indeed, two of these women were so disturbed as to be considered borderline psychotic. But second, and perhaps equally important, was the parents' intense narcissistic investment in the children who had died. The children typically were immensely idealized after their death by the parents, but as best we could gather from less emotionally involved sources, these children had in fact generally been quite bright, achieving, lively, and well liked. On their slim shoulders came to ride heavy parent identifications, dreams and plans—only to meet the crushing, irreversible defeat of death.

Furthermore, as others (Eissler, 1955; Feifel, 1959; Krupp and Kligfeld, 1962; Volkart, 1957; Wolf, 1958) have pointed out, modern American society in many ways makes such losses even more difficult to accept and integrate. Child death is now so relatively rare in major sections of our population, in contrast to earlier times or other lands, that it is totally unexpected, thus even more overwhelmingly a shock to the parents. Both unexpected and occurring in a culture so little ready to humble itself to "fate" or "God's will," a child's death is often reacted to as bewilderingly incomprehensible or as an undeserved and frequently rebelled against punishment. Our society's estrangement from and unwillingness to look squarely at death, as well as the smallness of our family units and the inten-

[1] We came to know shamefully little about these children's fathers, and can only say that in at least three cases, the father was by no means the frequently reported uninvolved, passive nonparticipant, standing by while the mother's psychopathology rode rampant. Rather, these three fathers appear to have been almost as actively involved as their wives in the disturbed mourning and consequent warping of the rearing of the substitute child.

sity of the bonds within them (Krupp and Kligfeld, 1962; Wahl, 1959) further combine to make adequate mourning and the readjustments intrinsic to it particularly difficult for us.

The intensity of the parents' reaction was severe and unrelenting —suicidal thoughts, despair to the point of believing "better we were all dead," bitter self-accusations,[2] inconsolable grief, recriminations, deep brooding, withdrawal from friends and neighbors into reveries, and utter inability to release the image of the dead child. Amidst this, a seeming resolution presented itself, or, as in three of our cases, was presented by the family doctor. To "take her mind off things," to "give her something else to live for," the mother decided or was advised to have another child "in place of" the dead child. (In five of the six cases other siblings remained, but clearly the other children in the family were not sufficient as substitute objects.) Thus the decision was made, consciously but not necessarily without hesitation and some conflict, to replace the lost child. We will shortly document in full the ways in which the attempt to "replace" was totally dominated by the image and memories of the dead child. It was perhaps most vividly demonstrated by one set of these parents who initially went to adoption agencies after their loss, requesting an eight-year-old, thin, blue-eyed, blond boy to replace their dead eight-year-old, thin, blue-eyed, blond boy.

I

The new child, the substitute, then, was born into a world of mourning, of apathetic, withdrawn parents, a world focused on the past and literally worshiping the image of the dead. All but one set of these parents had long given up intentions of having any more children until this was precipitated by the death of their child —and we have the feeling these older parents (five sets of them in their late thirties and early forties) had little remaining of the

[2] Self-accusations and self-reproach are now considered by some "extremely common if not universal in healthy mourning" (Bowlby, 1961a, p. 7). Studies like those of Bozeman et al. (1955), Orbach et al. (1955), Solnit and Green (1959), Natterson and Knudson (1960), and Richmond and Waisman (1955) have found that guilt-laden self-reproaches and driven, incessant questioning as to ways in which they might have been responsible are quite common maternal reactions to the death of a child. These widespread maternal reactions provide some support for Bowlby's position in contrast to earlier emphases on the relative lack of self-accusation in normal mourning (Freud, 1917).

energy, flexibility, and patience so vital to turning the clock back and again raising a young child. So in this sense, too, these parents were not prepared to have an infant in the home. Thus the parents were doubly unable to give to the new child. And the home the new child came to live in had an essentially funereal atmosphere. A tone of depression was pervasive with sorrow and yearning in the fore. But there was more than just a feeling "tone" or atmosphere involved: there were such matters as weekly—and in two cases daily—visits to the grave; a house chosen because it was closer to the cemetery; reality-dictated moves to another city rejected because "it would leave him all alone out there"; constant discussion of caretaking of the grave; nights filled with a mother's soft crying when a particularly poignant memory had been evoked; and discoveries of one's father staring for hours in a darkened room at the barely visible photograph of the dead child. The dead child lived on in a very concrete, day-to-day fashion. Photographs filled the household; in two cases the child's room was virtually turned into a shrine; each landmark in town elicited memories of what the child did there once; each recurrent event or holiday recalled how they had spent it together.

The parents talked on and on about the dead child, even as much as ten or eleven years later. Many of the parents said apologetically that they really knew they should not be talking about their dead child so much, they knew (often had been repeatedly told) it was not good for others in the family, but simply could not stop. Teachers reported that they "talked of almost nothing but their dead daughter," or that "this mother seems to positively enjoy talking about the dead child." The parents' lives seemed substantially wrapped around the half-throttled plea *"if only* it hadn't happened . . .": they could not move beyond this lament.

These parents grossly imposed the identity of the dead child upon his substitute, and unconsciously identified the two. Frequent slips were made, calling the new child by the dead child's name, not just in talking about the children, but in moment-to-moment interaction with the new child—in calling him to dinner, casually asking him how things went at school, or kissing him good night. The two children's looks, posture, facial expressions, ways of walking and talking were constantly compared. The parents' expectations, hopes,

and even demands upon the child for various kinds of excellence were all obviously modeled upon the achievements of the dead child —or, more accurately, upon the hyperidealized and grossly unrealistic image of the dead child. The dead children were, to listen to the parents' descriptions, intelligent, "the best liked in his class," friends with everybody, beautiful, sensitive, captain of the patrol, alert and clever, never any trouble, the neighbors' special "pet," always cheerful, affectionate, obedient—in brief, ideal, perfect, angelic children.[3] With the distorted images of these dead children who never did and never could exist in reality, the new child had to compete. The task was hopeless, and they soon came to know this. Interestingly enough, we found that many of these expectations could remain in force even if the substitute child was of the opposite sex from the dead child (this finding being in sharp contrast to the policies of some adoption agencies, who see the risks entailed with such parents, but feel the risks are obviated if the parents will accept a child of the opposite sex—or even of a quite different age).

The comparisons made between the two children were continual, both explicit and implicit, too often made right in front of the substitute child, and almost all unfavorable to him. Remarks like "if it were Billy, *he* would have . . ." were frequent. Even at their best these unfortunate replacements were spoken of as "a good boy, but . . ." and then comparisons with and longing for the dead child surged forward. And the new child's achievements were most likely to produce in the parent not praise or notice in their own right, but instead a bittersweet smile and sighs of how "just like" the dead child.

Another impact of the death of the child which was pathologically imposed upon the substitute child was that the mother's normal or, in some cases, initially abnormal phobic concerns over illness and accidents were much magnified. She carried the constant panic-laden fantasy of this child, too, dying. The slightest lump or fever or cough, ten minutes late coming home from school, or the sound of brakes being slammed on produced momentary terror.

[3] Amidst the bevy of praises for the dead child, some of the children who served as replacements became genuinely confused as to why God had "taken" their dead siblings if they had been so very, very good. Their parents, who had protested the same injustice, could be of little help with this.

The phobic concerns extended far beyond the specific features of the other child's death, and in all cases led to severe parental restrictiveness and overprotection. Matches, tree climbing, the crossing of streets, a sneeze or a tumble all signaled disaster. Little was allowed, and almost everything was tensely watched. In a few cases for lengthy periods this led as far as minute daily inspections of every bruise, lump, and sore, and routine examinations of the day's activity for danger points.

Around transgressions of restrictions lay death-focused warnings of what could happen and mournful tales of what *did* happen. Occasionally these were accompanied by the mother's anguished threats that if something happened to this child too, she would kill herself. And rewards and punishments were sometimes phrased in terms of whether the child would be allowed to join the dead sibling in heaven.

Lastly, we note that in at least two of the mothers there appeared to exist an especially noteworthy fantasy. By virtue of the magic that primary-process thought contains, these mothers unconsciously felt that the substitute, the child we were to see in the clinics, was somehow "responsible" for the death of the other child: this in the face of the temporal realities of his not having even been born during the dead child's lifetime. But the timelessness, facile displacements, obliviousness to contradictions, and unreason of the unconscious know no such boundaries of logic and reality. As best we can reconstruct the unconscious content and articulate it in secondary-process language it runs something like the following. "This new child is alive *instead* of our dead child. He has *taken his place.* This child is not our dead child, he was to be, it is his fault he is not. It isn't fair that he should live and our other child die. He is responsible for *all* this, it is *all his fault.*" Thus some of the ever-present displaced hostility and reproaches of the mourner came to land unconsciously upon the substitute child himself, along with other inappropriate objects.

II

The substitute children, four boys and two girls, ages seven to twelve years, ranged in psychopathology from moderate neuroses to (two) psychoses. As we turn to the disturbances created in these

children by the peculiar circumstances of their birth and their unconscious meanings to their parents, a statement of caution is in order. We shall see in these children blatant signs of pathology directly traceable to the parental environment just described. But these children clearly had other sources of disturbance, other symptoms and personality distortions that were at most peripherally related to the personality disturbances attributable to their being "replacements" for a dead child. Similarly, our syndrome-oriented presentation ought not blind us to the fact that these children also had, in varying degrees and kinds, significant areas of adequacy and adaptive functioning.

These children were, as it might be expected, filled with phobias and general fearfulness. A few minutes with the child or his parents elicited a long list of his phobic objects, and even in brief interviews or test sessions with the child he manifested many of his phobic concerns; e.g., George dreaded using a dictaphone, backed away when the interoffice phone buzzed, refused certain kinds of candy because "they might get stuck in my throat," spoke in a frightened fashion of eye tests, and dwelt upon the ravages of whatever current diseases were in his neighborhood. The phobias centered upon death, contained typical fantasies of abandonment, castration, and talion aspects; they also had specific reference to the death of the sibling and a crucial identification with him—of which we shall soon say more. The most prominent phobias, with their accent on illness and body-mutilating accident, appeared to combine the direct, overt imposition of the parents' phobic vigilance upon the child, with the customary phobic projections stemming from an overly close, hostile-dependent tie of the mutually ambivalent mother and child. For in four of these cases the child had been very closely tied to the mother—the world was much too dangerous a place for the child to move freely and explore. He must stay nearby, lest "something" happen. The results of this steady diet of closeness, overprotection, restriction, and overwrought warnings were clear enough: infantile, immature, home-bound children, with strong passive-dependent elements and widespread ego restrictions. All the children were convinced that they were inadequate, vulnerable souls living in a world of constant unpredictable dangers.

Not only general somatization, but hysterical identifications with

the dead child's physical symptoms were prominent; for example, the continual "clogged" throat, gasping for air, and preoccupation with things being caught in his throat of the boy whose brother choked on a piece of bread; and "arm pains" of the girl whose brother died of leukemia and had experienced peculiar sensations in his arms. The two children who were approaching the age at which their sibling died solemnly announced that they did not want to have any more birthdays—so total was the identification, they were convinced they would die at the same age. All were convinced they would die as children, "never live to grow up." Reassurance that "people don't die until they're old" mocked itself and simply left them more distrustful of such supportive efforts. The children's brooding conviction of their forthcoming death intruded itself in striking ways. Asked during his psychiatric evaluation what he wanted to be when he grew up, one boy somberly replied, "I won't, I'll die." Another boy would frequently blurt out, "I'm gonna die. Not everyone gets old."

Morbid preoccupations were widespread. One boy, surveying a pleasant Thanksgiving party, announced to his father, "Someone here won't be here tomorrow—he might be dead." Almost outdoing their parents, they were particularly interested in cemeteries, funeral homes, pictures of hurricane devastation, neighborhood graves of animals. They talked and inquired about deaths at great length. They always seemed to know of and reverberate to illnesses and deaths in the neighborhood, deaths of friends of the family, distant relatives, pets, etc. And they used such events as further evidence of how death hovered nearby, and how powerless doctors were before it. These children also lived with gross distortions of the disease process and its relation to death. Thus, the boy whose brother died of a poorly understood "severe infectious process," which his parents had explained in answer to his repetitive questions as "like a special, real bad cold," understood only that colds could quickly lead to death. The girl whose understanding of her brother's malignancy was that "he got a bump on his leg, and they took off his leg but it didn't help" of course lived in terror of everyday bumps and bruises, her fear augmented by her mother's regular, scrupulous examinations. All the more certainly then did death lie in wait for the child, if it could come from such common everyday causes.

Returning to these children's identity problems, they found they could barely breathe as individuals with their own characteristics and identity. Their parents compelled them to be like their dead siblings, to be identical with them, yet made it clear that they would never be accepted as "the same," and could never really be as good. Burdened with unbelievably detailed knowledge of their dead sibling, constant comparisons and imposed identifications, they continually talked about their dead sibling and asked themselves and their parents, "Do I really talk like him?" "What would she have done?" "Am I as smart as him?" Basically they were convinced they could never measure up: their parents' perceptions were fully, if grudgingly, internalized, and mention of the substitute child's own achievements often brought from the child *himself* a derogatory comparison with those of his dead sibling. At points there was evidence of feeble attempts to reject comparisons and throw off identifications, but all such efforts obviously failed. Other defensive efforts, fed by despair and desires to retaliate, were visible in hints of abortive negative identities and vengeful school failures, but these could only be self-defeating, for as these many pathological influences and reactions combined and further emotionally crippled the substitute child, he increasingly became the disappointment to his parents that he essentially was from his very birth, a vicious cycle thus being fully established. Worse yet, amidst the guilt-laden inexpressible rage aroused in the substitute child by incessant comparison with his invincible dead rival, he was asked not only to mourn but even to join in the idealization of his competitor.

In all these ways the image of the dead child cast its shadow upon his replacement. How totally the dead child may live on with the substitute child cannot better be expressed than by the children themselves in their use of the present tense when they repeatedly said, "I *have two* brothers" (one of them, of course, long dead), or stated, "My sister *is* twenty-three years old" (referring to the sibling who died twelve years ago at the age of eleven).

III

We spoke briefly earlier of the parents' inadequate or unresolved mourning. The nature of the mourning reaction, and the question of criteria for differentiating pathological versus "healthy" or normal

mourning have recently received increasing attention (Bowlby, 1960, 1961a, 1961b, 1961c; Engel, 1961; Jacobson, 1957; Knudson and Natterson, 1960; Pollock, 1961). Appended to this has been a recent focus upon the role of cultural factors in defining mourning reactions (Krupp and Kligfeld, 1962; Volkart, 1957). We must leave these larger issues for discussion elsewhere,[4] and will merely note for our purpose areas of general agreement on the psychological tasks necessary to adequate mourning (Bowlby, 1961a, 1961c; Freud, 1917; Jackson, 1959; Lindemann, 1944; Pollock, 1961). These include:

1. The full realization and acceptance of the object loss, the experiencing of the painful affects associated with it, and the ultimate abandonment of unrealistic strivings to regain the lost object.
2. Resolution of the anger and any irrational guilts which sprang from the object loss.
3. Loosening of emotional bonds, and significant withdrawal of emotional investment from the lost object.
4. A redirection of interest toward and readjustment to living in the bereaved's new environment with new objects. (This in no sense excluding the bereaved's establishment of a constructive, personally and socially acceptable formulation of his future relation to the deceased.)

By contrast, what we see in the parents of the children previously described is a noteworthy distortion of the mourning process, a *pseudo resolution* of mourning.[5] With the seeming turning toward a new object, toward life and the future, there is what appears to

[4] In the pursuit of this study, we encountered many more intriguing problems than can be dealt with in this brief paper: children's concepts of illness and death; children's unconscious realization of the meanings of intense parental phobic concerns about their death; the vicissitudes of "imposed" identifications, etc. But most compelling theoretically has been the light thrown by this and parallel studies on the mourning process when viewed outside the customary context of children's reactions to the loss of a parent, or adults' reactions to the loss of adult love objects; for instance, the paler role of introjection and identification in parents' mourning of a dead child.

[5] We should note here a number of parallel situations or cases brought to our attention in the process of gathering the materials for this study: replacement of a dead child via adoption; "replacement" of a dead child with one of his surviving younger siblings, with results strikingly similar to those described in this paper; and conscious or (more frequently) unconscious replacement of variously "lost" objects, including therapists, by conceiving a child (cf. also Greenberg et al., 1959).

be progress, or even the final step toward the resolution of mourning. This element or phase is variously described in the literature, but the accents are consistent on "moving forward" and a "redirection toward the living." In all but a superficial sense though, there has been no forward movement in these cases, no resolution of mourning. The bonds to and yearnings for the lost object, the dead child, remain intense. Sorrow and depression still are the prominent affects. But most important, the "new" object is brought into existence almost exclusively as part of an attempt to retain or regain the lost object, and the parents' relationship with the new, substitute child is virtually smothered by the image of the lost child.

Perhaps, then, it behooves us in general to take a closer analytic look at prospective "moves forward" or reinvestments in new objects by the bereaved, even where these are presumed to helpfully occupy and give solace to the bereaved, and are socially useful. The use of new objects "to keep their mind off things" may at times serve only to abort or divert mourning, not successfully resolve it; the psychiatric dangers thus engendered are well known (Bowlby, 1961a; Caplan, 1961; Deutsch, 1937; Fleming and Altschul, 1963). Similarly, even those apparent resolutions of mourning with obvious social value, such as volunteer work related to the nature of the mourned death, deserve careful scrutiny. At times, these in essence represent little more than continued bondage to the lost object; see, e.g., Bozeman's comment (1955) on some bereaved parents who stayed on interminably as volunteer workers in the leukemia ward, ". . . tragically unable to complete the work of mourning . . ." or Greene's study (1958) of the use of "vicarious objects" in the avoidance of mourning, and the effects of later failure of this defense. As Bowlby (1961c) phrases it, the personality reorganization intrinsic to mourning "takes place partly in connection with the image of the lost object, partly in connection with a new object or objects." It becomes, then, our task carefully to assess both the degree and the quality with which a lost object lives on in the bereaved's (prospective or actual) relationships to new objects; and as counselors, family physicians, ministers, or psychiatrists, to counsel accordingly where the opportunity presents itself. That making this assessment may be an extremely difficult task in some cases does not negate its possible clinical and theoretical rewards.

The syndrome we have described is sufficiently dramatic, and so obvious are its seeds in the parents' reaction to their tragic loss, that we have had to restrain ourselves from leaping first to simple causal inferences and then to categorical preventive applications. Our restraint is not so much based on the possible import of other etiological factors, for instance, the pre-existent phobogenic nature of a number of the mothers, which would have created child-rearing distortions under most conditions. Rather our caution stems primarily from the gross bias intrinsic to the gathering of our very small "sample." All six cases were first seen in psychiatric settings, referred precisely because they were *disturbed* children. From what we know of human variabilities, and the wide range of resolutions, adaptive and maladaptive, available to any constellation of conflicts, there is reason to believe that there can be basically intact, well-functioning children raised even against backdrops similar to those described here. But as "normals," by the very nature of our "sample" collection, they could not have been encountered. As such, we must take a rather conservative approach in assessing the dangers for substitute children; we also feel obligated to seek out as best we can nondisturbed or at least nonpsychiatric instances of substitute children—and this not merely by way of establishing the existence of such cases, but far more important, trying to learn from their study how some of the inherent tragic potentials in the replacement situation were avoided or healthily resolved.

But we would hope our conservative application of these findings, nevertheless, will serve as a counterbalance to the stunning casualness found in some pediatric quarters in recommending the "replacement" of dead children to grieving parents. In addition to suggesting that any such cases receive close study regarding the adequacy of the parental mourning, our investigation and a number of others (Lehrman, 1956; Natterson and Knudson, 1960; Solnit and Green, 1959) tentatively point to some specific, overt signs which indicate that attempts to replace a dead child are particularly fraught with danger: pre-existing major phobic, obsessive or depressive elements in the parents' personality; the age of the parents and its likely reflection in their lessened capacity to raise a young child; extreme parental idealization of the dead child; the suddenness of the child's death; and, as regards the syndrome we have described, the age of

the dead child—for the death of an infant makes less likely some of the later comparisons, identification, etc., than would be the case where fully developed, older children, with distinctive traits, features, and achievements have died.

In such cases, where professional advice is sought, any supposed advantage in the parents' having a substitute child must be weighed against an awareness of the risks such a course entails; at a minimum the value of a significant waiting period should be considered. If the parents still feel that having another child is the solution, a vigilant follow-up seems obligatory, to watch for and intervene should such pathogenic forces as those previously noted assert themselves.

As Richmond and Waisman (1955), Bozeman et al. (1955), Orbach et al. (1955), and Solnit and Green (1959) have well stated, in cases of fatal illness (and accidents) in children, the physician's responsibility is not only to the dying child, but to the entire family unit; and, in such situations as described here, his conscientious, insightful exercise of this responsibility may prevent the senseless arithmetic of adding a pathetically warped new life to the one already tragically ended.

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