Siblings of Retarded Children:

A Population at Risk

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ABSTRACT: One of the major tasks of contemporary child psychiatry is to build programs of early intervention to prevent the development of emotional illness in children. In order to construct such programs it is necessary first to identify those groups of children who are frequently seen at child psychiatric clinics and are likely to have emotional problems. Among the many groups of children frequently seen in clinics, the siblings of retarded children comprise one important identifiable group.

There are many factors responsible for the problems of this group: excessive parental attention to the retarded child and relative neglect of the siblings, the identification of a sibling with the behavior of a retarded child, a normal child's anxiety over the meaning of retardation and its relationship to his own sexual and aggressive fantasies. One of the most important factors responsible for the symptoms and symptomatic behavior of this group is guilt. Evaluation of these children and of their parents reveals the importance of unconscious parental guilt about the retarded child, the mechanisms that parents employ to deal with guilt, and the effect of these mechanisms on the sibling's personality, attitudes, behavior, and symptoms.

Parental guilt based on fantasies about the meaning of having a retarded child, unconscious and intolerable, is often projected onto the normal sibling who is then held responsible for the trouble. Parental superegos indict the sibling who is perceived as angry and destructive. Anger at the retardate, which further intensifies parental guilt, is displaced onto the scapegoated sibling whose own conflicts over aggression are intensified. Via the mechanism of introjection and identification the normal child in some cases takes

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on some of the characteristics of the retarded sibling; this identity both serves a defensive purpose to ward off anxiety and guilt and leads adaptively to parental acceptance. In other cases the child's guilt may lead to overcompliance, nonlearning, or a masochistic search for punishment. The guilt-ridden sibling may further project his own guilt and take on a blaming and attacking attitude toward others including therapists. The family mythology provides clues as to the blending of mechanisms used.

Clinical examples are cited and treatment implications discussed.

Among the many groups of children frequently seen in child psychiatric clinics, the siblings of retarded children comprise one important identifiable group. There are many factors responsible for the problems of this group among which are: excessive parental attention to the retarded child and relative neglect of his siblings, the identification of a child with the behavior of a retarded sibling, and a normal child's anxiety over the meaning of retardation and its relationship to his own sexual and aggressive fantasies.

One of the most important factors responsible for the symptoms and symptomatic behavior of this group is guilt. It has been suggested that every individual suffers an early existential sense of guilt because of the very nature of human life [1]. For the infant, the family is the means of survival possible only through sharing and mutual dependence. But, to take from others is to consume what they have and to leave less for the rest of the family. Thus, Melanie Klein [2: chaps. 5-7] has posed the beginning formation of the superego during the first year of life as part of the early process that takes place between the infant and its mother. In this early relationship it is postulated that anxiety about the loss of the mother militates against the wish for complete possession of her and thus of her consumption. Out of this conflict emerges a sense of concern for another person. This concern forms the theoretical basis for the establishment of a sense of guilt according to the Kleinian school.

The actual fate of each family member as discussed by Modell is important in determining how the early sense of guilt will be managed by the family. In most families in which there is a defective member, pervasive guilt permeates the family and is expressed in its characteristic style. The birth of a retarded child, his presence in the home, and even the knowledge that such a child once lived at home, greatly exacerbates this existential guilt. In order to expiate his guilt about a retarded sibling and to justify the gratification of his own needs and thus of his own right to existence, a normal

child develops fantasies to explain his sibling's retardation. For a normal child to fulfill himself becomes, in fantasy, a selfish, guilt-ridden activity that deprives the retarded sibling of equal opportunity.

The birth of a retarded child creates a number of immediate and difficult problems for the mother. The blow to her feminine narcissism, based on the belief that she can produce intact children, stimulates wishes to reject the child. The mother's own sense of early guilt, based in part on the fate of her original family members, is a factor that determines her relationship to her retarded child. Her thoughts, fantasies, and feelings translated into action are witnessed by the observing sibling. Parental guilt about a retarded child, the accompanying fantasies, and the methods used by parents to deal with this guilt have a profound effect on a child's early reaction to his retarded sibling.

The process of reparation defends against the guilt and anxiety-laden fantasies of having destroyed what is good in the family or in a particular individual. In a family in which there is a retarded child, the reparative process is essential to the alleviation of anxiety and guilt. Continued efforts at restoration of the damage in action and in fantasy bring about an expectation that good wishes will prevail over bad ones. Ambivalence becomes more integrated, and some control is established over the ambivalent fantasies. Guilt may mobilize efforts to love and care for the child with the fantasy of undoing the damage. Because retardation stimulates fantasies as to the cause of the damage, the retarded child may take on symbolic meaning to the parents and be seen as a negative result of their past actions or wishes. Caring for a retarded child may be seen as an act of sacrifice that brings absolution.

An assessment of the amount and kind of reparation is an important part of the diagnostic process. Parents first set the stage for reparative activity in the family. A commonly shared fantasy on the part of parents is that enough reparative activity will undo the damage and the child will no longer be retarded, a belief based on the fantasy of omnipotent control of the object. This kind of reparative activity does not bring constructive relief, but establishes an unending cycle for the expression of guilt. For reparative activity to bring relief to the family, there must be a process of gradually accepting the retardation and the reality of the child in the family, a process that involves mourning for the retarded child. A more realistic acceptance of the child's condition leads to better assessment of what is needed, whether the child is to remain at

home or to be placed outside the home. If a child remains at home, the parents must decide how much to sacrifice the needs of the other family members, including the mother herself. In this reparative process the role of the mother is crucial as the central, nurturing figure in the family. Crucial, too, is the father's ability to modulate the situation in a beneficial way so that other family needs can be met.

How a child deals with the presence of a retarded sibling is, in part, determined by the family style which is expressed to the child by his parents and by the other siblings. This family style is reflected in the attitudes and fantasies, spoken and unspoken, that exist from the beginning of the child's interaction with his mother. This composite of actions, thoughts, and fantasies has been called the family mythology [3]. A child interprets for himself this mythology at each stage of his development and adapts to the situation in a way that best meets his own needs in the context of the family's needs [4]. This adaptation must include some reparative efforts to deal with the early guilt now exacerbated by the presence of a retarded sibling.

A sibling of a retarded child develops fantasies that help to explain the meaning of retardation, its possible causes, and its implications for himself. The severity of the retardation, how apparent it is, and whether or not other physical defects are present are important factors in determining the kind of fantasies that develop. Parental fantasies about retardation are readily transmitted to the child in the context of the family mythology. This mythology seeks to explain the cause of the retardation in the context of the family history, including such factors as illness, poor eating habits during pregnancy, or as retaliation for past sins. The issue of causality is linked, at a deeper level, with a sense of responsibility and guilt shared by the family members.

A boy may interpret the retarded behavior of his sibling as evidence of masculine inadequacy. The implication of castration leads to anxiety about his own masculine intactness. He may fantasize that lack of control of his own aggressive feelings is similar to the outbursts of his retarded sibling.

The fantasy that retardation and mental illness are related is a common one. When neurological deficit results in seizures accompanying the retardation, the retardation itself may be linked in fantasy with madness and complete loss of control. A child may then fear for his own mental integrity if he dares give vent to his own pent-up feelings. In a general way, feelings of guilt shared by the

family members may generate the fantasy that any demands placed on the retarded sibling will lead to further damage to that child. This results in overprotective, solicitous behavior and displacement of angry feelings from the retarded child.

We have selected cases that illustrate various ways that families deal with a retarded child. Parental guilt, based on fantasies about the meaning of having a retarded child, unconscious and intolerable, is often projected onto the normal sibling who is then held responsible for the trouble. Parental superegos indict the sibling who is perceived as angry and destructive. Anger at the retardate, which further intensifies parental guilt, is displaced onto the scapegoated sibling whose own conflicts over aggression are greatly intensified. The case of Tony illustrates the phenomenon of projection of guilt.

The normal child, in some families, takes on some of the characteristics of the retarded sibling via the mechanisms of introjection and identification. This identification serves both a defensive purpose to ward off anxiety and guilt and leads adaptively to parental acceptance. These factors are clearly seen in our second case, that of David.

In the case of Chris, the child's guilt may lead to overcompliance, nonlearning, or a masochistic search for punishment until the family is able to find more constructive, reparative activities for their feelings.

In the last case of a precocious 11-year-old boy, the Oedipal theme is pervasive as the child adapts himself to his mother's conflicts at the expense of his own unmet dependency needs.

Tony

This 12-year-old boy expressed both for himself and for his family tremendous guilt and anxiety via temper tantrums, suicide threats, and controlling school phobic behavior. Tony was referred to the clinic because of severe school phobia, complaints of stomach pains, and hysterical outbursts including suicide threats and accusations that he was being poisoned by his father. The Richards had long endured at home a 13-year-old, severely retarded daughter who, in addition to being mongoloid, also had a cardiac defect and a bleeding ulcer. The parents had been told that she would not survive long, and the threat of death was always present.

Evaluation of this family revealed a great deal of guilt and anxiety about the retarded daughter on the part of all family members, and the mother had strong death wishes which were verbalized at times. Tony had been very much neglected because of his parents' preoccupation with Karen. After Karen's birth Mrs. Richards did not want another child, and she was very upset by her pregnancy with Tony. She was very concerned about Karen's survival during the early months of Tony's life.

During the first few diagnostic sessions, temper tantrums and suicide threats predominated, and it was clear that Tony could not contain his anxiety and aggression. He made hysterical accusations against his parents and against clinic personnel. He could not be contained in the interview room until the fifth session when he started to verbalize anguished feelings about himself, his sister, and his parents. Tony told his therapist that he had two gerbils, but that one gerbil ate the other and the surviving one died of loneliness. He told how when the police came for the emergency hospitalization of Karen, he thought they were coming to take him away. His sister's condition had many meanings to him, but clearly Tony felt responsible for her problems, and he had great fear that her death would be caused by his rage at her demands. He told his therapist how confused and helpless he felt when his sister climbed into bed with him or with his brother.

This family dealth with their guilt by much projection. Tony had become the dangerous, disturbing element brought to the clinic in a raging, threatening tirade. Both parents stood helplessly by while the therapist had to calm and control Tony. Tony dealt with his own feelings not only by somatizing and the development of phobic reactions but also by projecting his own feelings onto the world around him.

Mrs. Richards' history reflects a great deal of early pathology. Her mother had a breakdown after the birth of a "late child" at age 40, began to drink excessively, and had to be hospitalized. Mrs. Richards was left to care for her newborn sister. This sister later required outpatient psychiatric treatment. In addition, subsequent to maternal grandmother's breakdown her younger brother had a breakdown after he was discharged from military service. In her married life, Mrs. Richards was overburdened with Karen, anxious and angry about her predicament. Her own family was unable to give her any support after Karen's birth and tended to reject Karen and ignore the problem. During the evaluation, Mrs. Richards related in a controlling, aggressive way, withholding much of her feelings. It was extremely difficult for her to verbalize any guilt and anxiety. She focused on Tony's provocative behavior and projected many of her own feelings onto Tony.

Mr. Richards proved to be a passive, reticent man who worked hard as an accountant and deferred most decisions to his capable wife. He was the youngest of three boys. He told us that he saw little of his own hard-working father. His mother relied heavily on him at home and required a great deal of support from him during his growing years because of her own physical problems. She died when Mr. Richards was 20.

This family projected their feelings, including tremendous rage, onto Tony. They were not able to mobilize constructive reparative efforts, probably because of the terminal nature of Karen's illness, as well as their own defensive mechanisms.

David

This case dramatically illustrates the internalization of a retarded sister's behavior on the part of a five-year-old boy.

David, at age five, is the youngest of three siblings. His seven-year-old, severely retarded sister was placed in an institution when David was three years old. David was described by his kindergarten teacher as being intelligent and alert. He was seen by his parents as intermittently withdrawn, having difficul-

ties with peers, and easily frustrated. His parents were also very concerned that, at times, he would speak in a confused, incoherent manner and that his language development had been very slow. They had questioned whether his hearing was intact and, in short, had concerns about his whole neurological and physical development. They wondered, with alarm, whether he, too, was retarded. They brought David for a complete neurological examination, and when no negative findings were apparent, they were referred to us for psychiatric evaluation.

At the time that these parents came for help they were on the verge of divorce and the household was very chaotic. Recent events had brought about a dramatic change in roles on the part of the parents. Mr. Masters had been unemployed for some time and enjoyed staying at home looking after the children. Mrs. Masters worked all day and was beginning to find a new identity for herself. Her newfound satisfaction in her job and her pleasure at being away from the children reflected her intense ambivalence about being a mother.

David was conceived accidentally when the retarded daughter was 1½ years old. The death of paternal grandmother, with whom mother had been very close, as well as the birth and management of a severely retarded child who was kept at home, caused a severe depression in Mrs. Masters during this pregnancy with David and after David's birth. This young mother tried very hard to fulfill her role. She started breast feeding but became very ill with an infection and had to discontinue. It is probable that she could not relate to David closely in a consistent manner. David was a healthy, large, and precocious infant. He imitated his retarded sister early in his first year, and during his second year he would steal her bottle and insist on being cared for as completely as she was. When David was three his retarded sibling was placed in an institution. Mrs. Masters was relieved by the placement, but her depression continued sporadically as well as many phobic restrictions on her daily life. David became toilet trained only after his sister was institutionalized.

David initially responded very eagerly in his diagnostic sessions. However, he became more withdrawn as the interviews progressed and seemed unable to hear and to understand at times.

Mr. Masters had described David as having "introjected Anna"; at times he would walk and make sounds like she did and, in general, take on the appearance of her retarded behavior. Frequently he wanted to see his sister and would ask to visit her.

Our evaluation of this family revealed that David's behavior reflected the family's overriding obsession with Anna's retardation and his own attempt to deal with his very close relationship to her and the loss of her presence in the home. At the same time, David was jealous of the complete attention that Anna required from his mother, and he seemed to be competing for this attention at Anna's level. Both the positive and angry feelings were reflected in this family's concern for David's imitative behavior.

Chris

The case of Chris Taylor is illustrative of a family in mourning over the birth and immediate placement of a mongoloid child.

Chris is a six-year-old boy, withdrawn and depressed in school, unable to

learn, and with no friends. At home, he is affectionate and warm but demanding and controlling of his mother with a very low tolerance for frustration. Two older children are doing very well, are assertive, aggressive with peers, and in the family. When Chris was five years old a brother was born, diagnosed immediately as mongoloid, and placed within weeks in an institution. This infant had no obvious physical defects, was responsive, and was a normal-looking baby. The family has been visiting monthly at the institution, bringing Chris with them. Chris has been quoted as saying after a recent trip, "Why doesn't mother bring Tommy home?"

Chris's developmental history was unremarkable except for some control battles over toilet training. He went to kindergarten with no separation problems although he was quiet and somewhat fearful. In the first grade he had to board a large bus and go to a much bigger school at which time he developed a phobia, crying and unable to get on the bus. Chris's mother was, at that time, just recovering from the birth and placement of Tommy. She had been depressed after each child but after Tommy's birth was more depressed than ever.

The Taylors belonged to a small religious sect that allowed no smoking, drinking, dancing, or movies. Much of their lives was centered on religious observances. During her initial visits to the clinic Chris's mother showed very little affect except when she talked about Tommy. Mr. Taylor was much more expressive and took the initiative. Chris's father and mother met at the hospital where both worked. He had felt drawn to her because of her shy, proper behavior. He had been very attached to his religious mother, and, in many ways, Mrs. Taylor resembled her. At first the marriage was difficult because of sexual problems. She was unable to respond sexually and had a great deal of guilt about any physical pleasure. After several years of marriage Mrs. Taylor felt that God had given her a sign to conceive her first child. In this way she received permission for sexual expression. For this very religious woman, the birth of a retarded child substantially mobilized guilt about emotional expression. Her increased depression then became of obvious concern to the family and the marriage came under great strain.

When Chris was brought to the clinic he showed much aggression in his play but remained very guarded and fearful. Verbal exchange included "I don't know" and "I forgot." He seemed particularly anxious about his more aggressive feelings. His school phobia reflected fears of rejection and abandonment as well as concern and anxiety about his mother.

We offered this family short-term therapy with a focus on their grief over the loss of Tommy and their feelings of guilt and anger at having a mongoloid child. As the interviews progressed, mother looked and dressed brighter and was able to verbalize more of her feelings about Tommy. Her husband was very clear about his dissatisfaction with the marriage and about his wish for more participation by his wife. Mrs. Taylor expressed fear of having another retarded child. Her overidentification and involvement with Chris was somewhat diverted when she joined a community group for parents of retarded children. She cared for a friend's baby for several weeks and became very responsive and involved with the infant as a temporary replacement for Tommy.

A follow-up with the family showed that they were continuing to do much better and that Chris was participating more openly and assertively in school. In his play sessions at the clinic he had been able to verbalize his anxiety about Tommy and his placement in the institution.

Peter

This case illustrates an Oedipal theme superimposed on a pattern of reaction formation to deal with dependency needs and anger in an 11-year-old boy.

Peter Heath was referred to the clinic because of severe stuttering. He was described as a very emotional child who had outbursts of temper. The family pediatrician dated the onset of his stuttering to the time when his sibling was diagnosed as retarded. Peter, who also has two older brothers and a younger sister, is described as "the most adored son," sensitive, and mother's special helper. He has assumed a great deal of responsibility for the care of his retarded brother, taking time to teach him skills at home and generally looking out for him. He spends much of his time at home available to meet his mother's needs as well as those of this brother. In school he is shy and anxious and has few friends.

Mrs. Heath is bitter and angry about her retarded son, calls him "a pest," "a great eater," and, in general, feels overwhelmed by this boy's needs. Mr. Heath thinks that he is lazy and does not accept the retardation; neither does he offer much support or understanding to his wife. He is a passive man who has had periodic episodes of unemployment and currently works as a delivery man. Mrs. Heath devalues and is very critical of her husband. She is very much in control, a pattern similar to the one in her own family where she was the youngest of seven children. She was very close to her own father who managed a grocery store and was seen as very successful. This family has always lived in the maternal grandfather's two-family house taking one apartment and then moving into the other on the death of maternal grandmother a few years ago.

Peter was described as a placid baby whose development was without incident. At age five, however, he was "nervous," had many stomach upsets, at which time his mother was preoccupied with the evaluation of the retarded sibling. Peter's stuttering was described as starting shortly after he entered first grade. Mrs. Heath looked to Peter for the emotional support and comfort which she desperately needed at that time to deal with her own depression. Mr. Heath had not been able to fulfill his wife's needs, partly because of his own difficulties and partly because of his wife's negative view of him as an inadequate male. Peter quickly adapted to his mother's pressing needs with precocious, solicitous behavior both toward her and the retarded brother. His relationship with his mother continues to feed into his own Oedipal wishes and creates severe anxiety about his wishes.

In his own interviews Peter was a very gentle, mild, sensitive boy who had a difficult time expressing any aggression. He presented himself as a mature, precocious young adult who was insulted when he was invited to play. When he became anxious or excited, his stuttering would become worse.

The Oedipal theme is very striking in this case with strong secondary satisfactions for both mother and son, at the cost of suppression of Peter's aggressive and dependent needs. Mrs. Heath's controlling and ambivalent attitude toward masculinity was a determining factor early in Peter's life. The birth of the retarded sibling intensified the mother's conflict and increased her own needs during Peter's early school years. For this mother the retarded child was a strong blow to her narcissism and to her self-esteem. This woman had always seen herself, both as a child and in her later married life, as perfect and capable. It was left to Peter to contend with his mother's increasing anxiety and needs until the clinic intervened.

Summary

The siblings of retarded children comprise one important identifiable group frequently seen in child psychiatric clinics. A major factor underlying the symptoms of this group is guilt. We have discussed guilt from an existential point of view as fundamental to human life. The existence of a retarded child in the family exacerbates this early sense of guilt. Parental reaction to a retarded child as reflected in their fantasies and in their defenses has a profound effect on the emotional development of siblings. Siblings will respond by developing fantasies and behavior in keeping with the family style to defend against guilt and anxiety.

The process of reparation as discussed by Melanie Klein is essential to the alleviation of guilt and anxiety. Before reparation can be constructive and effective, a family must accept the reality of the retardation and grieve for the retarded child.

Fantasy plays an important role in dealing with the ambivalence and with the conflicts that arise both in the child and in his parents. Fantasy plays an important role in the process of reparation.

We have selected four cases that illustrate various ways that families deal with a retarded child. We have not discussed treatment methods extensively in this paper but have stressed awareness of the importance of guilt and of the reparative process in understanding the problems of the siblings of retarded children. Awareness of the underlying conflicts sets the direction for the treatment process.

One of the major tasks of child psychiatry is to develop programs of early intervention to prevent the development of emotional illness in children. Identification of the siblings of retarded children as a vulnerable group is one step in this effort. Although we cannot expect to eliminate completely the conflicts that arise inevitably in a family in which there is a retarded child, we can hope to alleviate internal conflicts sufficiently to allow the sibling of a retarded child to fulfill his own potential.

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