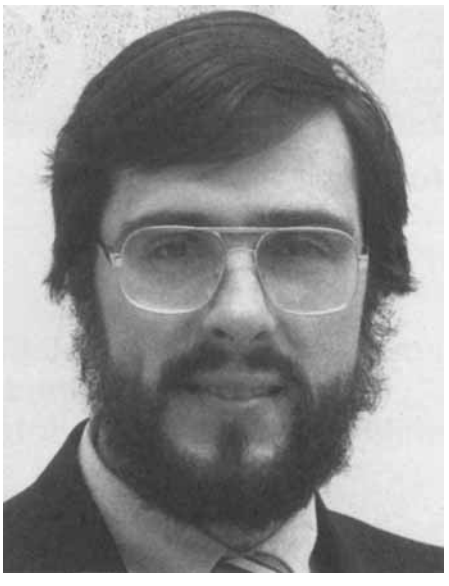
# Love and anger in relatives who 'adopt' orphaned children: Parents by default

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**Although much has been written about the psychological effects of loss of a parent on surviving children, little has been written about the effects of this event on the families who then choose or are forced by circumstance to look after these children. Yet their lives are disrupted and their ability to give the love and care that is needed may be the crucial factor which determines whether or not the children will transcend this loss.**

**In this important paper Paul Brinich analyses the predicament of these 'parents by default' and provides helpful guidelines for assessing their needs.**

**Editor**

## Abstract

**Children whose parents die often become the responsibility of other family members; in the United States culture these are usually maternal grandmothers and aunts. Whether or not these new caretakers want to take on this responsibility, they often feel required to do so. Thus people who themselves are in mourning sometimes feel forced into a parental role which they did not want. Not surprisingly, their performance as substitute parents often reflects the intense inner conflict which they feel about taking on this role.**

**This paper reviews experience gained from work with 51 maternally-bereaved children and the relatives who take care of them who were seen in the Childhood Loss Program over the past five years. We describe assessment and treatment issues encountered in work with these children and their caretakers. Common problems include the caretakers' ambivalent feelings towards the children, towards the dead mothers, and towards the fathers. These are addressed in treatment which oscillates back and forth between parent guidance and individual treatment (of the child, of the caretaker, or both). These treatment efforts take place in the context of bereavement, but often have more to do with ways in which the anger associated with multiple, and often violent, losses interferes with the flexibility required to handle the normal developmental issues of childhood.**

## Introduction

The Childhood Loss Program (CLP) at University Hospitals of Cleveland offers a variety of psychological services to children and families who have suffered losses via separation, divorce, illness, and death. Some 429 family members were referred to the CLP during its first 57 months; 63 per cent of these (i.e., 271 people) were referred following a death.

This group of 271 included 82 children whose mothers had died. Of these 82 children, 32 per cent (26 children from 17 families) were living with their fathers; 62 per cent (51 children from 39 families) were placed with relatives other than their fathers. While some of the latter group of children still had living fathers, these fathers were not able or willing to act as parents. I have chosen to group these children together and to call all of them 'orphans'.

The ages of the children varied across a range from three to 17 years, with no clear modal age. Fifty-one per cent of the children were male and 80 per cent were black. The causes of death and the ethnic backgrounds of the 39 mothers appear in Table I; illness claimed 33 per cent, accidents eight per cent, homicide 44 per cent, and suicide five per cent. [There are fewer mothers than children because some of the children we saw were siblings.]

**TABLE I — Cause of maternal death by ethnic background for maternally-bereaved children living with relative caretakers.**

| Cause of death | Ethnic Background | | | | | |
|---|---|---|---|---|---|---|
| | Black | White | Other | Total | % | |
| Illness | 10 | 2 | 1 | 13 | 33 | |
| Accident | 2 | 1 | 0 | 3 | 8 | 56% |
| Murder | 14 | 3 | 0 | 17 | 44 | |
| Suicide | 2 | 0 | 0 | 2 | 5 | |
| Other | 1 | 0 | 0 | 1 | 3 | |
| Unknown/ ambiguous | 3 | 0 | 0 | 3 | 8 | |
| Totals | 32 | 6 | 1 | 39 | 101 | |
| (%) | (82%) | (15%) | (3%) | (100%) | | |

Almost all of the children (80 per cent) were placed with female relatives on the mother's side. These relatives have often taken on the task of raising these children alone, without the support of a spouse.

Thus we are dealing with a group of children who have suffered multiple losses. These losses include the deaths of their mothers, the loss (or absence) of their fathers, and subsequently being placed out of their own home.

These children usually come from chaotic families and are taken in by maternal relatives who have themselves suffered important recent losses in the deaths of the children's mothers. These relatives often receive little support for their efforts from the children's fathers, from spouses, or from social agencies. Inner and outer resources are both in very short supply. It is not a hopeful combination.

## Issues in the 'adoption' of bereaved children by their relatives

The title of this paper refers to relatives who 'adopt' orphaned children. Usually these are not formal adoptions, but because the arrangements are permanent and involve all the usual parental rights and duties, the relatives do become, in many ways, adoptive parents.

Most of these caretakers had been involved in the lives of the maternally-bereaved children for many years prior to the mothers' deaths. The children have often received a considerable amount of their 'parental' care from these relatives.

However, although these caretakers have a good deal of prior experience with the children, and although these children often regard the caretakers as quasi-parents (even before the deaths of their mothers), the adjustment to

the new relationship is rarely an easy one for either the caretakers or the children.

We often see a pattern in which the new caretaker is, on the one hand, very loving and even indulgent toward the child and, on the other hand, quite rigid in the management of some normal developmental issues.

A key to understanding the combination of love and rigidity which we have seen in the caretakers has been an appreciation of the anger which is also part of the relationship. Some of this anger seems related to the fact that these caretakers did not choose to become parents to these children; they were forced to step into the gaps created by the deaths of the mothers.

This choice—to take on the care of a maternally-bereaved child—is usually a very costly one for the caretaker. In almost every case we have seen it has required major shifts in personal commitments, and in most cases it has also involved substantial financial sacrifices.

These adjustments have had to be made against a background of personal mourning: the dead mother of the child was often also a dead daughter or sister of the caretaker. Matters seemed to be complicated further when the caretaker took on responsibility for the child at the request of a dying mother. We have heard caretakers say: 'You know, I'd send you away in a minute but I promised your mother I'd look after you.' It is not hard to see the anger in such a statement.

This anger, expressed toward the child, often has important connections to the dead mother. Whether or not the dead mother contributed to her own death (and in many cases she did), the caretaker felt angry toward the person who left her with the burden of the child. This anger was usually not acknowledged. If it appeared at all, it was in derivative forms such as: 'I know that she didn't want to die; she would have preferred to raise her child herself.'

This unstable mixture of loving and hating feelings often gets in the way of the caretaker's relationship with the child. While a child requires a certain amount of flexibility in management, the caretaker feels stressed and angry and is thus in a poor position to respond empathically and flexibly to the child's needs—needs which often have been amplified by the death of the child's mother.

Another source of anger towards the dead mother often plays an important part in the family dynamics. Almost without exception, the caretakers of these children have expressed their misgivings about the kind of care the children received before the mothers died. Many of the mothers lived very disorganised lives. Some of the mothers—especially those who died after lengthy illnesses—seem to have regressed to child-like positions before their deaths, and encouraged complementary regressions in their children. Thus caretakers often inherited disorganised, regressed children who would tax anyone's patience, even without adding the complications of bereavement.

A final area of intense ambivalence in the caretakers has to do with the issue of identification; i.e. with the tendency to see similarities between the children and their mothers. This tendency seems natural enough and yet is a problem, for the mothers are dead. The question of whether or not the children were going to follow in their mothers' footsteps was not very far beneath the surface in most of our cases.

Identifications with the children's fathers were also problematic, especially in cases where the fathers had abandoned or killed the mothers. Caretakers spoke of the 'bad blood' which ran in the veins of these children, leaving them lazy or inept or vulnerable or murderously dangerous.

### Conflictual identifications and ambivalence in the children

Many of these psychological issues in the adult caretakers appear in complementary forms amongst the bereaved children. For example, many of the children struggle with the problem of whether or not they wish to be like their parents. A boy whose father did not support the boy's dying mother may admire some aspects of his father while detesting others. A girl whose mother has died may admire some of her mother's qualities, but she does not want to be like her mother in so far as that means being dead.

Many children are frightened by what has happened to their dead parent; some children then try to prove to themselves that they are not afraid by acting out the very things which frighten them. Some children may actively attack others, or they may passively provoke others to attack them. Other children voice worries that they will end up dead, like their mothers. Still others develop somatic symptoms which mimic those of their dead mothers.

Conflicts regarding identification —with mother and/or father—are by no means the only intrapsychic hurdles faced by these children. Many of the children are consciously aware that, with the deaths of their mothers, their lives actually took a turn for the better. For the first time in their lives some order exists in their lives. They are glad about this, but feel guilty for feeling glad. These feelings combine with the feelings of guilty responsibility often associated with the death of a loved one. The children who had felt a loyalty conflict between their mothers and their eventual caretakers while the mothers were still alive seemed to have an especially hard time. Faced with such internal, guilt-provoking conflict, the children sometimes provoked rejection by their new caretakers.

Finally, the relationships between these children and their caretakers often reflected a pervasive fear on the part of the children that their new caretakers would also die. Some children responded to this fear with inhibition; others seemed bent upon testing the limits of their caretakers' health and nerves every minute.

### Implications for Clinical Practice

Our observations have several implications for clinical practice. I will first consider the evaluation phase of this work and then move on to issues which arise in ongoing parent guidance work. [I will take for granted the general principle that the first consideration is the development of a detailed understanding of the internal worlds of both the bereaved children and of their caretakers.]

In the evaluation phase we try to learn how the children and the caretakers have each woven the mothers' deaths (and all the preceding and surrounding events) into their internal models of themselves and of the world around them. Did they (realistically or not) play a part in the death? How have they understood it (e.g., as a punishment)? Do the children or the caretakers see the children as destined to repeat their mothers' fate?

With the caretakers, we try to see at what phase of their lives they were when they took on this new responsibility. What adaptations have they had to make? What losses have they suffered beyond the death of a daughter or sister? What support have they received from others as they take on these responsibilities? Did they have a wish to take on this task of child-rearing, or were they boxed into it by deathbed requests, or by the limitations of other family members who would have been more appropriate to the task (e.g. the children's fathers)? Have the caretakers been able to tolerate and support the experience of mourning, in the

children and in themselves? Can they absorb some of the bereaved children's anger without feeling personally attacked? Can they tolerate some of the children's love for other family members (especially for the fathers) without feeling rejected? And what are the caretakers' own prior experiences of loss and bereavement?

We cannot get the answers to all of these questions in a brief evaluation. This requires ongoing, long-term parent guidance work.

Such parent guidance often returns to one of several themes. Prominent among them is the fact that the caretakers are parents by default; most did not want to take on this work, however much they might feel that it is now their wish and/or responsibility. Grandmothers, especially, often feel that they have already 'served their time'; the transition back into parenthood is a difficult one for them. Much of our effort with these caretakers is aimed at helping them to find ways in which they can get some support and satisfaction for themselves while continuing to respond to the needs of the children.

A second prominent theme in parent guidance has to do with the relationships between the caretakers and the dead mothers. These mothers were daughters or sisters to the caretakers and the caretakers have very intense feelings about them. It is important that the commonly-encountered guilt about surviving the dead mothers, and the anger at their dereliction of duty, should not be acted out towards the children. It is also important that the anger should not be acted out by the therapists towards the caretakers at those points when the caretakers' own needs lead them to either deny or neglect those of the children.

A third theme in parent guidance concerns the relationships between the children, their fathers, and the caretakers. The caretakers are often very angry at fathers whom they perceive as neglectful, selfish, or dangerous. It is hard for the caretakers to help the children to come to terms with their own ambivalent feelings toward their fathers, since any signs of affection expressed by the children towards their fathers make the caretakers furious.

## Conclusion

I have described some of the problems we encounter in working with relatives who take on the job of raising the children of their dead daughters and sisters. These problems centre around the caretakers' ambivalent feelings towards the children (whom they love, but who cost them dearly), towards the dead mothers (whom they love, but who died and left them with the tasks of childrearing), and towards the fathers (whom they often see as neglectful or as murderous).

I would like to emphasise that the caretakers and children we see are a skewed sample. Most are chronically stressed and abused people with few resources (internal or external). They differ in important ways from the families described by Altschul where 'the majority of the families considered themselves reasonably well functioning prior to the death'[1]. I conclude with an example of a family in which our intervention was brief, focused, and successful (at least in the short run).

Ms. A., the mother of a four-year-old boy, John, had died of an illness. Ms. A.'s sister, Mrs. B., took the boy into her home during the final stages of the mother's disease. Mrs. B. was married and had several children of her own. She was a full-time homemaker and John's arrival did not force a change in her role. Ms. A. had never identified John's father; instead she had encouraged her sister's husband, Mr. B., to fill a paternal role for John. Fortunately Ms. A. had purchased a large life insurance policy soon after John was born, before she became ill. Thus the family suffered no financial hardship when Ms. A. died.

Mr. and Mrs. B. brought adequate resources, both internal and external, to the task of substitute parenthood. When John began to test out his aunt's and uncle's resolve to keep him, they were able to tolerate this behaviour as something to be expected during his adaptation to his new family. When John expressed his sadness about his mother's death, his new family was able to share in the sadness and to support him through these painful times. And while there have been occasional bumps in the road, the adaptation appears to have gone well.

Most of the caretakers and children we see are not so fortunate. They usually had little to start with and lost much of what they had when their daughter or sister died. In working with these caretakers, we aim to help them to recognise the sources of their ambivalent feelings and to limit the extent to which these feelings interfere with their ability to respond flexibly to the needs of the children. We hope that such preventive mental health services will help the children and caretakers from falling into a cycle of loss, anger, guilt, provocation, and rejection which would make what is already a difficult adaptation into an impossible one. We hope, too, to provide some support to children and caretakers alike as they are confronted with the painful and wearying tasks of grieving their loss and then building new foundations.

**Reference**

1. Altschul S (ed.). Childhood Bereavement and its Aftermath. Madison, Connecticut: International Universities Press, 1988.

This article is based on a paper presented at the International Conference on Grief and Bereavement in Contemporary Society, sponsored by Cruse, held in London in July 1988.

[A longer, more detailed version of this paper, built around a case illustration, is available upon request from the author at the Division of Child Psychiatry, University Hospitals of Cleveland, 2040 Abington Road, Cleveland, Ohio 44106, USA.]

## FORTHCOMING COURSES AND CONFERENCES

**Cruse Bereavement Courses.** A number of Cruse Branches are running Bereavement Courses this autumn. Cruse workers will find details in the September issue of Cruse Bulletin, and information is also available from Cruse House (Tel. 01-940 4818).

**The Lantern Trust,** a registered charity, offers courses for professionals on giving care to people with HIV infection or AIDS. Courses can be arranged to suit participants' requirements. Contact Cyril Ives, Co-ordinator, The Lantern Trust, 72 Honey Lane, Waltham Abbey, Essex EN9 3BS (Tel. 0992 714900).

**Perinatal Bereavement.** London. 21st September, 1989. One-day symposium at Queen Charlotte's and Chelsea Hospital. Fee £40. Details from the Symposium Secretary, Royal Postgraduate Medical School, Institute of Obstetrics and Gynaecology, Queen Charlotte's and Chelsea Hospital, Goldhawk Road, London W6 0XG (Tel. 01-740 3904).

## LETTER TO THE EDITOR

### Open University Course on Care of the Dying and Bereaved

From: Professor Malcolm Johnson

Dear Editor,

In response to requests from a very wide range of people, the Open University's Department of Health and Social Welfare is proposing to develop a short, multi-disciplinary course on the care of the dying and the bereaved. This will be a package of written materials supported by audio and video tapes that individuals study at their own pace, but which may also provide a structured basis for group work. Our current intention is to prepare the course in ways which would meet the needs of all who are involved with dying and bereaved people.

To help us get an accurate feel to the kind of course that is most needed, we warmly invite readers of *Bereavement Care* to let us know their answers to the following questions:

1. What issues would you most like to see covered in the material?
2. Who do you think would be interested in using the course?

Thank you for your co-operation.

Yours sincerely,

MALCOLM JOHNSON
Director, Department of Health and Social Welfare, The Open University, Walton Hall, Milton Keynes MK7 6AA.

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