Aggression and guilt during mourning by parents who lost an infant

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The authors conducted in-depth interviews with 38 mothers and fathers who had lost an infant. The focus of the interview was aggression and guilt during mourning work. The participants felt strong shame after separation. Phenomena such as strong irrational guilt, aggression, and hesitation toward others were similar to feelings typical of the paranoid-schizoid position. However, mourners did not lose their sense of reality, continued to do daily chores, and kept taking care of others. In this period, mourners were in disintegration, similar to individuals in the paranoid-schizoid position. Shame may be the feeling in the residue of the paranoid-schizoid position, through which they felt persecuted by others, their partner, relatives, and God. Their aggression was strong, but generally their aggression and impulses came to be used constructively and they progressed to integration. At the moment their children died, mourners fluctuated between disintegration and integration. After a certain interval, fluctuation subsided or integration predominated. In times of fluctuation, containers were very important for mourners to move toward integration. Participants reported changes in their lifestyle after the loss of a child. Mental health professionals should view aggressive impulses among such people during mourning not as an obstacle, but rather as a means to move toward integration. The authors speculate that a psychotherapist can serve as a container for mourners. (Bulletin of the Menninger Clinic, 68[3], 245-259)

Most psychological studies of people who have lost an intimate have focused on sorrow, sadness, and grief following the death of the loved one

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(Burnett, Middleton, Raphael, & Martinek, 1997; Horowitz et al., 1997; Jacobs, Kasl, Ostfeld, Berkman, & Chapentier, 1986; Prigerson et al., 1995; Prigerson et al., 1999). When reported, aggression and guilt have always been treated as having little importance or, at best, as accompanying symptoms of grief or depression. However, bereaved family members often demonstrate excessive guilt and aggression, sometimes toward medical staff, despite the fact that the loss of the loved one was unavoidable. Sorrow, sadness, and grief appear after aggression is resolved or after a person has managed to face the loss. On the basis of his psychotherapeutic experience, Worden (1991, pp. 22-23) stated, that the way in which aggression was treated had important implications on the working through of mourning.

Few studies have examined aggression and guilt in bereaved family members. We report here our observations that aggression and guilt are of central importance in terms of adaptation. As Hagman (1995) stated, there are few studies of the normal mourning process. In this study, we focus on and interpret aggression and guilt during the normal mourning process.

Method

Thirty-eight women and men were recruited through various means, such as fliers sent to members of the Sudden Infant Death Syndrome (SIDS) Family Association Japan. Thus, they were a convenient sample. The interview consisted of two sections, the first being an unstructured interview exploring feelings and events before and after the child's death, grief reaction, and psychiatric symptoms using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID; First, Gibbon, Spitzer, & Williams, 1996). After an interval of 10 minutes, the second phase of the interview was conducted, consisting of questions about family background, past life events, and past psychiatric history using the SCID. The total time of the interview was about 3 1/2 to 4 hours. Prior to the interview, we explained the aim of this study to each participant and obtained written informed consent from everyone. After the interview, participants were paid 10,000 yen as an honorarium. The contents of the interview were taped only when the participants agreed. This study was approved by the Ethics Committee of the National Institute of Mental Health, Kohnodai Campus.

Results and discussion

Fluctuation between disintegration and integration

Some psychoanalysts have divided guilt into two types, persecutory and penitential, based on Klein's position theory (Grinberg, 1964; Kosawa,

1932; Okonogi, 1979). They have defined persecutory guilt as the individual perception of threat and punishment arising from a persecutory object. Persecutory guilt may be activated in the paranoid-schizoid position. In contrast, penitential guilt is defined as individual remorse for past events, often accompanied by feelings of sorrow and grief. Penitential guilt may be activated in the depressive position.

In his review of Grinberg's book (1992), Britton (1994) stated that Grindberg's two types of guilt were similar to, but not quite the same as, those described in Klein's theory. Britton stated that Grinberg focused on the preponderance of destructiveness in the paranoid-schizoid position, whereas Klein focused on the depressive position and the segregation of destructiveness. Badal (1964) argued that Grinberg's division was static, because he ignored the role of defense mechanisms such as introjection and projection.

Winnicott (1986) examined the variety of senses of guilt. He concluded that the sense of guilt was the ability to tolerate ambivalence between love and hate, and therefore, the sense of guilt implied some degree of emotional growth, ego health, and hope. He stated at the end of his article that a caretaker had to offer an infant some appropriate environment, because the infant's own guilt is still primitive and crude.

Klein (1975a, 1975b) wrote that the depressive position must be overcome during the course of development. On the other hand, she claimed that the depressive position continues throughout human life. Likierman (2001) stated that Klein never thought that mental life in adults fluctuates between the paranoid-schizoid and depressive positions. Moreover, Klein did not suggest that the depressive position is simply progressive. Likierman settled the confusion by separating the tragic depressive position from the moral depressive one. In the tragic depressive position, an infant experiences irrevocable loss. To an infant, losing a good object amounts to the loss of the life-oriented core of the self. In this position, the world is entirely destroyed. However, an infant has the capacity to tolerate guilt for attacks on the imperfect and frustrating object. In this position—the moral depressive position—the world is not completely destroyed by means of the continual reparative activity of the infant. Thus, infants are responsible for their own aggression. The moral aspect is based on the results of its tragic aspect, meaning that whenever an infant experiences perfect destruction, he or she experiences restoration of the world as a result of developing memory systems. The tragic depressive position needs to be overcome, and if an infant fails to do so, he or she cannot tolerate a normal rivalry with peers following the depressive position and goes back to be in fear and anxiety. Therefore, it is difficult to speculate that an adult who has

already overcome the tragic depressive position will revert to the paranoid-schizoid position.

Lewis (1971) proposed the concept of shame and guilt, based on Freud's theory. She defined shame as feelings of embarrassment, mortification, humiliation, chagrin, sheepishness, discomfiture, abasement, disgrace, ignominy, dishonor, and feeling ridiculous, disconcerted, or abashed. Although a variety of feelings are involved in shame, cognitive content is monothematic, relating to deficiencies of the self. Anxiety in shame is diffuse and nonspecific. Shame is evoked by moral or nonmoral events. Furthermore, in shame, the other is personified. Characteristic defenses against shame are turning away and using denial and repression. Shame derives from a public exposure of transgressions. The feeling places the emphasis on a bad self, as embodied by the thought that *I* did that horrible thing. Although guilt signifies responsibility, failure of duty, obligation, offense, and culpability, in guilt, the cognitive content may vary according to the variety of transgressions and accompanying circumstances. Anxiety in guilt is specific to the real event. In guilt, the other is not apparent. The characteristic defenses against guilt are isolation of the affect and rationalization. Guilt is viewed as a private experience involving conscience and refers to a specific behavior, as embodied by the thought that I *did* that horrible *thing*. On the basis of the theoretical argument of Lewis, Tangney (1990) and Tangney et al. (1992a, 1992b) speculated that guilt could be separated into components of guilt and shame. By conducting research on the self-report measure that they developed, they showed that proneness to shame is more problematic, maladaptive, and pathogenic than proneness to guilt.

Lewis (1971) stated that guilt and shame were equally developed through different superego functions and different routes of identification. She stated that hostility evoked by shame leads toward the other. However, simultaneously the target of hostility is beloved or admired. As a result, these aggressive wishes evoke guilt. This statement may be similar to the mechanism that Klein found in the depressive position.

We propose two types of guilt, but this may, in fact, be simplistic. We considered that shame as proposed by Lewis was the residue of the paranoid-schizoid position. Tangney et al. (1992a) reported that shame is connected with psychiatric problems. Although shame is certainly a problematic feeling, it appears in all people. Money-Kyrle (1955) coined the term *persecutory guilt* in "Psycho-analysis and Ethics." He claimed that guilt consists of both persecutory and depressive elements and is seen among psychologically healthy individuals. He also stated that there could be a qualitative change in the guilt.

When people with borderline personality feel shame, because it is a painful feeling, they cannot tolerate it and thus revert to the para-

noid-schizoid position. Their defenses against shame are static, weak, and ineffective. Therefore, they fluctuate from the paranoid-schizoid to the depressive position. We believe that shame is a feeling that triggers reversion to the paranoid-schizoid position. Although people with a neurotic personality organization continue to hold on to feelings of shame, they do not revert to the paranoid-schizoid state, but rather remain in the depressive state.

According to Spillius (1994), Bion developed the idea of fluctuation between the paranoid-schizoid and depressive positions—core concepts of Klein's theory. However, Bion ignored other elements about both positions described by Klein. The phenomenon of fluctuation has been noted in all people. Like those people in the paranoid-schizoid position, those in the residue of such a position may also have primitive and crude guilt. In the residue of the paranoid-schizoid position, every person has the feeling of shame and tends toward disintegration.

Disintegration

Most parents who were interviewed expressed the feeling that they were being blamed or attacked by others. They felt that they were criminals. In their minds, they had killed their infant, even though this was not the reality. Mothers and fathers who had lost an infant seemed to mistakenly believe that their aggression had killed their infant. Thus, they blamed themselves as well.

I blame myself. What I was thinking was wrong. I think that my child died because I thought like this and because I cannot be loved. (H.S.)

I feel that everyone thinks that I killed my first baby and thus when they see that my second baby has caught a cold, they suspect that I will kill [him/her] as well. (H.Y.)

When police officers came to us and asked understandably whether we had taken insurance on the baby, I felt as if I had killed the baby and I became "mad." (E.A.)

If only I had given some medicine. If only I had taken him/her to the hospital. I let my child die. I killed my child. The thought that I killed my child was horrifying. In those days, I thought I had a heavy cross to bear, my life was branded as a failure, and there was no future for me. I just spent days only avoiding killing myself. (W.K., age 35)

During this period, from immediately after the death of the child to 6 months to more than a year later, the sudden death of the child reactivated violent aggression on the part of parents. It became apparent that

most parents expressed aggression toward people around them, including their partner, parents, parents-in-law, relatives, health professionals, neighbors, and even God. Very often their aggression was directed toward their partner and family members.

When I gained consciousness after the operation (curettage for a miscarriage), I felt disgusted to see my husband. I did not like him to see me weeping or crying. I felt so miserable that I kicked him out. I wanted nothing but to be left alone. Having lost my first daughter [due to sudden infant death syndrome], I asked myself why on earth I should be unhappy like this, losing yet another by miscarriage. I was hurt very much by the death of the first child. Why should I be ill-fated once again? I lost my feelings of self-worth because I felt jealous for other people, asking why it should be only me. I knew that I should not say something like this, but in my heart I thought like that very much. (H.S.)

I could not trust other people. In a situation like that, one's understanding is twisted. I criticized myself, thinking that it was my fault . . . There was a hole in myself and I only managed to put up with the hole. (K.O.)

All parents expressed feelings of self-blame and felt some responsibility for their child's death. They felt responsible for doing or not doing something to help their child. Moreover, the fact that they could not obey the rules set by society added to their feelings of guilt. They blamed themselves for failing as parents. Grinberg (1964) quoted Freud as saying that guilt belongs to the realm of aggressive instincts, aggression being turned toward the ego as a punishing force, acting through the superego.

I blamed myself for a year. I lost the means to suppress feelings of irritability. (K.M.)

Freud (1917), in discussing mourning and melancholy, stated that mourners denied the reality that a loved one was no longer present, and that facing reality was necessary to maintain normality. This suggests that mourners are tentatively not normal, being unable to use usually effective defenses. As a result, aggression is stronger than the ego's ability to control it, and the ego has to expend its ability to defend in stabilizing the inner world during this period. Even the autonomous ego function (Hartmann, Kris, & Loewenstein, 1949) would be weakened. In this period, even normal people begin to disintegrate.

Freud (1917) hypothesized that aggression is a death instinct derived from human nature and is thereby a biological feature. Similarly, Klein stressed fear and anxiety over death. Winnicott (1963), however, said that an infant does not have a death instinct, but actively interacts with the environment. Hartmann et al. (1949) stated that aggression contributes to differentiation between the environment and human beings during their development. Using a case study, Mahler (1981) showed that utilizing aggression was very important for daughters to become independent from their mothers in separation-individuation. Aggression tends to force one to face an event that causes aggression rather than to escape from it.

From these psychoanalytic theories, aggression is seen as an important impulse that is essential for human adaptation. If the impulses are used constructively, life can be much more productive. We viewed the source of this power as aggressive impulses. Mental health professionals should view aggressive impulses of such people not as an obstacle to mourning, but rather as a means to lead to the depressive position. To determine whether aggression is destructive or not, the existence of containers is very important. Experiencing the loss of a child is new for almost all the parents, and thus so is the emotion from this experience.

The existence of containers

Because the separation from an infant was very painful, none of the mothers and fathers could manage their emotions on their own. However, at the same time, they also had difficulty verbalizing their feelings. They were afraid of the reactions (bewilderment) of people they spoke to. People who know parents who have lost an infant also have difficulty addressing the topic. As a result, parents had to contain their thoughts and emotions.

I want to talk of my child, but because my parents would worry about me, I can say nothing. (EY.)

I tried not to cry when C [older daughter] died because I thought that if I cried, other people would feel sadder. (Y.K.)

Consequently, they hesitated to go out, and they no longer trusted other people.

I have hardly come back to my parents' home. Even when I do so, I return to my own home as soon as possible. I cannot stay at my parents' home longer because I fear that I would be heard about what happened to my son. I do not want to be spoken to by others, I do

not want to be told anything, I do not want others to talk about everything. (S.H.)

Before my child died, my relationship to my mother was rather that for sisters than mother-daughter relationship; I was always with her. When I lived in a flat, we frequently met. However, I hated to see her for 1 year after my child died. I hardly saw her. (W.K.)

Mourners often project their unbearable raw emotions, sensations, or experiences onto people around them because they cannot contain their feelings. If the other people have the capacity of reverie and if they can contain the emotions projected onto them, identify and transform them, and give them back to the mourners, then the mourners reintroject the experience. In addition, mourners introject the function itself (Spillius, 1983). People surrounding an individual who has lost an infant or loved one must care about how the individual expresses feelings lest he or she turns vengeful in the external world.

Although people said that I should not, I blamed others and I blamed myself until somebody said that nothing was abnormal about that. (W.K.)

I have long been feeling guilty, though I rarely disclose it to other people. Probably these feelings lie deep within my heart. This does not bother me usually. It would not help me even if somebody listened to me talking about this guilt. However, I would feel relieved if somebody listened while I talked about it. If only there were a means to get rid of my guilt! This feeling may last until I die. I cannot tell this to my husband; my mother would be worried if I told this to her. I cannot have an ordinary life if I worry about this. There is no point feeling so sad. (Y.K.)

On the other hand, if people around mourners are incapable of reverie and tolerance, or if they ignore the mourners, the mourners' aggression will become even stronger.

A woman in the neighborhood said, "It was very hard for me to take care of my baby." When I heard this, I involuntarily had a thought to let her experience the same thing as I did; at the moment the woman looked aside, I reached out my hands on the baby's neck. I was afraid of myself doing that, and I rushed home. After this episode, I feared to see other children. I consulted with a health visitor. (M.N.)

She was afraid of the sudden harshness that she had never experienced before. After this, she began to suffer from unexplainable symptoms

such as hand tremor. Her aggression was clearly caused by a lack of understanding by her neighbor, and the aggression was a natural reaction.

My mother is such a type of woman who says that it is no use crying over things past and there is no meaning to "count the age of a dead baby." She does not let me talk of it. I want to talk about it. Thus, I intentionally take a psychological distance toward my mother. But my friends, who come to my home, whether they knew "my desire to talk about my lost child" or not, said, "Here was your baby!" I felt relieved because they understood my feeling and I had a chance to talk about it. They accepted the emotion just as I felt. (M.M.)

I could not talk about the episode because everybody did not "allow" me to weep or cry because it causes embarrassment in him/her. (M.H.)

When the residue of the paranoid-schizoid position is active, people around the mourner, including medical professionals, should seriously take care of the mourner. Through these periods, mourners fluctuate between disintegration and integration, and with the help of surrounding people as containers, they can move toward integration of their painful events.

Like people who lost their children, we have to believe in seeing our child again, and live with trust because the soul of the child always looks upon us. I want to see my child as soon as possible but cannot and should not commit suicide. Because I do not know when I will die, I have to live with all my might. (R.Y.)

We believe that a psychotherapist acts as a container for people who have lost a loved one. Freud (1917) thought that psychological equilibrium could be restored after the loss of a loved one by incremental divestment of libido (decathexis) and by redirection of libido to available survivors (Hagman, 2001). Family members and others who are related to the mourners may have sympathy for the individuals but cannot listen to their pain.

While my husband suffered from his own sorrow, I suffer from my own sorrow as well. People with sorrow cannot get together. I was sorry for my husband. (Y.E.)

A recent analytic model of grief has stressed that attunement of a psychotherapist is of central importance in facilitating the mourning work.

Responsiveness to the need for comfort and protection is also important (Hagman, 2001). Strong irrational guilt of long duration, which is thought to be a residue of the paranoid-schizoid position, may be a sign of a poor prognosis. In such cases, intensive psychotherapy may be needed. Psychotherapeutic techniques such as interpretation of transference may be useful (Klein, 1940; Safa-Gerard, 1998).

Toward integration

People whom we interviewed managed to integrate their painful separation into their lives.

Because this child was born and died, I became more willing to understand what other people feel. Before that event, I used to think of myself, but now I can understand other people more deeply. (Y.Y.)

I should like to make something good come out of the death of my son. Because of the impact of this experience, I forgot what happened prior to the experience. My life has changed. I should be happy if I could do things like volunteer activity in the future that make the best use of my experience. (Y.E.)

I wondered what meaning the death of my son had for my life. It has tightened our marital bond. We can talk more freely. We can see not only small areas just around ourselves but also more global parts of the thing. I have a wider perspective because I experienced that. The experience was really heartbreaking, but I have become stronger on the inside. The ultimate result may be good. As far as my personality is concerned, I used to think that it would be all right if only I were happy, but now I am delighted when I learn that not only my relatives and friends but also all other people are happy. I used to think that what happened to other people had nothing to do with us because I had no heartbreaking experiences, but now I do not think like that any longer. (M.O.)

They reported that their lives completely changed after experiencing separation. They felt more deeply and thought more about other people and the environment. They felt that they would obtain something good in their life, even from painful experiences. They seemed to feel that what developed in their personalities was proof of the very existence of the infant. This might represent a new relationship with the separated infant (Hagman, 1995, 2001). Progress in this sort of process seems very difficult.

As Klein (1940) stated, people who have lost a loved one can receive a new gift after they sustain their activated early developmental posi-

tion as much as an infant can develop a new ability after he or she sustains the infantile depressive position. Among parents who have lost a loved one, violent aggression is activated during disintegration, which they try to sublimate by various means. Perhaps they experience anguish in the disintegration. Because they cannot endure their violent aggression in the inner world (persecution), they try to sublimate their aggression into socially constructive behavior. The existence of containers is the most important element in this process. The guilt deriving from bereavement will never disappear, but individuals will seek to create meaning from the loss.

It is of clinical interest that mental health professionals pay little attention to the aggression and guilt of bereaved family members. This is particularly the case in Japan. The Japanese may be afraid of having to face aggression in people who lost an intimate person, or the cultural background may contribute to the fear of aggression (Hagman, 1995). Aggressive impulses seem to be viewed as a negative trait collectively among Asians. People in Asian countries tend to find it difficult to express aggressive impulses in front of others. A person expressing aggressive impulses toward other people is viewed as immature, whereas one who suppresses his or her aggression is seen as mature.

Most bereaved family members feel aggressive impulses toward medical personnel and have difficulties dealing with such feelings. Moreover, medical personnel often fear the negative attitudes of bereaved family members when treatment is not successful in preventing the death. When the medical staff feels that bereaved families blame them for the death of a loved one, they try to escape from or avoid bereaved families. However, bereaved families do not always want to criticize them, but rather want to ask about the cause of death, even in cases where the medical staff does not know the "answer." Bereaved families always seek the "reason" they had to experience the loss of a loved one (Attig, 2001). Medical professionals are often scared of being unable to answer such questions correctly.

Moreover, before treatment, bereaved family members have a fantasy of medical personnel as being omnipotent. This kind of fantasy is important in the relationships between patients and medical personnel. With such fantasies, patients do not accept any treatment with some risk. There are some bereaved family members who take out their grievances on medical personnel when the results are not what they want. Medical personnel have to be prepared to deal with this fantasy. Avoidance on the part of medical staff makes families even angrier. It also makes them suspicious toward themselves and the hospital. Thus, a vicious circle appears to form between medical staff and bereaved fami-

lies. This kind of circle often causes additional problems between medical staff and bereaved families.

While in hospital, the pediatric surgeon gently explained to us so I wrote to him. He replied with photocopies of the details of the operation. At the end of the letter, he mentioned that although there was nothing wrong about the choice of the operation, he apologized for not being able to save my child. Having read this, I cried. I still have this letter. I did not want them to excuse themselves but simply want them to say "sorry." (Y.E.)

After my baby's death, my wife and I thought that the reason for the death might be a side effect of the shot [of vaccine]. A committee meeting of doctors was held which reported that there was a possibility of such a side effect. There was no apologetic comment from the Ministry of Health and Welfare. Only the city authority sent an official letter to us. And they sent us money. I thought that if they admitted it, they should apologize. But this idea may be childish. When I see someone having a shot of vaccination, I will have an urge to say, "That will kill you." I am crazy! (K.M.)

Limitations

There are several limitations to this study that should be considered when interpreting the results. The participants chose to take part in this study on their own, and thus their responses cannot be readily generalized. Perhaps our participants already had an ability for integration. However, even though our participants may have had the ability, we believe that feelings toward disintegration were strongly activated and they had difficulties controlling them. This fact leads us to conclude that even psychologically normal people need professional psychological support during mourning.

We interviewed each parent once. The phenomenon of fluctuating between disintegration and integration and the process of moving toward integration could not be observed directly. Furthermore, Freud (1958) referred to excessive guilt of the bereaved family. He speculated that the source of the excessive guilt was aggression on the part of the bereaved family toward the lost loved one. We could not detect this kind of phenomena in this research. Therefore, we cannot clarify these mechanisms. Longitudinal, clinical observation is necessary. Nevertheless, interviews of this kind are not without advantages. Our observation in a single interview session suggests that many parents who have lost an infant can sublimate their aggression without any professional support. By this we do not mean to suggest that grief counseling is

meaningless. Mental health professionals must believe in the human ability to progress to integration. Finally, certain problems cannot be identified in this type of research. We did not refer to pathological guilt as proposed by Winnicott (1963). Further research is needed to investigate this matter.

There are complicated processes in mourning, as other clinicians and researchers have stated. Our hypotheses about mourning may be simplistic compared to the real phenomena. We do not claim that our hypotheses will explain all related phenomena.

Perhaps clinicians may use comprehensive interpretation techniques even with a client with neurotic personality organization, if they are persecuted in the inner world. Normal and pathological mourning can hardly be differentiated with clarity. They may be located at opposite ends of a spectrum from pathology to normality. Clinicians treating mourning have to clearly identify where a client is on this spectrum.

Bereavement is a very painful event. As Kübler-Ross (1970) mentioned, people who are bereaved change their value system, lifestyle, and identity. Aggressive impulses contribute to these changes. Containers need to use aggression constructively for mourners.

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