The Replacement Child— A Developmental Tragedy:

Some Preliminary Comments

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ABSTRACT: Some of the clinical and theoretical issues thought to be involved in the psychology of "replacement children" are discussed. A developmental framework is proposed within which to view such children. The replacement child is becoming an identifiable clinical syndrome, and a developmental framework is sorely needed to encourage more systematic research. A replacement child perceives his status differently on both a cognitive and emotional level within the context of each developmental phase, and the affective and associative links need to be reworked each time. We view the status of being a replacement child as a developmental interference insofar as demands are placed on the child's immature ego which he might not yet be equipped to cope with.

When a child has died, the parents sometimes attempt to assuage their pain and suffering over the loss by rather quickly conceiving a new infant or starting adoption proceedings. The new infant's entry into the family may interrupt, distort, and delay the mourning process but cannot resolve it, even though the expectations once held for the dead child are now transferred to a live one. For the child the situation is hazardous—not only does he have to begin life in an ambience of parental mourning, but moreover as he grows he has to establish self-identity in the shadow of another identity projected onto him via the family myth.

We would like to discuss, in a preliminary way, some of the clinical and theoretical issues that we believe may be involved in the psy-

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chology of replacement children. Our discussion is based on direct clinical experience with only one such latency-age child and, hence, is drawn more generally from our knowledge about psychological development and the tasks faced by children as they proceed through the developmental stages. We believe that it is helpful to formulate a preliminary developmental framework within which to view such children, even if it is based on limited clinical in-depth experience, insofar as it might stimulate the required more systematic collection of data, which in turn will permit us to refine our conceptualizations. It is our impression that more clinicians are becoming aware of an identifiable clinical entity known as the "replacement child" but that these impressions lack a developmental framework from which more systematic exploration can proceed.

We can speak of replacement as being a developmental interference; that is to say, it is an external and environmental interference impinging usually adversely on the child and making demands which the ego has not yet the capacity to cope with. The fact of having replaced a dead child will be perceived differently and have a changing significance both cognitively and emotionally as the child matures, and the affectual and associative links have to be reworked in the context of each progression. When adaptation has been poorly made during earlier stages, the replacement child is likely to be vulnerable and at risk during adolescence, as was the case with one intelligent 16-year-old girl.*

A. was admitted to the hospital for investigation of a pneumonia that had persisted for 9 months. The parents spoke of accident proneness and self-mutilating tendencies. Two years previously when a broken leg had been casted, there had been complications because of skin lesions under the cast, thought to have been self-induced by the introduction of a foreign substance. This and other incidents led to the request for a psychiatric consultation whereupon the complicating factor of a typical replacement syndrome was uncovered. The patient was the youngest in a family of five, an acknowledged replacement for the middle child who had died at age 3 years (prior to the conception of the patient), presumably a case of sudden death syndrome. The significant fact for the father was that respiratory arrest occurred shortly after a severe verbal admonishment from him and her being put in her crib and left alone in the bedroom. She was a child who had a history of breath holding when frustrated. When A. was born, she bore a strong resemblance to the dead child, and father said it was as if the dead child had come back to give him a second chance, and he would do anything to take care of her.

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*The authors wish to thank D. Trivedi, MD, for bringing this example to their attention.

Replacement children have received very little direct attention in the literature. Cain and Cain [1] discuss a series of six children referred for psychiatric evaluation, all of whom had replaced a sibling dying in latency or early adolescence. They observe such children to be interested in the topic of death and of naturally occurring catastrophes. Discussing the identity problems those children had, the authors note the relative absence of a sense of individuality, insofar as the parents ambivalently tried to transform them into replicas of their dead children.

Poznanski [2] describes the case of a 15-year-old girl with "depressions, a suicide attempt, nightmares of death and dying and the acquisition of a boyfriend who attempted to kill her." This girl had been conceived 2 months after the death of a 5-year-old sister who, according to the family myth, had predicted her own death and replacement. The literature appears not to have many specific references to cases in which the dead child died in infancy, yet this would seem to be a significant variable influencing the clinical picture. To substitute for a child who reached 5 or more year of life entails a steady progression toward a feared anniversary age with increasing awareness and growing comprehension of the reality of death. Nevertheless, until that anniversary is passed there is a historical real child to identify with as well as the distorted and idealized parental memory. In contrast to this, when the dead child did not survive infancy, the replacement child has passed the crucial age of his predecessor before becoming aware of the facts. The replacement for an infant death does not have even for a few years the historical "real child" to identify with. By the time he has reached an awareness of his replacement status there is only the family myth, fantasies, and expectations held by the parents that have never been actualized by a live child of his own age. It should not surprise us if these children show a peculiar quality of detachment, aloofness, and feyness and have even greater difficulty in building up a sense of self-identify.

When such children are genetically well endowed they may be gifted, creative artists, as for example in the case of Beethoven and van Gogh, but with only a fragile and tentative hold on life. Most biographers of Beethoven are somewhat silent about his early life. The first child born to Beethoven's parents, called Ludwig after a grandfather, died in infancy. Beethoven, born a year or so later, was given the dead infant's name, and it seems very probable that he was to some extent a replacement child. In van Gogh's case his letters to Theopillus and a psychoanalytic study made by Nagera [3] provide a clear picture of replacement as a developmental interference.

Replacement as a Developmental Interference

When we study the files of those replacement children for whom psychiatric evaluation and help have been sought, a picture emerges of children who walk in the shadow of death. One adopted replacement child who was referred for psychiatric evaluation in prelatency because he was considered dangerous to himself and others had a history of being afraid of ghosts and spooks. He told the examining physician, "Caspar spares mothers but not little boys. Ghosts scare me, they can kill you. They are mean and can kill you with a knife and cut you into little pieces."

Cain and Cain [1] comment on the preexisting pathology of those parents who, unable to tolerate and withstand the painful process of mourning a dead child, take a flight into new parenthood. It is not our present purpose to inquire into the antecedents of such a decision but rather to examine the consequences for the new child. It seems to us that such an examination has a certain timeliness, for as more parents restrict the size of their family, in accordance with present trends, there seems to be an increased probability that an intentional replacement child may be planned whenever a child dies. It is our position that in order for such a child to have a possibility of becoming a person in his own right there should be an appropriate lapse of time between the death and either conception or the start of adoption proceedings for a new child. The more common practice of expediting replacement may not be in the best interests of those most closely concerned. In the many interfaces between psychiatry and other medical specialties, especially pediatrics and obstetrics, there is an opportunity for preventive psychiatry in this respect. But if we are to convince others, we first have to be clear ourselves about the obstacles and stumbling blocks that a replacement status puts in a child's path causing detours from normal development.

Perhaps the circumstance of life most nearly analogous to that of the replacement child is the experience of being a twin. Reviewing the literature, Joseph and Tabor [4: p. 276] note that various authors found that "being a member of a twin pair (either fraternal or identical) had profound effects on personality development. By and large there is a mutual interdependency and failure completely to differentiate one's self from the twin, so that a complete self representation is not found." The "twinning reaction" results in a fusion of self- and object representations. The consequences are disturbances in ego boundary and identity for the twin. It may be that a replacement

child often may have the experience of being ambivalently tied to the "dead child" and that his situation vis-à-vis the dead child is likely to bring about difficulties similar to those just described. Moreover, the profound effect of guilt that may stem from being a replacement child should not be overlooked—his predecessor had to die in order for him to have been either conceived or adopted. Although consciously and intellectually the replacement child may recognize that he is not responsible for his predecessor's death, it can be hypothesized that at some level and probably unconsciously some of the "psychology of survivorship" may be operating. It can further be inferred that a substantial degree of existential anxiety, a sense of the finiteness of things, will be experienced due to feelings that are associated to the dead child, a sense of "there but for the grace of God go I." The identification with the dead child would encourage such an attitude. In terms of character traits, in our limited clinical experience with a replacement child, it can lead to impetuousness, pleasure seeking, here-and-now gratification, and a sense that fate and chance govern life.

If we look closely at the developmental sequences as they should unfold in the 1st year of life, it becomes apparent that a number of crucial developmental tasks are significantly vulnerable to the interference of the replacement status and its accompanying phenomena. It can be seen that the experience of being received into a grieving family and, as it were, handed a prefabricated identity, not one's own, represents a massive insult to early developmental processes, and this even when the congenital equipment, the genetic heritage, and irreversible perinatal influences show excellent potential for healthy development.

Anna Freud [5] describes the first 3 months of life as the stage of biological unity between the mother and infant couple. It is also a "relationship of adaptiveness." Hartmann [6: pp. 51-52] points out that "the newborn is in close touch with his environment not only by his need for its continuous care, but also by his reactions to its stimuli, though of course these reactions are often not at first specifically adapted." The mutuality between mother and infant, which represents a developmental achievement for the infant, is based on his own genetic endowment and on the mother's attitude toward him, described by Winnicott [7: p. 250] as "her capacity to make real what the baby is ready to reach out for, to discover or to create"; the main thing is the communication between the baby and mother in terms of anatomy and physiology of live bodies. How primitive

and rudimentary this dialogue is and how dependent on the mother's sensitivity to the infant's cues and her role as an auxiliary ego are highlighted by Spitz [8].

In one of his earliest writings Sigmund Freud [9] addresses himself to the topic of stimuli coming from the inside and the role these play in initiating dialogue. As a result of stimuli originating inside the body, as, for instance, hunger, the infant experiences tension that can be removed only through a change in the outside world. The infant can only discharge, not permanently relieve, his tension by random movements, screaming, and the like. The outside help that is necessary is activated by the infant's behavior. Freud [9: p. 318] points out that "this path of discharge thus acquires a secondary function of the highest importance, that of communication." The replacement child may have a harder than usual time in bringing about an understanding with the two most important people in his life, namely, his grieving parents. Sander [10] recognizes that the earliest interactions between mother and neonate bring about the initial adjustment and the formation of a "first regulatory stability" regarding the rhythms of feeding, elimination, sleeping, and waking. We wonder if mothers of replacement children may have difficulty responding to the rhythms of the new infant and try to impose the pattern of the dead infant. One mother described herself as at a loss to understand the new baby; she enumerated the differences between the new baby and the infant who had lived for only a few months—it was clear that she watched carefully for behavior in any way reminiscent of the dead infant. Such behavior, while consciously painful to her, nevertheless brought her quickest response. From the earliest months the behavior that is reinforced, by receiving the most parental attention, is likely to be behavior in some way reminiscent of the dead child. The reciprocity being built up between mother and infant may lack the spontaneity of a unique new relationship, for interposed between the mother and the new infant will be the shadow of the other child now and always. Behavior that is an any way reminiscent of the dead child may give rise to anxiety or grief, while behavior not like that of the other child may not be experienced positively by the mother either.

Polsby [11] broadens the term *replacement* to include those adopted children who replace the wished-for as well as the actually conceived child. One sees adoptive parents who are disappointed in their adopted children because of their failure to live up to the fantasied image of the ideal biological child. This causes the parents difficulties in detaching themselves from the imagined biological child and attaching themselves emotionally to the adopted child. In one such case,

the adoptive parents hoped for a child who would have fit their temperament and personality, which essentially was reflective and socially conservative. Instead their adopted child was action oriented and socially less restrained. This "mismatch" caused difficulties for the parents in terms of their inability to mourn the fantasied ideal biological child. In a similar vein, Deutsch [12], speaking of adoptions that are planned to replace an actual loss, states that "often the adoption represents an attempt to interrupt the mourning violently—a mistake that is usually followed by bad consequences." She finds that "the child adopted as a comforter has very poor chances of conquering the mother's heart" [12: p. 415].

As the replacement baby becomes more responsive to the mother, it may not be uncommon for her to withdraw from him. The parents, finding that the new infant has done little to resolve their grief, and that his presence has become conflictual for them, may retreat to activities outside the home, often becoming considerably involved in these. When this takes place in the second quarter of the infant's 1st year, it will coincide with the libidinal position of the narcissistic stage. The infant is now entering upon a need-fulfilling or anaclitic relationship with the mother, which, as Anna Freud [5: p. 65] points out, "is based upon the urgency of the infant's body needs and drive derivatives, is intermittent and fluctuating, since object cathexis is sent out under the impact of imperative desires and withdrawn again when satisfaction has been reached." The mother is perceived only in terms of her function as satisfier of the infant's needs. When the object, that is, the mother, is desired in and of herself, the stage of need satisfaction is left, and the beginnings of object constancy appear.

The need-fulfilling stage corresponds with Mahler's symbiotic phase during which the infant depends upon the auxiliary ego, that is, mother, to serve as a protective shield. When the mother is unavailable to serve as a protective shield, and according to the degree of her unavailability, cumulative trauma may occur and lead to ego distortion during the early phases of ego differentiation [13].

The 3rd to 6th months, the stage of need satisfaction in Anna Freud's terms, and of symbiosis between mother and infant in Mahler's, coincide with the libidinal position of primary narcissism [14]. When the psychological environment is impoverished during these months, development proceeds against heavy odds. In order to sustain a minimum of the necessary positive narcissistic feelings at this time,when the infant requires the caretaking adult partner as a provider of physical necessities and psychological warmth, the appropriate interaction between mother and infant makes possible the infant's

libidinal development, the unfolding of the ego, and the expanding of object relationships. The maternal cathexis toward the replacement infant, however, is likely to be distorted by grief, guilt, longing, and fears that offer interferences with the maternal pleasure in and acceptance of the infant as a unique organism. It is unlikely that the mother and infant will be able to experience a sufficiently rich and mutually rewarding symbiosis in preparation for the next libidinal position, that of object love in which the tasks of differentiation and individuation, leading to a stable sense of identity or self-constancy, have to be begun by the infant. When the earlier need for involvement and symbiosis has not been sufficiently satisfied, immature clinging to the object may alternate with too great a detachment from it.

Kohut [15: p. 215] discusses the developmental steps from the earliest libidinal position of autoerotism to the next position, that of primary narcissism as "a move toward increased synthesis of the personality due to a shift from the libidinal cathexis of individual body parts, or of isolated physical or mental functions to a cathexis of a cohesive self." Although at first this self will be grandiose, exhibitionistic, and unreliable, nevertheless, "the nuclei of the body self and of the mental self coalesce and form a superordinate unit." Kohut suggests that transmuting internalization of the mother's basic soothing and calming activities results when the child experiences an optimal amount of frustration. When the mother proves to be grossly unempathic the child clings to an archaic "unconditional perfection."

The infant then fails to develop certain internal functions that enable him to reestablish the narcissistic equilibrium through either self-soothing or an appropriate appeal to the idealized parent. Depending, among other factors, on the extensiveness of the mother's faulty response, there will be a hypersensitivity to disturbances in narcissistic equilibrium, with a tendency to react to sources of narcissistic disturbance by mixtures of wholesale withdrawal and unforgiving rage [15: p. 65]. Often because the mother is still grieving the lost child, her preoccupation precludes intuitive and empathic response to the replacement child and exceeds an optimally frustrating level. Kohut writes that "the small child, for example, invests other people with narcissistic cathexis and thus experiences them narcissistically, i.e., as self-objects. The expected control over such others is then closer to the concept of the control which a grownup expects to have over his own body and mind than to the concept of the control which he expects to have over others" [15: p. 26]. It seems that with replacement children this does not become modified in later stages, and at

7 or 8 they may still tyrannize over their objects in this way. It becomes almost a fight for survival, control of the object representing safety for the child.

From the fourth quarter of the 1st year the increasing motor skills allow the child to gain in autonomy; he can now make some decisions for himself, he can move away from, and back toward, the mother. The interferences in the earlier months may be reflected now in a too great disregard for mother and a tendency to wander out of her sight or by a clinging and not being able to leave her side. Anna Freud [16: p. 16] writes of situations where "the looseness and breaking of the emotional tie originate with the child, not with the parents." Such children's capacity for object love may be "underdeveloped for either internal or external, innate or acquired reasons." She points out that "this defect may become manifest in the symptoms of early wandering, frequently getting lost, truanting, etc. In these instances, the children do not accuse other people [of losing them] nor do they feel guilty themselves." This behavior has frequently been displayed by one patient, and we would expect it to be not uncommon among replacement children.

As the child grows into the 2nd year, the problem of separation-individuation increases for the mother, who, having lost one child, may tend to be overprotective, oversolicitous, and overrestrictive in her attitude.

Together with the hypersensitivity to disturbances in narcissistic equilibrium we find in these children a marked lack of cathexis of their own bodies [2]. The qualitiative lack in the object relationship has reacted adversely against investment of cathexis of their own bodies, thus enhancing the danger of self-destructive behavior. These children seem at times, as they grow older, to treat their bodies as expendable and to lack sufficiently strong ego attributes of self-preservation. They are from all aspects children at risk occuping a space that has a quality of otherness.

This quality of otherness may have a bearing upon certain identifications the young replacement child builds up. Freud has referred to the attainment of the position of esteem held by the object, as a motive for identification; for replacement children the object whose position of esteem they envy is the dead child. A complicating circumstance not to be overlooked is the conceptual gap that will exist for several years between an understanding of the dead child as an object of parental esteem and an ability to conceptualize death as a final state of no return. Identifications with the dead child probably are built up subtly, starting before there is comprehension of the other's

existence. It was noted earlier that the mothers of these children tend to reinforce behavior reminiscent of the dead child; it seems this gives a first impetus to what will come. Schecter [17: p. 66] discusses the link Spitz made between Piaget's conceptualization of stages of imitation and the infant's mirroring parental gestures. "The imitations occur in the course of the unfolding object relations mostly in games" and become "placed into the service of the child's spontaneous actions and games even in the absence of the adult." Spitz considers such interiorized imitations as evidence of identification proper since there is a modification of the ego's structure based on the perception and memory of actions observed in the libidinal object. Spitz [18: p. 394] comments that these early identifications are used for object relations and mastery, for defense, and attack.

We wonder if the games played with the replacement child are likely to be repetitions of games parents once shared with the dead child either in actuality or fantasy; which it is does not matter so much as does the attitude of the playing parent, and a psychological distance coming between adult and child as the play evokes for the parent a fantasy of playing with the other child. Thus the child has a model for "not being present." An early identification with this pattern of behavior may later become the behavior described by the mother of one replacement child: "He walks through the room as though it were empty, just drifts through without seeing us." The parent of a replacement child is inevitably in conflict; on the one hand, there is overinvestment in the replacement child as just that, while on the other hand, such a child is a constant reminder of the dead child, and the parent may therefore unconsciously wish him dead too, an attitude that the replacement child may sense and identify with.

As the child moves through the toddler years, it is expected that his imitative play will help him to build up identifications that will prepare him to take his place outside the home. Schecter [17] writing of identification and individuation, notes that "identifications function as organizing structures in which the mastery of relatively autonomous ego functions (e.g., motility, speech, cognition) can join forces with attempts at mastery of emotionally laden conflicts." The need to give up the symbiotic mother and the resulting experience of loss and frustration tend in normal circumstances to push the child forward to higher levels of identification, but when the symbiotic partnership has never progressed to a satisfactory dialogue it cannot be given up. One replacement child's solution was to move away from people and to identify with dogs and animals; though present, identi-

fications with people were tenuous. The replacement child is caught in a dilemma, for he is not likely to have a mother who can reliably be present for *him*, who can be experienced as specifically his emotional nurturance. The mother may indeed be reliably present, may indeed be the source of supplies, yet the child will experience deprivation—the cathexis accompanying the parenting is directed toward another child, toward a painful memory, and things are done for him and to him as if he were another child. It is not his self but another's that is cherished. His primary objects respond to him "as if" he were another, and in turn he starts behaving "as if" he were the other. A reciprocal reinforcement begins with parents and child becoming locked into a pseudoreality.

Schecter [17: pp. 74-75] speaks of "magical attempts to fulfill the ideal" that one sees in the inauthentic identification of "as if" personalities. This aptly describes one replacement child's many and varied attempts to take on the identity of another. For many months he refused to stay as himself during therapy sessions but presented his therapist with a parade of characters who came in fleetingly one after the other but who could seldom be engaged in meaningful dialogue or persuaded to stay. This constant trying on of pseudoidentifications with a curious detachment from reality and often exaggerated speech and mannerisms was a poignantly clear reenactment of the dilemma of this replacement child who is also an adoptee. The replacement child's self-identity is jeopardized because parents tend to impose on him a dead child's identity; the adoptee's sense of self is threatened by the very fact of not knowing his biological origins. Nevertheless, in our limited experience, it is impressive that where both variables are present the factor of being cast in a substitute role for a dead child appears to be the incisive factor in pathology.

Schecter [17: p. 75] raises the question as to whether pseudoidentifications can in any way lead to the same outcome of normal identification processes that results in an alteration of the self and increasingly differentiated psychic structure, while at the same time permitting the self to retain the "basic continuity" of its own identity. Schecter draws an analogy from embryology remarking that "in order for tissue to be plastic and susceptible to taking on the form of inductive tissues it must be in a state of relative undifferentiation." He asks whether "the de-differentiation of aspects of the self that occurs during the various forms of 'attachment' with the love object represent a similarly 'plastic' precondition for the initial stages of identification. . . . ('Before I can become *like* you in this way, I must

experience *being* you')" [17: p. 75]. We would agree that this may imply a temporary blurring of the boundaries of self and object in the service of further growth and differentiation.

The above conceptualization of the normal process of identification helps us to understand the pull toward the otherness of death in prelatency replacement children and yet their fear of it when hurt. One boy, referred to earlier, twice endured pain and hurt through self-destructive acts and each time greeted his rescuer with an outburst of tears and sobbing that he didn't want to die. If, as Schecter proposed, "before I can be *like* you in this way, I must experience *being* you in this way," then in order to win the parents' esteem through identity with the dead child it is necessary first to experience being dead, yet this experiencing being dead is meant to lead to an identity that will sustain life. The conflict between living and dying is enhanced by the young child's partial concept of death.

The replacement child seems often to be so burdened with a search for a living and livable identity that he has neither time nor freedom for age-appropriate play. This, of course, is a gross oversimplification, but predictably the prelatency replacement child is not free to enter into age-appropriate levels of peer play. Freud [19] introduced the term *repetition compulsion* to describe the child's inner pressure to repeat unmastered experiences. Greenacre [20: p. 63] thinks "we might more accurately speak of repetitive tendencies of which the repetition compulsion is one form." Greenacre [20: pp. 65-66] reminds us of how play is driven by an inner maturational push to grow and a psychological wish that exerts a pull to grow up. Since the young replacement child is conflicted over growing up, he is not likely to participate in play arranged with this theme in mind. He may often not be able to anticipate a long-range future for himself, nor is he helped by the possibility that, as Greenacre [20: p. 66] says, "play may appear as a paradoxical kind of make believe reality testing, in which the child holds the joker through the fact that much of play is make believe even when expressed in overt action. It is not then 'real reality.'"

In the case of one replacement child, it was not until he was 8 years old that he could tell the therapist about "different kinds of being real," implicitly appreciating the difference between pretense and reality. A model Christmas tree he had made was a real one—but when they got the tree with leaves at home, that would be a different kind of real, and a tree outside with roots in the earth would be still another kind of real. Much of the play behavior of this replacement child is solitary or in terms of a one-to-one encounter with another

person. For the replacement child, the reality of his own identity cannot be used as a reference point from which he can securely participate in the make-believe reality testing of play, in Greenacre's sense.

Not a lot is known about van Gogh's manner of playing. Nonetheless, some remarks made by Greenacre [21: pp. 626-627] concerning identity are relevant. She suggests that for artists particularly there is an instability of identity because of their peculiar contextual relationship to their surroundings, their sense of multiple identities, and so forth. Therefore, we may assume that the status of replacement child sits with extraordinary heaviness on a particularly gifted or sensitive child.

What we have attempted in the above is to trace the unfolding of early development, interweaving what we infer and what we observed, albeit in a limited way, to be the peculiar developmental obstacles that a replacement child and parents are faced with in the passage of the child through successive developmental stages on the way to formation of a consolidated identity. If the above developmental foundations serve as a springboard for more systematic investigations, then we have achieved our aim.

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