USE OF THESES

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Bereavement and Personal Change

by

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1976
David Hume

David Hume

Acknowledged.
and all sources have been
This work is my own composition.
. . . I will not hold back
these mad cries of misery, so long as I live.
For who . . . who that thought right
would believe there were suitable comforting
words for me?
Forbear, forbear, my comforters.
These ills of mine shall be called cureless
and never shall I give over my sorrow,
and the number of my dirges none shall tell.

Sophocles: Electra

Ay, go to the grave of buried love and
meditate! There settle the account with thy
conscience for every past benefit unrequited -
every past endearment unregarded, of that
departed being, who can never, never, never
return to be soothed by thy contrition!

Washington Irving: Rural Funerals

Man by suffering shall learn.
So the heart of him, again
Aching with remembered pain,
Bleeds and sleepeth not, until
Wisdom comes against his will.

Aeschylus: Agamemnon
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I

MOURNING AND GRIEF.

The numerous systematic studies of bereavement
behaviour made in recent decades probably stem from Freud's
"Mourning and Melancholia" (1917) and have been much influenced
by his concept of the "work of mourning". The aim of this
paper is to consider the meaning of this term, the processes
which it connotes and its appropriateness in the light of the
large body of knowledge now available about bereavement
behaviour.

'Grief' is taken to mean the ordinary painful
emotion experienced at the death of a loved person who has
been significant in the life of the bereaved. Freud wrote of
"the normal emotion of grief"; Autton (1967) wrote, "Grief
is an emotion and a very painful one" and quoted the classic
account of the grief experience of King David:

And the king was much moved, and went up to the
chamber over the gate, and wept; and as he went
thus he said, 0 my son Absalom, my son, my son
Absalom! Would God that I had died for thee, 0
Absalom, my son, my son! (II Sam 18:33)

It is the pain of loss, the sorrow of separation, the hurt of
permanent severance from someone who is felt to be a "part"
of oneself. Its most common expression is tears of sadness
and regret which flow unbidden and unsought as the pang of
grief is felt.

The pain of grief is just as much a part of life
as the joy of love; it is, perhaps, the price
we pay for love, the cost of commitment.
(Parkes 1972 p.5)
'Mourning' is taken to refer to the behaviour of the bereaved person which is the concomitant and expression of grief. Most mourning behaviour is overt and visible. There is a wide range of mourning behaviour, varying from attending a funeral service in pained silence to taking part in wildly abandoned wailing and dancing; from sea-bathing to physical mutilation. Social custom determines the parameters of permitted mourning behaviour. It may be expressed in formal ceremonies and formulae of words which are culturally prescribed. It is not inappropriate to see mourning behaviour as expressive of a dramatic role in the social milieu; the mourner is required or permitted to act in certain ways only when he is bereaved, as though society, on the one hand, says, "You must do this and this if you want us to treat you as bereaved"; and as though the mourner, on the other hand, says, "I am mourning, so you will permit me to act in this way."

The length of time in weeks or months, during which the mourning behaviour is acceptable, is often prescribed by social custom.

The distinction between 'grief' and 'mourning' seems to be worth keeping. So it did to Parkes when he wrote (1972 p 108n): "'Grief' is taken to imply the experience of deep or violent sorrow whereas 'mourning' implies the expression of sorrow." (Parkes' italics). Grief is a subjective experience, a symptom, known to the bereaved person; mourning is objectively observed behaviour, a sign, known to the observer. Despite this useful distinction, the common use of language is such that 'grief' and 'mourning' seem often to be used synonymously, and when this happens in scientific writing it causes problems of communication and interpretation.
Difficulty arises also from the way in which 'grief' may be used to refer not only to the emotion as described above but also to the whole range of feelings and emotions and attitudes that are associated with grief. Even when a specific attempt is made to define the terms 'grief' and 'mourning', clarity is not always achieved.

'Mourning' will be used to denote the psychological processes that are set in train by the loss of a loved object and that commonly lead to the relinquishing of the object. 'Grief' will denote the sequence of subjective states that follow loss and accompany mourning. (Bowlby, 1961a: p.318)

Grief is a peculiar amalgam of anxiety, anger and despair ... Mourning is the whole complex sequence of psychological processes and their own manifestations, beginning with craving, angry efforts at recovery, and appeals for help, proceeding through apathy and disorganization of behaviour, and ending when some form of more or less stable reorganization is beginning to develop. (Bowlby, 1961a: p.332)

When a love tie is severed, a reaction, emotional and behavioural, is set in train, which we call grief. (Parkes, 1972: p.xi)

No doubt the use of these words 'grief' and 'mourning' has changed over recent decades as mourning customs have changed. The word 'mourning' has an archaic flavour, reminiscent of nineteenth century funeral customs with compulsory black clothing, black arm bands and solemn family ceremonies not much observed today. Over the same period when 'mourning' was falling into disuse, 'grief' was becoming a respectable, medical and 'scientific' word, largely because of the considerable influence of Lindemann (1944) in his famous study of acute grief. He defined grief as a syndrome of symptoms and by means of his report and even by the phraseology of the title "Symptomatology and Management of Acute Grief" lifted the study of mourning and bereavement out
of the specialised issues of psychoanalysis and pastoralia and made it recognizably a matter of general concern for medical science. In the introduction he wrote:

The points to be made in this paper are as follows

1. Acute grief is a definite syndrome with psychological and somatic symptomatology.

2. This syndrome may appear immediately after a crisis; it may be delayed; it may be exaggerated or apparently absent.

3. In place of the typical syndrome there may appear distorted pictures, each of which represents one special aspect of the grief syndrome.

4. By appropriate techniques these distorted pictures can be successfully transformed into a normal grief reaction with resolution. (1944:p.8)

It is clear from this summary and the evidence that follows that the widest range of physical and psychological phenomena are comprised in the grief syndrome. As well as the various emotions, feelings, attitudes and thoughts associated with bereavement, the syndrome includes every kind of mourning behaviour, "normal" and "abnormal". By an admirable and shrewd insight, Lindemann transformed the Freudian phrase "the work of mourning" and called this process "grief work". In scientific studies today the terms "grief reaction" and "the reaction to bereavement" are used interchangeably. For example, Parkes wrote, "Two types of reaction became apparent in the disturbed group: one was a tendency for grief to be prolonged; the other was a tendency for the reaction to bereavement to be delayed." (1972:p.107)

It seems to be a matter of regret that these semantic changes have taken place. Confusion arises from
misunderstanding of what an author may mean. The word 'grief' is commonly used with a very diverse range of meanings. Sometimes an author seems to want to assert that one of the "symptoms of Grief" is grief. Parkes often uses the word in its widest sense, as having various phases and processes: "irritability and anger are a feature of the early (yearning) phase of grief." (1972:p.79); he can also write of grief as a specific pain:

The most characteristic feature of grief is not prolonged depression but acute and episodic 'pangs'. A pang of grief is an episode of severe anxiety and psychological pain. At such a time the lost person is strongly missed and the survivor sobs or cries aloud for him.

Pangs of grief begin within a few hours or days of bereavement and usually reach a peak of severity within five to fourteen days. At first they are very frequent and seem to occur spontaneously but as time passes they become less frequent ... (Parkes, 1972:p.39)

A more important difficulty that has arisen in modern discussions which use 'grief' in the widest sense, is that the means of coping with the pain of grief, the strategies employed to tolerate, minimise or otherwise deal with it, are referred to as "symptoms" of grief. Many of the behaviours categorized by Lindemann as "symptoms" seem rather to be strategies for relief of discomfort: for example, preoccupation with the image of the deceased, self-reproach and guilt feelings, denial, hostility, identification and other neurotic responses. It is as though the "symptomatology" of cutting your foot were described as pain, a bleeding cut, sitting down, applying digital pressure, being irritable or angry with others, sympathy-seeking behaviour or self-reproach; or denial of the injury and vigorous
cutting of more wood. There is a difference between those consequences of bereavement which may be called "signs and symptoms" and those consequences which may be called "first aid" or "coping strategies". This distinction should be made in studies of bereavement behaviour.

A further cause of confusion is listing symptoms and strategies according to a sequence of categories, and making generalisations about the course of grief or the sequence of the grief reaction as though all bereaved persons "go through" a sequence of behaviours. Lindemann (1944:p17) first used the term "phases of grief" in a rather general way in referring to the anticipatory grief reaction of those who are expecting someone to die; but Bowlby's account of "Processes of Mourning" described a specific three-phase theory which has been influential:

At all ages, we now see, the first phase of mourning is one of Protest, the second one of Despair, and the third one of Detachment. (Bowlby, 1961:p.338)

In conclusion he wrote:

Points I have stressed particularly are .... the urge to recover the lost object that is dominant throughout the first phase of mourning, the weeping and aggressive acts that are part of it, and the roles of disorganization and subsequent reorganization that are the main processes in the second and third phases. (Bowlby, 1961:p.338)

The influence of Bowlby's three "phases" is seen in a number of books written for counsellors and ministers:

First, however, it is necessary to understand what "complete mourning" means. An analytic description by Bowlby has pictured mourning, both in its overt and hidden reactions, as
covering a series of three overlapping stages. The first stage, set in motion by the news of the death, is characterized by a kind of numbness and disbelief as the bereaved person attempts to deny the reality of what has occurred. A second stage involves the disorganization of the bereaved one's personality as the death is reluctantly accepted as a fact. Eventually this stage of disorganization should give way to a third stage in which the personality of the bereaved undergoes reorganization. He sees his loss in a new perspective, as something that has occurred in the past, whereas he still has future time in which to live. (Paul, 1969:p.181)

Pangs of grief begin within a few hours or days of bereavement and usually reach a peak of severity within five to fourteen days. Bowlby has called this the phase of yearning and protest. Anger is also at its peak during this phase. (Parkes 1972:p.39)

Interpreting bereavement behaviour by means of the medical model of disease can be misleading. As has been mentioned above, it encourages the categorization of coping strategies as symptoms, and the postulation of a progress or course of behaviours through which a bereaved person must move, on the analogy of the progress of a fever or the healing of a physical disease. Further, there is the implicit assumption that once the course of action is set in motion, barring pathological fixation at some stage, the bereaved person will move along the prescribed course as if responding instinctively. The hint of biological determinism is very strong.

Rather than defining phases or stages of a medical or physiological kind, we may profitably think in terms of the diverse ways persons adjust their responses to unpleasant realities, change their self-image in accord with reality feedback, modify their behaviour in response to environmental pressures, and accept the interior pains of change and growth and becoming.
This inquiry is concerned primarily with the experience of bereavement following the death of a loved, significant person, but it should be recognized that other kinds of painful loss show the typical features of bereavement: for example, prolonged separation caused by such conditions as war or imprisonment; divorce, desertion by spouse or parent or child; loss of limb, disablement (such as that of stroke or injury) or disfigurement; loss of job (as through illness or retirement or termination of contract or demotion); loss of possessions or property; loss of pets; departure of members of family from home; relocation of dwelling. Although it is not the intention of this study to examine these kinds of bereavement behaviour in detail, the facts are of significance. They suggest ways in which adjustment is made to serious loss other than bereavement and they emphasise the importance of self-image, self-confidence and self-esteem in the adjustment of the "bereaved" person.

A related experience of loss is that which Lindemann called "anticipatory grief reaction". A person can be so deeply concerned about the expected death of a loved member of the family that he goes through all the phases of grief: depression, heightened preoccupation with the departed, a review of all the forms of death which might befall him, and anticipation of the modes of re-adjustment which might be necessitated by it. (Lindemann, 1944:p.17)

This can mean that a person is already partly adjusted to the death when it occurs and the grief reaction is less painful. When anticipatory grief reactions take place in regard to an absent soldier who returns or to a sick person who is believed to be dying in hospital but recovers, there can be a painful
readjustment at the re-union when the "bereaved" person must allow herself to enter into a vulnerable relationship again to accept new interaction. (Bermudes, 1973)

Such unfortunate and painful experiences emphasise the importance of the personal relationship which the "bereaved" person has with the "lost" person and the central significance of the self-image which is formed out of the perceived personal relationships. It is the self-image which facilitates the painful adjustment when the personal interaction with the reality or memory of the loved person is frozen or deliberately diminished to allow the "bereaved" person to function in a situation of painful loss and anxiety. It is the self-image again which must alter when the anticipated grief reaction must be reversed and the personal interaction and personal relationship must be reheated and re-activated after the lost person returns home.
II
THE WORK OF MOURNING.

Having observed that mourning and melancholia are brought about by the same kinds of external influences, Freud (1917) proposed to study the nature of melancholia by comparing it with "the normal emotion of grief and its expression in mourning." His idea of mourning included reaction not only to the loss of a loved person but also "to the loss of some abstraction which has taken the place of one, such as fatherland, liberty, an ideal, and so on." He assumed that this loss of a loved one would bring about a state of grief in most people but in those with a "morbid pathological disposition" the bereavement would lead to melancholia.

According to Freud's observations, the features of mourning and melancholia are the same except for one. They both manifest

1. a feeling of pain or "painful dejection"
2. a loss of interest in the outside world
   (except in so far as it recalls the dead one)
3. loss of capacity to love (which would be a replacing of the one mourned)
4. an inhibition of or turning away from all activity not connected with thoughts of the dead person.

The feature he observed in melancholia and not in normal mourning was: a fall in self-esteem, expressed in self-reproaches and condemnations and in an expectation of punishment.
In normal grief, the ego is inhibited and circumscribed by its "exclusive devotion to its mourning" which leaves no energy or interest for any other matter. If we did not know that the cause was the bereavement, we would consider such an attitude as pathological. By a remarkable insight, Freud described the activity of mourning as a "work"; that is, he saw the person as striving to accomplish something difficult that required energy and effort of will; the work was bringing about a desired end or state such that when the end was reached the work could cease; while the work remained unfinished the person would experience discomfort but when it was completed he would enjoy his rest. There is some suggestion that he saw the work of mourning as similar in some ways to the work of psycho-analysis itself by which a patient was able to be liberated from the dominance of painful memories by releasing each memory from its charge of negative emotion and incorporating the "de-fused" memory into the consciousness. Of the work of mourning, Freud wrote:

Now in what consists the work which mourning performs? I do not think there is anything far-fetched in the following representation of it. The testing of reality, having shown that the loved object no longer exists, requires forthwith that all the libido shall be withdrawn from its attachments to this object. Against this demand a struggle of course arises - it may be universally observed that man never willingly abandons a libido-position, not even when a substitute is already beckoning to him. This struggle can be so intense that a turning away from reality ensues, the object being clung to through the medium of a hallucinatory wish-psychosis. The normal outcome is that deference for reality gains the day. Nevertheless its behest cannot be at once obeyed. The task is now carried through bit by bit, under great expense of time and cathetic energy, while all the time the existence of the lost object is continued in the mind.
Each single one of the memories and hopes which bound the libido to the object is brought up and hyper-cathexed, and the detachment of the libido from it accomplished. Why this process of carrying out the behest of reality bit by bit, which is in the nature of a compromise, should be so extraordinarily painful is not at all easy to explain in terms of mental economics. It is worth noting that this pain seems natural to us. The fact is, however, that when the work of mourning is completed the ego becomes free and uninhibited again. (Freud, 1917:p.144)

The principles enunciated here may be expressed in this way:

1. Emotion-charged memories concerning the lost person continue to dominate the thought and action of the bereaved as though all the emotional "unfinished business" of the relationship demands attention.

2. The bereaved person must systematically consider each memory by which he is attached to the dead person and, acknowledging the reality of death, sever the emotional attachment.

3. This is a painful process because the emotions, negative and positive, must be entered into, acknowledged and dealt with.

4. It is a work or a task, undertaken deliberately by the bereaved person, "carried through bit by bit" until "each single one of the memories and hopes which bound the libido to the object is brought up" and, presumably consciously, released of its charge of emotional energy.

The concept of the responsible and determined activity of "work" is indicated at other places where Freud adverts to this topic.
In grief we found that the ego's inhibited condition and loss of interest are fully accounted for by the absorbing work of mourning. (1917:p.145)

Mourning occurs under the influence of reality-testing; for the latter function demands categorically from the bereaved person that he should separate himself from the object, since it no longer exists. (1926;p.290)

Writing of the same process taking place in melancholia, he said,

this withdrawal of libido is not a process that can be accomplished in a moment, but must certainly be, like grief, one in which progress is slow and gradual. (1917:p.158)

Again writing of this work of mourning in the case of 'normal grief' he said,

In normal grief, the loss of the object is surmounted, and this process absorbs all the energies of the ego while it lasts ....

Reality passes its verdict - that the object no longer exists - upon each single one of the memories and hopes through which the libido was attached to the lost object, and the ego, confronted as it were with the decision whether it will share this fate, is persuaded (by the sum of its narcissistic satisfactions in being alive) to sever its attachment to the non-existent object ....

The work of grief, by declaring the object to be dead and offering the ego the benefit of continuing to live, impels the ego to give up the object. (1917:p.157-160)

The similarity of this process to the regular psycho-analytic means of therapy used in cases of neurosis is obvious. In writing of the earliest researches Breuer and he undertook, Freud wrote,

Our hysterical patients suffer from reminiscences. Their symptoms are the remnants and memory symbols of certain (traumatic) experiences .... they cannot escape the past
and neglect present reality in its favour. This fixation of the mental life on the pathogenic traumata is an essential, and practically a most significant characteristic of the neurosis. (1910:p.8)

After bereavement, the emotionally-toned material associated with the lost person which, because of unpleasant negative feelings has been forgotten or repressed, must be activated and acknowledged if the work of severance from the lost person is to be accomplished. As each memory is entered into, and appropriated and its negative elements resolved, neurotic behaviour associated with memories of the lost person is largely eliminated; at the same time, the bereaved person can bring about the emotional severance of the lost person from his own self-image. More and more he sees himself as functioning and enjoying satisfactions without the lost person. This severance may usually be accomplished by the effort of the bereaved, with the encouragement of empathic friends and the assistance of opportunities provided by mourning customs of society.

Sometimes the lost person may be associated with very painful and deeply repressed material from earlier years. When this happens, there is probably a need for skilled counselling or psychotherapy to deal with the disabling neurotic or psychotic symptoms that may manifest, and which will prevent the necessary severance being accomplished until they are adequately dealt with.

It is possible for the death of a less significant person (for example, of a distant relative or of a national figure like a President, or even of a domestic
pet) to activate the unresolved grief of an earlier, more significant loss, if the person first lost was associated with repressed material. In this case, the recall and appropriate management of the repressed material is necessary to permit the bereaved person to effect the emotional severance from the first person. When this begins to take place, the subsequent grief can usually be resolved.

Freud, in the long passage quoted above (p.11), mentioned his difficulty in understanding why the process of hyper-cathexis in mourning is so painful. He took this up again some years later and observed the "peculiar painfulness" of mourning. (1926:p.287) The pain of mourning work is of particular importance, for it is this pain which tends to prevent a bereaved person from carrying out the necessary work. It may be likened, in a crude way, to the removal of a splinter from the skin. The process is painful; the skin must be pricked and torn to effect a release. Sometimes we would rather disregard the discomfort or deny it rather than go to work. Of course, when a worse discomfort develops by our neglect, we may take courage and plunge in the needle, or require someone else to inflict the pain on us.

The bereaved person is often aware that he prefers to turn away from the painful memory and shirk the necessary work. Of a widow, Mrs. C., Parkes wrote:

She still found her memories so painful that she tried to avoid them but she felt that there was something wrong about this. "I don't talk about him. I avoid thinking about him. It's easier to die than to keep on like this." (1972:p.11)
Sometimes friends and family contrive to inhibit the expression of painful feelings. A widow described how her sister would not let her cry:

"At the funeral she said, 'People can hear you.' The undertaker told her to leave me alone .... My sister says, 'He's gone and there's an end to it.'" (Parkes:1972:p.139)

Parkes gave his opinion that there is an 'optimal level of grieving' which varies from one person to another. Some will cry and sob; others may express their painful feelings in another way. "The important thing is for feelings to be permitted to emerge into consciousness." (p.162) "Give sorrow words," said Malcolm to Macduff. "The grief that does not speak, knits up the o'erwrought heart and bids it break."

In referring to the pain of the work of mourning, Freud wrote:

In discussing the subject of mourning on a previous occasion I found that there was one feature about it which remained quite unexplained. This was its peculiar painfulness. And yet it somehow seems self-evident that separation from an object should be painful. Thus the problem becomes more complicated: when does separation from an object produce anxiety, when does it produce mourning and when does it produce, it may be, only pain? (1926:p.287)

He frankly admitted that there was no way of answering that question at that time but made the following observations.

1. Anxiety is the reaction to the danger which the loss of a loved person entails.

2. Pain is the actual reaction to the loss of the loved object. The common usage of speech has created the notion of internal mental pain and treats the feeling
of loss of the loved object as equivalent to mental pain. The "intense cathexis of longing which is concentrated on the lost object (a cathexis which steadily mounts up because it cannot be appeased)" is comparable to the "cathexis of pain which is concentrated on the injured part of the body" in physical pain.

The cathetic process continues and it cannot be inhibited or reduced as long as the loved object is so cathected. This is what produces the state of mental helplessness. The only course of action for the bereaved person which will lead to a healthy adjustment is to undertake the work of mourning while the pain of grief is being experienced.

3. Mourning occurs under the influence of reality-testing. The loved object no longer exists and reality requires that the bereaved person should separate himself from the object. "Mourning is entrusted with the task of carrying out this retreat from the loved object in all those situations in which it was the recipient of a high degree of cathexis." (1926:p.290-291)

The task of mourning is painful because it must be undertaken by (i) reproducing from memory the very situations which expose the bereaved person to the "cathexis of longing which is concentrated upon the object", and while so doing, by (ii) undoing the ties that attach him to the object.

A more recent statement (Pollack 1961) of the Freudian doctrine emphasises the necessity for the mourner to experience and tolerate the pain associated with loss.
This acceptance of pain and of reality is seen as essentially the biological principle of an adaptation of the organism to the environment.

In "Mourning and Melancholia" Freud states that mourning work involves the testing of reality that shows that the loved object no longer exists and requires 'that all the libido shall be withdrawn from its attachment to this object'. Thus when reality-principle operation takes over, there is a consciousness of the external world without the departed object. This absence is not only perceived but is confirmed by repeated confrontation of the external world, and is finally noted and remembered. There may be partial repression of the pain involved in the loss. This pain will be re-experienced periodically throughout the mourning process and the experience integrated in the later stage of mourning work. As the ego passes judgment on the truth and permanence of the loss, action and thought processes are utilised to facilitate appropriate alterations of reality with subsequent adaptation. (Pollack, 1961: p. 348)

The implication of these statements is that mourning work is always accompanied by the pain of the awareness of loss of the loved person; pain, however, is not always accompanied by mourning work, as much of the empirical evidence confirms. For the pain of grief to be accompanied by effective mourning work, there must be a willingness to accept the reality of death and its consequences. When reality is denied in any way, the pain may be ameliorated but it is ultimately inconsolable.

Helene Deutsch made a distinguished contribution to the study of the work of mourning in her reflections on several cases of bereavement when grief was notably absent (1937). She accepted Freud's principle and described it as "a normal function of bereaved individuals by which the libido invested in the lost love-object is gradually with-
drawn and re-directed towards living people and problems." She commented that we might expect that if the force of the positive ties binding the person to the loved one were very great, the result might be that the work of mourning could be excessive or delayed. The result of her clinical observations, however, corroborated Freud's finding that in the bereaved person, more important than the intensity of the positive ties was "the degree of the persisting ambivalence".

If there exist negative and inimical feelings towards the lost person which had required forceful attempts to overcome them, then the work of mourning would encounter great difficulties as the person retreated from a position so achieved. If a bereaved person had serious guilty or hostile feelings or experiences of severe hurt in relation to the deceased loved person, these feelings, denied or defended against by vigorous psychic energies, would not readily surface to consciousness where they could be dealt with by the ego; so, the work of mourning would be frustrated. The result for the bereaved could be the occurrence of severe anxiety and even "lead to a brooding, neurotically compulsive even melancholic character."

These processes were observed, she claimed, in several case studies characterised by absence of grief. She gave the opinion that

1. Omission of reactive responses to bereavement is as much a variation from the normal as is excess

ii. Unmanifested grief will be found expressed to the full in some other way.
It may be assumed that the true feelings associated with the lost person are so unpleasant as to provide a vital threat to the ego. If the intensity of the affect is too great or if the ego is too weak (or otherwise occupied, as when it is subjected to intense cathexis on some other account, as for example, the case of a widow needing to care for infants) then a defensive and rejecting mechanism operates to screen out the offensive truths; the result may be the omission of affect, the absence of normally expressed grief feeling.

She gave several illustrations:

i. A man was angry with his mother in infancy because she left him. At his mother's death when he was 19 he had no feelings and had a history of breaking off friendships without pain. He presented as "unmotivated depressions."

ii. A man who hated his mother in infancy was indifferent to her death when he was 32 but manifested tormenting guilt feelings and organic symptoms of conversion hysteria, with compulsive weeping isolated from any reference to his mother.

iii. A boy's mother died when he was 5 years. His negative and aggressive feelings were so repressed that by 30 his entire emotional life was dead.

iv. A woman whose parents were divorced when she was a child manifested in adult life a complex emotional disturbance characterized by weeping for no apparent reason, and emotionless behaviour in situations when emotion would be anticipated.
Deutsch concluded that "every unresolved grief is given expression in some form or other." This striving for realization inherent in the grief feelings leads to wholesome detachment of the feelings from the loved person in the course of normal mourning. She wrote:

The process of mourning as reaction to the real loss of a loved person must be carried to completion. As long as the early libidinal or aggressive attachments persist, the painful affect continues to flourish; and vice versa, the attachments are unresolved so long as the affective process of mourning has not been accomplished. (Deutsch, 1937:p.21)

Whatever the motive for excluding the affect of grief, and whatever way it may find pathological or otherwise disguised expression (which may be displaced, transformed, hysteriform, obsessional or schizoid) the flight from the suffering of grief is only a temporary gain for "the necessity to mourn persists in the psychic apparatus."

Perhaps it may be put rather differently: the painful feelings of longing and loss which focus on the loved and lost person can never be relieved until the true feelings, positive or negative, can be brought into present experience so that the tie may be severed once and for all. While some feelings are denied and driven to neurotic or pathological expression there can be no true liberty for the bereaved person to become re-constructed by the creation of new relationships.

The process by which the bereaved person separates himself from the loved person has been the subject of a good deal of complex controversy. Despite the immense value of systematic clinical studies of bereavement behaviour which
was demonstrated by Lindemann's work, much of the discussion about theory of mourning has continued without close reference to an adequate body of clinical material.

For Freud, the method of the work of mourning was for the bereaved ego to effect identification with the lost object, the identification being regarded as compensation for the loss sustained in separation.

When it happens that a person has to give up a sexual object, there quite often ensues a modification in his ego which can only be described as a reinstatement of the subject within the ego ... ; the exact nature of this substitution is as yet unknown to us. (1923:p.254)

If one has lost a love object or has had to give it up, one often compensates oneself by identifying oneself with it. (1933)

It is rare to find this theory related to clinical evidence. Bowlby objects to the emphasis on identification because he is not satisfied that it is the main process involved and because, in Freudian theory, identification is seen to be almost exclusively oral in character. (1961a:p.319) In any case, Bowlby objects to what he calls the "hydrodynamic model of instinct" in Freudian theory by which libido is seen as a quantity of energy which undergoes transfiguration. Instead he attempts to formulate a concept of mourning based on a theory of component instinctual responses. Another objection of Bowlby is the Freudian view that narcissism is primary and precedes object relations. Bowlby implies that the work done in clinical observations on children's behaviour sets aside as irrelevant much of Freudian theory on the dynamic of object relations.
Melanie Klein (1940) assumed the primary importance of object relations and recognized how important infant experiences of separation and bereavement are for later personality development. The way a child responds to separation and loss of a loved one in infancy and early childhood determines the way he deals with bereavement in later life. She saw mourning as a work of reorganizing object relations and despite her undue emphasis on the importance of breast-feeding and weaning and the process of oral introjection in her understanding of identification, she emphasised that the work of mourning is one of "re-establishing and re-integrating" the inner world. Like Bowlby, she saw mourning as a phase of disorganization followed by one of reorganization. The image she used is one of building the world of the self, implying that the bereaved person is required to reconstruct his life space with new inter-personal structures:

The pain experienced in the slow process of testing reality in the work of mourning thus seems to be partly due to the necessity not only to renew the links to the external world, and thus continuously to re-experience the loss, but at the same time and by means of this to rebuild with anguish the inner world which is felt to be in danger of deteriorating and collapsing. (Klein, 1940)

The "inner world" which Melanie Klein believes must be rebuilt after bereavement is the self as perceived by oneself. It must be rebuilt because the bereavement has caused a partial disintegration of the old self. The death is external to the bereaved self but the meaning of that death for the bereaved person is a kind of death within himself and the necessity for irrevocable change in the perceived self. This change is accomplished by the severance of those parts of the self-image that experienced need-satisfaction in relation to
the deceased. The bereaved person will literally "never be the same again". Accepting the severance of part of oneself and the development of a new self-image, through the cultivation of new relationships and new kinds of need-satisfactions, is the work of mourning. It might well be called the severance task.
Lindemann's study (1944) ended an era of inquiry about the meaning of mourning and initiated another. His approach moved the debate out of the psycho-analytic journals into the larger fields of medical science. His work was based on interviews with 101 patients with a variety of bereavement experience. Each series of interviews was analysed in terms of the symptoms and of the changes of mental status reported progressively through the series. Lindemann claimed that the picture shown by persons in acute grief was so remarkably uniform that it can properly be designated a syndrome:

1. **Sensations of somatic distress:**
   
   (a) respiratory disturbance such as tightness in the throat, choking, shortness of breath, sighing;
   
   (b) unpleasant digestive symptoms such as distaste for food, lack of saliva, empty feeling in the abdomen;
   
   (c) feelings of exhaustion and weakness; together with some or all of these somatic discomforts there occurred an intense subjective distress described as tension or mental pain.

2. **Intense pre-occupation with the image of the deceased.**

   This is expressed in a sense of emotional distance from other people and of unreality, together with special experiences of a hallucinatory kind or as of a "waking
dream" e.g. an imaginary experience of the dead person speaking or calling to them of such vividness that they cannot attend to reality.

3. Feelings of guilt and self-reproaches. The bereaved person would search in his memory for evidence that he had failed or erred in some way or had contributed to the discomfort or death of the lost person.

4. Feelings of hostility to others, even friends and family. Irritability and anger to others which the bereaved person cannot understand and which he may find painful and embarrassing. He may feel indifferent to others and wish to withdraw from their company.

5. Restless activity, moving about in an aimless fashion and "continually searching for something to do". He realises that much of his previous action was done in relation to the deceased and now he lacks initiative in undertaking tasks and clings solemnly but without satisfaction to performance of prescribed routine activities.

There is another characteristic shown by patients who border on pathological reactions:

6. The appearance of traits of the deceased in the behaviour of the bereaved. He may see in himself a growing likeness to the deceased; or others may see in him a development of mannerisms or traits which characterised the deceased; he may pursue the work or hobbies of the deceased.
Having made these observations, Lindemann developed his theory of the processes by which a bereaved person becomes emancipated from these unpleasant and debilitating symptoms. He rephrased Freud's term, "the work of mourning" and coined the phrase "grief work". By this he implied that the bereaved person undertook the deliberate activities of freeing himself from the bonds attaching him to the dead person, and of re-adjusting to life without that person, and of creating new relationships.

The duration of a grief reaction seems to depend upon the success with which a person does the grief work, namely, emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships. (Lindemann, 1944:p.11)

Lindemann did not explain how the process of "grief work" is brought about by the bereaved person either by his own efforts (with or without the assistance of friends) or with the intervention of a psychiatrist. He does make the definite claim that if a psychiatrist "shared" the grief work with the bereaved during a short series of interviews, an ordinary grief reaction could be settled.

With eight to ten interviews in which the psychiatrist shares the grief work, and with a period of from four to six weeks, it was ordinarily possible to settle an uncomplicated and undistorted grief reaction. This was the case in all but one of the 13 Cocoanut Grove fire victims. (1944:p.12)

He seems to treat grief reaction of an ordinary kind as an illness needing "proper psychiatric management" in order to prevent possible serious and prolonged social maladjustments and potential medical disease in the client. He observed
that not only should over-reaction be dealt with but also
that under-reaction may be followed by subsequent delayed
responses with dangerous distortions which may be destructive.

His nearest explanation of the nature of grief
work is in these words:

The essential task facing the psychiatrist is
that of sharing the patient's grief work,
namely, his efforts at extricating himself
from the bondage to the deceased and at finding new patterns of rewarding interaction.

In this work of the bereaved of separating himself
and of creating new attachments Lindemann noticed the
essential part played by the pain of grief. It seemed
necessary for the patient to accept intense distress in
recalling his relationship with the deceased in order to be
freed from the attachment sufficiently for him to make new
relationships. Patients tended to avoid the pain of
conscious reflection and attempted all manner of ways of
avoiding this painful acceptance of loss.

One of the big obstacles to this work seems
to be the fact that many patients tried to
avoid the intense distress connected with
the grief experience and to avoid the ex-
pression of emotion necessary for it.

Men victims particularly of the Cocoanunt Grove
fire showed their tension in tightened facial musculature and
a refusal to relax in case they might "break down". Lindemann
accepted the necessity for the psychiatrist to attempt to
lead the patient to experience and express the painful feelings
of grief. This contrasts strongly with the usual attitude of
friends who may become anxious at any expressions of feeling
by a bereaved person, which they take to be signs of possible breakdown, and discourage him from thinking or feeling about his loss. Likewise our culture generally prohibits expressions of grief as being unmanly, especially in males.

Lindemann took the view that conscious experience of the pain of grief and verbal and other expressions of it are essential to quick recovery and are, in fact, the 'grief work' that must be done.

It required considerable persuasion to yield to the grief process before they were willing to accept the discomfort of bereavement. (1944:p.11)

An expression of the unwillingness of patients to accept the conscious pain of grief was the hostility exhibited in some towards the psychiatrist. One man assumed such a hostile attitude that he forbade all conversation about the deceased. Lindemann observed that his prognosis was not good and implied that his unwillingness to experience and discuss his grief contributed to his serious condition. On the other hand those who "became willing to accept the grief process and to embark on a program of dealing in memory with the deceased person" experienced a rapid release of tension, and were able to take part in animated conversation in which the deceased was idealised and in which they explored their misgivings about future adjustments.

Several case descriptions show the interviewer at work. In one, he set about assisting the patient to describe "her painful preoccupation with memories of her husband and her fear that she might lose her mind". In subsequent inter-
views she "succeeded in accepting his loss and then only after having described in detail the remarkable qualities of her husband, the tragedy of his having to stop his activities at the pinnacle of his success, and his deep devotion to her". Later he helped the patient to deal with her feelings of attachment to the interviewer and to make plans for the future.

In another, the psychiatrist assisted a widower to accept the pain of experiencing and acknowledging his grief and the meaning of his relationship to his dead wife. At first this was too difficult to do.

Any mention of his wife produced a severe wave of depressive reaction, but with psychiatric assistance he gradually became willing to go through this painful process, and after three days on the psychiatric service he seemed well enough to go home. (1944:p.11)

Subsequently, he made himself extremely busy in his business and planned to sell all he possessed to avoid encountering anything that reminded him of her. The psychiatrist saw this as avoiding the pain of accepting his grief and in conversation enabled him to do the necessary grief work rather than seek to erase all memory of his wife.

Only after considerable discussion was he able to see that this would mean avoiding immediate grief at the price of an act of poor judgment. Again he had to be encouraged to deal with his grief reactions in a more direct manner. He made a good adjustment. (1944:p.12)

The process of grief work as described by Lindemann seems to be

1. Acceptance of the pain of conscious recall of memories associated with the deceased.
2. Experiencing and expressing feelings associated with these memories. (Lindemann does not say much about the place of negative feelings but the evidence of many other studies suggests that they are probably of great importance. It is probably fear of or reluctance to acknowledge negative feelings towards the deceased that play a major part in preventing a person from entering the pain of grief.)

3. Accepting the reality of the death. In doing this, the deceased is often idealised. Idealisation may be accompanied by identification of the patient in some ways with the deceased. (Lindemann does not mention the danger of idealising the deceased before negative feelings are acknowledged, which can result in a pathological fixation on the ideal, inimical to the acceptance of reality and the resolution of the grief.)

4. Creating new relationships and developing new life goals and activities in a world in which the deceased is not. Perhaps this can be understood as the acceptance of oneself as becoming once more a whole person without the deceased.

The morbid grief reactions which Lindemann observed may perhaps all be understood as the means by which the bereaved person seeks to avoid the pain of conscious acknowledgement of his loss and the painful feelings and memories associated with the lost person. This avoidance or denial takes many different expressions. It is to be seen in the course of "normal" grief and adjustment, but in such cases its expressions are temporary and not deep and respond to the realisation of reality. The very nature of morbid grief reactions is the
deeply fixed and permanent nature of the avoidance or denial, and the significance this has for the person's ordinary social adjustments and encounters.

Lindemann describes morbid grief reactions under two headings:

(a) **Delay of Reaction.** The reaction is delayed for some reasons. One common reason is that the bereaved person has important tasks to do, for example, working for and maintaining the morale of other members of the family. As Deutsch had earlier observed (1937) Lindemann reported that a recent bereavement may be linked with another bereavement which occurred many years ago. The grief reaction to the early experience may have been minor but in the subsequent bereavement the surprisingly severe reactions might be traced not to the recent bereavement but to the earlier one.

The discovery that a former unresolved grief reaction may be precipitated in the course of the discussion of another recent event was soon demonstrated in psychiatric interviews by patients who showed all the traits of a true grief reaction when the topic of a former loss arose. (1944:p.13)

Two examples of delayed grief reaction precipitated by the death of pets have come to the attention of the present writer.

%1. Shortly after his arrival in a parish, a minister made a visit to a family unknown to him and found a woman aged about 60 in tears. She reported that the cause of her tears was the death of her pet dog 3 days before. Since its death she had wept inconsolably and neither her husband nor children nor grand-children could bring
her any comfort. In conversation she brought to memory something she said she had not thought about for a long time, the death of her own 12 year old son more than twenty five years before. She expressed some hostility towards the doctor and her husband for this death. She herself suggested that the dog's death had opened the old wound. Her conversation about the son apparently relieved her from the fits of sobbing which did not recur.

#2. A minister visited a widow of 7 months. It was one of several visits which began on his arrival in the parish four months after the husband's death. The widow had expressed her intention of keeping the large house furnished exactly as her husband had known it. On this occasion the woman was deeply depressed and weeping because her parrot had been killed by a cat. The response to the parrot's death seemed unduly severe and when it was still evident a few days later, the minister encouraged conversation about the dead husband. There followed some violent expressions of rage and bitterness against the dead man and remorse for her holding such feelings. In several subsequent conversations the parrot's death was forgotten and the widow seemed to come to a more willing acceptance of her husband's death and began to assure the minister what a fine person her husband had been. Her depression lifted and she subsequently made arrangements to sell the large house they had lived in and take up a new life in an apartment near her daughter in another town.
These reactions seem to express an avoidance of the pain of grief and especially of acknowledging the painful negative feelings associated with the memories of the dead person. In each case bitter resentment and guilt were strongly felt; in one case the negative feelings were directed towards the doctor and family and in the other towards the deceased. Apparently these feelings were so unpleasant and conflicted so strongly with the bereaved person's self-image that they were intolerable and were largely repressed. The consequence of this was that the bereaved person could not accept and explore the meaning of the pain of loss (the grief), and was unable to appropriate the reality of the separation. Presumably the pain of loss, and the associated resentment and self-condemnation, found symbolic expression in the tears and depression precipitated at the death of the pets. Experiencing the pain and exploring and acknowledging the associated negative feelings seemed to give relief. Presumably this relief from depression and sorrow was made possible because the negative feelings and the pain of loss were integrated into the conscious part of the person's life instead of being rejected or unacknowledged.

Lindemann's second category of morbid reaction (1944:pp.13-15) was:

(b) Distorted Reactions

These are observed in alterations of the patient's conduct which may not be so severe as to warrant her seeking psychiatric help. Lindemann considers them usually to be superficial and to be responsive to psychiatric management.

These alterations may be considered as the surface manifestations of an unresolved grief
reaction, which may respond to fairly simple and quick psychiatric management if recognized. (1944:p.13)

He classified these distorted reactions as follows:

1. overactivity without a sense of loss. The bereaved person may zestfully and expansively carry out activities bearing resemblance to former activities of the deceased.

2. acquisition of symptoms belonging to the last illness of the deceased

3. a recognized medical disease, one of a group of psychosomatic conditions, predominantly ulcerative colitis, rheumatoid arthritis and asthma.

4. a conspicuous alteration in relationship to friends and relatives. This is seen in irritability with friends and avoidance of social activities which leads to progressive social isolation. The patient "needs considerable encouragement in re-establishing his social relationships."

5. An overflowing hostility over all relationships with perhaps a furious hostility against specific persons. The lawyer or doctor or member of the family may be the object of bitter and paranoid accusations. Special psychiatric techniques and the use of associated social workers or ministers may be needed if the hostility and associated guilt are severe.

6. Some hide their hostility behind a wooden and formal and unemotional facade resembling schizophrenic pictures. There is marked absence of warmth in personal encounters, the face is mask-like and the movements stilted.
7. **Lasting loss of patterns of social interaction** marked by lack of decision and of initiative. No activity seems rewarding; he can do nothing alone except the routine essentials carried out in small steps as though with great effort.

8. **Actions detrimental to his own social and economic existence** such as over-generous and indeed foolish dealings with property which may deprive him quickly of family, friends and possessions.

9. More serious is a state of **agitated depression**, the picture of classic "melancholia" with "tension, agitation, insomnia, feelings of worthlessness, bitter self-accusation, and obvious need for punishment." This condition, says Lindemann, is likely to occur in patients with "obsessive personality make-up and with a history of former depressions."

Lindemann makes a general observation that if the deceased person is a key person in a social system, so that his death is followed by disintegration in the social system and severe disruption in the life patterns of people within the system, his death can lead to severe reactions in them. When such a person was associated with considerable hostility and consequent guilt feelings in the bereaved, the grief reactions could be severe. The degree of intensity of interaction with the deceased (consider, the case of a mother who has lost a young child or a family which has lost a father and bread-winner who is of dominant significance in the life of the family) is more important than any previous history of neurotic reaction.

Further evidence of the association with bereavement of serious diseases like ulcerative colitis and cancer may in time confirm the commonly-held theory of their connection with hostility and guilt or may otherwise clarify their relationship with bereavement.
In considering the method of treatment, Lindemann laid stress on the willingness of the bereaved person to accept the pain of his experience. He affirmed that bereaved persons need more than comfort. He made some observation concerning the part played by "religious agencies" in dealing with the bereaved. He said they provide "comfort" by means of:

(a) dogma which supports the patient's wish for continued interaction with the dead

(b) assurance of forgiveness which counteracts "the morbid guilt feelings of the patient"

(c) rituals which maintain the patient's interaction with others.

Despite these comforts, Lindemann says, the patient has to accomplish his grief work by:

(a) accepting the pain of his grief, and expressing his sense of sorrow and loss

(b) reviewing his relationships with the deceased

(c) "working through" his feelings of hostility associated with the deceased and "verbalising his feelings of guilt"

(d) finding a new relationship with the deceased

(e) finding persons who can help him acquire new patterns of conduct.

While these measures have helped countless mourners, comfort alone does not provide adequate assistance in the patient's grief work. He has to accept the pain of the bereavement. He has to review his relationships with the deceased, and has to become acquainted with the alterations in his own modes of emotional reaction. His fear of insanity, his fear of accepting the surprising changes in his feelings, especially the overflow of hostility, have to be worked through. He will have to express his sorrow and sense of loss. He will have to find an acceptable formulation of his future relationship to the deceased. He will have to verbalise his feelings of guilt, and he will have to find
persons around him whom he can use as 'primers'
for the acquisition of new modes of conduct.
All this can be done in eight to ten inter-
views. (Lindemann, 1944: p. 16)

This very comprehensive description of the processes
of grief work from the psychiatrist's or counsellor's point of
view has hardly been bettered. Lindemann's contribution has
been extremely important and has led to a vast and growing body
of empirical observations of bereavement behaviour. He did not
attempt to discern what the grief work meant for the inner life
of the patient or what was going on when the patient was finding
"an acceptable formulation of his future relationship with the
deceased" and acquiring "new modes of conduct". The challenge
of the empirical evidence is to understand what is happening
in the counselling situation which facilitates such changes
towards healthy adjustment. His last tantalising remark "All
this can be done in eight to ten interviews" is in sharp con-
trast with such psychoanalysts as Fleming and Altschul (1959)
who report urbaneely of events "at the 280th hour" and "at the
450th hour" in a five year process.

Whether the process is long or short, the empirical
evidence points strongly to the necessity of "the work of
mourning" or "grief work" or what may be called "the task of
severance". When this task is interrupted or absent it seems
necessary to penetrate the defensive denial, to provide a
climate in which the negative attitudes can be tolerated and
dealt with and to activate the task of severance. Only in
this way can the pathological consequences of unfinished
mourning or inadequate severance be subverted.
IV
SEPARATION TRAUMA.

John Bowlby's study (Bowlby 1951) of the effects of maternal deprivation was followed by a number of papers in subsequent years concerned with the formation of affectional bonds in early life and with the results of their severance. These inquiries have led him to repudiate many formulations of the psychoanalysts on the nature of grief and to develop a theory of grief which emphasises the primitive biological processes that are at work. Psychiatrist Colin M. Parkes began in 1959 to develop what he calls 'a biological theory of grief' (Parkes 1972, p.28) and since 1962 has collaborated with Bowlby at the Tavistock Institute of Human Relations in working towards a comprehensive theory.

The evidence of his WHO report led Bowlby to assert that it is no longer an open question whether deprivation causes psychiatric disturbance. "The prolonged deprivation of a young child of maternal care may have grave and far-reaching effects on his character, and on the whole of his future life" (Bowlby,1953:p.53). The deprivation was shown to have bad effects on a child's development not only during the period of separation and during the period immediately after the restoration to maternal care, but even, in a small proportion of cases, permanently.

The children at risk may be exposed to different forms of deprivation. It may be caused by a definite period of several months of separation during the first three or four years, or by changes from one mother-figure to another
during those early years, or by lack of opportunity for forming an attachment to a mother-figure during the first three years. He describes the characters of children so deprived as likely to become 'affectionless, isolated, anti-social and delinquent.'

The condition of the typical separated infant of the age range of six to twelve months was the subject of numerous and systematic studies. The separation syndrome showed characteristic listlessness, quiet misery and unresponsiveness which suggested the conclusion that it was very similar to the clinical picture of depression:

It is undoubtedly a form of depression having many of the hallmarks of the typical adult depressive patient of the mental hospital. The emotional tone is one of apprehension and sadness. The child withdraws himself from all that is around him; there is no attempt to contact a stranger and no brightening if this stranger contacts him. Activities are retarded and the child often sits or lies in a dazed stupor. Lack of sleep is common and lack of appetite universal. Weight is lost and the child easily catches infection. (Bowlby, 1953: p. 27)

Observations were made of 95 infants separated from their mothers after an association from birth of six to nine months. Twenty per cent responded to separation by severe depression and 27 per cent by mild depression. Restoration to the mother led to rapid recovery and a substitute mother brought definite improvement if not complete recovery.

Separation in the second and third years could lead to an even more severe emotional distress. Substitute mothers were often rejected, the child becoming acutely and inconsolably distressed for days or a week or more. He might continue in a state of agitated despair, screaming, moaning,
refusing sleep or consolation, until exhausted. He might relapse into a quiet apathy and for weeks or months might regress to infantile behaviour, bed-wetting, refusing to talk and demanding to be carried. In some cases the behaviour was so regressed that the child was mistakenly thought to be mentally defective by nursing staff inexperienced in dealing with children so deprived.

The consequences for adult life of infants who suffered severe maternal deprivation could be serious. Many forms of maladjusted personality, of anxiety and depression are thought to derive from or be made worse by deprivation experience. The Bowlby report suggests that some adults show permanent emotional crippling: dependancy with excessive demands on the person or persons selected as substitute mothers; excessive activism and optimism based on denial of their unsatisfied emotional life; inability to make personal relationships and consequent a-moral psychopathic life-style; resentment and hostility often repressed and variously disguised; chronic feelings of guilt and unworthiness arising from the intuition that their deprivation is a punishment for some fault of their own; there is some evidence too of permanent mental retardation.

The report expressed the conviction that maternal care in infancy and early childhood is essential for mental health and that separation at this sensitive formative period of development could cause irreparable harm. It emphasised that "the kind and degree of psychological disorder following deprivation depends on the phase of development a child is in at the time". In enunciating this theory Bowlby used the biological analogy of embryonic traumata. Abnormalities are
produced when harm is caused in a region where there is active growth taking place. Injuries received early are likely to lead to widespread abnormalities of growth; later injuries are likely to lead to merely local changes. It is as though forming a close relationship with mother in the first year is a psycho-biological necessity for later mature development. Deprivation impairs a vital growth process of the personality. The mother by her presence and love and personal communication is an essential biological "organizer" in the undeveloped stage of early growth.

The WHO report indicated that the direction of further research could well be towards "the embryology of personality" and the biological model has influenced Dr. Bowlby's subsequent investigations, even into the study of bereavement and mourning. His observations of "separation anxiety" link the study of maternal deprivation to that of bereavement.

Thirteen years after Bowlby's original WHO report, Dr. Mary Ainsworth wrote two additional chapters for the 1965 second edition of "Child Care and the Growth of Love" in which she presented a review of the issues and the research stimulated by the WHO report.

An important area of current studies at that time concerned the concept of protest coined by James Robertson (1953a, b) to characterize the first phase of response to separation. He observed the behaviour of children aged 15 - 30 months separated from their mothers on admission to hospital or to some residential institution.

In this initial phase, which may last from a few hours to seven or eight days, the young child has a strong conscious need of his
mother and the expectation, based on previous experience, that she will respond to his cries. He is acutely anxious that he has lost her, is confused and frightened by unfamiliar surroundings, and seeks to recapture her by the full exercise of his limited resources. He has no comprehension of his situation and is distraught with fright and urgent desire for satisfactions only his mother can give. He will often cry loudly, shake his cot, throw himself about and look eagerly towards any sight or sound which might prove to be his missing mother. (Robertson, 1955a)

Robertson observed three phases of response to separation

(i) **protest**: the child cried and suffered acute distress, doing all it could to get her to return.

(ii) **despair**: the child grieved for the absent mother, showing hopelessness and withdrawal and decreasing efforts to regain the mother.

(iii) **detachment**: The child became more and more accepting of the separation and received the care of substitute persons with a measure of passivity or apathy. When the mother returned, the child showed a loss of attachment-behaviour, as though it were accepting the "bereavement" and could not readily undo the processes of detachment which the pain of separation had brought about.

This three-fold kind of response to separation was confirmed by other observers. Their work, published between 1953 and 1963, is summarised by Ainsworth (1965). 'Protest' behaviour was noted in children under 5 years having surgery; the reactions to hospitalisation of children aged between 2 and 12 years showed, in those aged from 2 to 4 years, a marked initial distress connected with separation from parents; a comparison of children aged 15–30 months admitted to a
residential nursery with a comparable group admitted to a day nursery and so separated only part of the time showed degrees of violent hostility in the former not seen in the milder protest of the latter. Those in the residential nursery formed far more intense and ambivalent relationships with nursery staff and displayed more resistance and hostility to adults; other studies confirmed that separation and hospitalization of children more than seven months old causes the characteristic pattern of "protest behaviour". Breaking the affective tie, once it is established, is disturbing and painful and causes disruption in general behaviour and development. The severity and pervasiveness of disruption increases with age.

The description of "separation anxiety" displayed by these children deprived of adequate maternal care (whether it be by natural mother or a substitute mother) was reminiscent not only of some adult psychotic states of depression but also of the experience of grief in adults. This fact influenced Bowlby's subsequent research, for he believed that an understanding of infantile separation anxiety would throw light on the processes of mourning. He later came to use Robertson's description of separation (protest, despair, detachment) as directly applicable to grief behaviour; his theory of mourning (Bowlby 1961a) and that of Parkes (1972) owe much to the studies of infant separation trauma.
AFFECTIONAL BONDING AND SEPARATION ANXIETY.

Bowlby's studies arising out of his observations of maternal deprivation and separation trauma in infants have been so influential that it is necessary to examine the processes of his thought more closely. He says quite explicitly (1961a) that in understanding the different forms of mourning he drew on the hypothesis advanced in his own paper "The Nature of the Child's Tie to his Mother" (1958).

The hypothesis conceives the tie as mediated by a number of instinctual response systems, which are a part of the inherited behaviour repertoire of man. In the early months of life they come to be oriented towards a particular mother-figure, and it is she who habitually provides the stimuli that affect their operation. Although this theoretical model was proposed for the purpose of explaining the behaviour of infants and young children in a particular relationship, I believe it provides a useful model also for our other libidinal relationships, for example sexual (genital) and parental ones. (1961a, p.332)

Bowlby (1969a) and Parkes (1969) have both since then developed the theoretical aspects of emotional attachment/detachment as a human response pattern of biological adaptation to the environment for the survival of the species. Bowlby argues that the survival of our ancestors depended absolutely on their possession of proximity-promoting mechanisms and that only those individuals who possessed such mechanisms could survive and pass on their traits to their children. Early members of our kind who lacked effective proximity-promoting mechanisms would become isolated from the safe environs of the tribal-family group and be destroyed by predators.
His early observations of the link between gross disruptions in the mother-child relationship in infancy and the development of psychopathic personality traits led him to consider subsequently the nature and development of the affectional bond. Bonding came to be seen by Bowlby and by other clinicians and behavioural scientists as a major issue. Empirical studies were made of affectional bonding in other animal species as well as in humans.

Some basic assertions are the result of common-sense observations rather than of empirical science:
- At each phase of life we do make affectional bonds with a few particular people, which provide us with a matrix of security; when bonds are broken by forced separation or death we experience pain.
- Many species of birds and mammals show the growth of strong bonds between two individuals.

Thus affectional bonding is no recent evolutionary development - still less a perquisite of being human; it is built deep into our biological inheritance. (Bowlby 1969a p.39)

- The essential feature of affectional bonding is that partners tend to remain in proximity. If a third party tries to separate the bonded pair, there is vigorous conflict.
- The cement of the bond is emotion. Our strongest human emotions, love, fear, anger, grief, joy, are experienced in connection with making, maintaining, disrupting or renewing these bonds.

In considering the nature and origin of affectional bonds, Bowlby dismissed the view that was widely held, he says, until the mid 1950s: that bonds develop because an
individual uses another individual as a means of satisfying primary drives like food, sex, security; in doing so it develops secondary drives, for example, "dependancy", (which Bowlby refers to as an "unfortunate" term for the mother-child bond). This theory emphasised that bonds develop in association with pleasures (primary drive satisfactions); likewise, that fears develop in association with pains.

In the past several decades new evidence has confirmed that in animals:
- Bonds may develop without apparent association with primary pleasures;
- Young creatures show fear and avoidance in response to novel experience without pain;
- Survival of wild animals demands that individuals must have more equipment to deal with the environment than an attraction to satisfy hunger and sex and a revulsion to avoid pain.

Bowlby cited the evidence of Lorenz in his observations of "imprinting" which showed that some immature birds form strong bonds with a mother substitute without reference to food and apparently merely through familiarity and proximity (Lorenz, 1965). Similarly the work of the Harlows with monkeys suggested that some young creatures who would normally become attached to a mother will approach and remain in proximity with any object provided it gives them certain visual auditory or tactile satisfactions. A young creature exhibits infant-mother "dependency" in relation to a cloth covered object or a cardboard box. What seems to satisfy him is the proximity to a familiar object and
presumably the sense of security and comfort and "acceptance" that this proximity provides. (Harlow and Harlow, 1961).

Bowlby concluded that "attachment behaviour" is a distinct and primitive response. It is expressed in attaining and maintaining proximity with a chosen individual; it is characteristic especially of a young or subordinate individual towards an older or more dominant individual. The complementary behaviour of the mother or older figure is called by Bowlby "caretaking" behaviour. The attachment-caretaking bond is found in more species of birds and mammals than is long-term heterosexual pair formation. Attachment behaviour is, he asserts, a "basic part of the instinctive equipment of a large array of animal species, from birds to man". (1969a: p.46). His observations of attachment behaviour in children in the first three years of life and the evidence of studies of other creatures, especially baboons, led him to assert that each animal "is equipped with an instinctive disposition to avoid isolation and to maintain proximity." Complementary to this instinctive attachment behaviour towards the familiar is the instinctive response of alarm and wariness towards anything unusual or sudden. These behaviours mediating protection are more significant than behaviours mediating nutrition and reproduction.

Having laid the basis of this argument, Bowlby attempted to account for the prevalence of separation anxiety, which, you will remember, Freud always insisted was something quite different from fear of some threat from the outside world. (1969a:p.49)
Before considering Bowlby's theory of mourning in detail, and the way he used the Freudian term "anxiety of separation" and related it to grief, it is necessary to consider in detail the meaning Freud gave to the term in his observations of infant behaviour.

Freud (1923:p.273) spoke of "the anxiety of separation from the protecting mother" as observable in three very different experiences: in the first great anxiety state of birth, in the infantile anxiety of longing for an absent person, and in the fear of death in melancholia. This separation anxiety in melancholia arises because the ego feels itself hated and persecuted by the super-ego, instead of being loved. The ego must know itself loved by the super-ego or it cannot live. When the ego finds itself in imminent catastrophic danger from the condemnation of the super-ego, it sees itself as deserted by all the forces of protection (which were associated with the father and are now attached to the super-ego) and lets itself die.

Freud gave further consideration to the relationship between separation anxiety, pain and mourning (1926:p.286-291). He distinguished them in this way:

1. **The danger of losing a loved object leads to anxiety.**

   Consider "the situation of the infant when he is presented with a stranger instead of his mother. He will exhibit the anxiety which we have attributed to the danger of loss of object." The anxiety arises because he is aware of the danger that he may lose his loved object, or believing himself to have lost his object, he is aware of being in danger which that loss entails.
2. **Awareness of a need unsatisfied because of absence leads to pain.** "The expression on his face and his reaction of crying indicate that he is feeling pain as well." He cannot distinguish between permanent loss and temporary separation. He behaves as if she is lost for ever. Only experience teaches him that separation is followed by reunion (and games of hide and seek strengthen the lesson that out of sight does not mean lost for ever).

The consequence of the infant's confusion and misunderstanding is that the absent-mother situation is a **danger** situation (leading to anxiety); but if he happens at the time to be feeling a need which she only can gratify, the situation becomes a painful **traumatic** one. Repeated experiences of gratification have established the mother as an object. This object, whenever the infant feels a need, receives an intense cathexis of longing. Unsatisfied longing results in **pain**.

> Pain is thus the actual reaction to loss of object, and anxiety is the reaction to the danger which that loss entails, and, in its further displacement, a reaction to the danger of the loss of object itself. (1926:p.288)

3. **Loss of the loved object, confirmed by reality-testing, leads to mourning.** Reality-testing demands that the bereaved person separate himself from the loved object, since it no longer exists. The work of mourning is to ensure that in every situation in which the loved object received a high degree of cathexis the bereaved person deliberately withdraws from the object. It is to be expected that the process is painful because in order to accomplish the severance from the loved person he must
enter and experience the pain of unsatisfied longing which accompanies any contemplation of the deceased while the task of severance remains incomplete.

That this separation should be painful fits in with what we have just said in view of the high degree and insatiable nature of the cathexis of longing which is concentrated on the object by the bereaved person during the reproduction of the situations in which he must undo the ties that attach him to it. (1926:p.291)

It is clear from Freud's careful statements that he made clear distinctions between separation-anxiety, the pain of unfulfilled longing in the absence of the loved object, and the work of mourning. This last he saw as the difficult and painful task of systematically reproducing the situations in which the affection-bonds are experienced and of de-cathecting each situation until the bereaved person is emotionally as separated from the lost object as he wishes to be.

Bowlby's concern with attachment behaviour, which he considers to be instinctive, leads him to assume that the separation anxiety observed in infants is the instinctual basis of mourning behaviour.

To avoid isolation and to maintain proximity to a familiar figure is also good strategy, since once again it minimises the possibility of danger and maximises safety. This enables us to account for the prevalence of separation anxiety, which, you will remember, Freud always insisted was something quite different from fear of some threat from the outside world. Separation anxiety, it is proposed, is what each one of us experiences whenever our attachment behaviour is elicited and we cannot find our mother figure, or whatever person or even institution has come in later years to stand in her place. (Bowlby,1969a:p.39)
This statement is probably not out of accord with Freud's definition but in interpreting mourning behaviours in adults as expressions of this primitive and infantile separation anxiety, Bowlby does not seem to give due weight to Freud's concept of mourning nor of the evidence of what mourning behaviour accomplishes.

Bereavement certainly leads to separation anxiety and its consequences are seen in the well-known somatic and mental symptoms, including the many methods of denial, by which the anxiety is mitigated. In healthy mourning, a work is carried out by the ego by which the reality of loss and change is accepted, the ego is separated off from its attachment to the lost object and a new ego-formation results. As this takes place, the separation anxiety dissolves and the various expressions of it, whether they be mild or pathological, are diminished accordingly.
VI
THREE PHASES OF MOURNING.

Bowlby's four principal papers on mourning (1960b, 1961a, 1961b, 1963) constitute a major contribution to the study of bereavement and its consequences. The starting place for his studies was in the responses of infants and young children to the loss of mother which he observed to be descriptively similar to the behaviour of an older child or adult experiencing bereavement of a loved person. "Both", he contended, "required the same description, namely mourning; in both age-groups the subjective experience appeared to be that of grief" (1961a:p.317). He expressed dissatisfaction with psycho-analytic studies on two grounds: many analysts seem not to have identified the processes in question as those of mourning, or saw them as radically different from mourning in adults; on the other hand, some analysts emphasised the grief and mourning arising from weaning and loss of breast in the first year but tended to disregard the grief and mourning experience of later years.

The connotations Bowlby gives to the terms 'grief' and 'mourning' may well explain part of the cause of his dissatisfaction with psycho-analytic studies. He seems at times to identify "separation anxiety", "grief" and "processes of mourning". As is noted above, he observed that both infant separation behaviour and adult bereavement behaviour required the same description, and could be characterised as "mourning". In his paper "Processes of Mourning" he wrote:
The main thesis I am advancing in these papers is twofold: first, that once the child has formed a tie to a mother-figure, which has ordinarily occurred in the middle of the first year, its rupture leads to separation anxiety and grief and sets in train processes of mourning; secondly, that in the early years of life these mourning processes not infrequently take a course unfavourable to future personality development and thereby predispose to psychiatric illness ... I believe that an understanding of the nature of these unfavourable outcomes turns on a clear grasp being obtained of the nature of the mourning processes themselves, and of their variants and deviants .... Here the task is that of exploring some of the basic psychological processes engaged in mourning and their biological roots. (1961a:p.317)

It may be inferred from these statements that the behaviours associated with infant separation anxiety and adult grief and mourning are to be identified; they are to be seen as the same kind of biological response of the organism to an identical kind of stimulus. The use of these terms almost as synonyms in his writings leads to some obscurity.

In "Processes of Mourning", Bowlby's main concern seems to be with the pathological effects upon personality development of early maternal deprivation.

The hypothesis I shall be advancing is that unfavourable personality development is often to be attributed to one or more of the less satisfactory responses to loss having been provoked during the years of infancy and childhood in such degree, over such length of time, or with such frequency, that a disposition is established to respond to all subsequent losses in a similar way. (1961a:p.317-318)

He provided empirical evidence to support his main thesis and showed that the separation which accompanies early maternal deprivation is a bereavement which can have long-lasting effects. It may result in unfavourable personality development which, in subsequent bereavement, predisposes to psychiatric illness.
In advancing his hypothesis, he made a critical survey of psychoanalytic studies of mourning and reviewed relevant ethological studies of animal responses to loss. Then he proceeded to state his own theory of the "three phases" of mourning. His theory of mourning does not seem essential to the main argument of the paper, which is well supported by empirical clinical evidence. Its value is rather in the strong claim it makes for a biological theory of bereavement.

Bowlby at several places defined 'grief' and 'mourning'.

'Mourning' will be used to denote the psychological processes that are set in train by the loss of a loved object and that commonly lead to the relinquishing of the object.

'Grief' will denote the sequence of subjective states that follow loss and accompany mourning.

Although a common outcome of mourning is relinquishment of the object, this is not always so. By defining the term 'mourning' to cover a fairly wide array of psychological processes, even including those that lead to a retention of the object, the different courses that mourning may take, healthy or pathological, are, I believe, more easily understood. (1961a:p.318)

These definitions are so broad as to allow the words to be used interchangeably, as indeed, they probably are in common speech. A "wide array of psychological processes" would surely incorporate the "sequence of subjective states that follow loss and accompany mourning", and is so general as to comprehend any behaviour consequent to bereavement. Further, the definition of grief is so broad that it comprehends any and every feeling and emotion, including what we usually refer to as 'grief'.

...
Subsequently in the same article Bowlby defines the terms again.

In old and young, human and sub-human loss of loved object leads to a behavioural sequence which, varied though it be, is in some degree predictable. In human beings, moreover, the behavioural sequence of subjective experiences begins with anxiety and anger, proceeds through pain and despair, and, if fortune smiles, ends with hope. Not that either sequence runs a smooth unvarying course. On the contrary both behaviour and feeling oscillate violently, especially in the early phases: yearning, protest and rage alternate with blank, mute despair. Nevertheless there is plainly discernible a trend from protest through despair to some new equilibrium of feeling and behaviour. To the whole course of this subjective experience the term 'grief', I believe, is applicable. Grief, I believe, is a peculiar amalgam of anxiety, anger, and despair following the experience of what is feared to be irretrievable loss. It differs from separation anxiety in that anxiety is experienced when the loss is believed to be retrievable and hope remains.

Mourning is best regarded as the whole complex sequence of psychological processes and their overt manifestations, beginning with craving, angry efforts at recovery, and appeals for help, proceeding through apathy and disorganization of behaviour, and ending when some form of more or less stable reorganization is beginning to develop.

Like all biological processes, mourning may take one of several different courses. Those which enable the individual ultimately to relate to new objects and to find satisfaction in them are commonly judged to be healthy; those which fail in this outcome pathological. (1961a: p.331-332)

Despite the comprehensive nature of mourning and grief there are some responses to loss, he maintains, that cannot be included in either category. Such are the condition described by H. Deutsch (1937) as 'absence of grief' and the tendency described by Green (1958) "instead of grieving oneself, to succour others who are grieving". It
seems necessary to assert that "absence of grief" observed by Deutsch, although Bowlby admits it does not fit his categories, is a significant if pathological response to bereavement and must be accounted for in any comprehensive theory of bereavement.

The characteristics of Bowlby's "Three Phases of Mourning" may be set out thus:

<table>
<thead>
<tr>
<th>Phase 1.</th>
<th>Phase 2.</th>
<th>Phase 3.</th>
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<tr>
<td>Yearning</td>
<td>Disorganization</td>
<td>Reorganization</td>
</tr>
<tr>
<td>(Urge to Recover the Lost Object)</td>
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**MOURNING (behaviour)**

| Disequilibrium | Apathetic inaction; Stable reality-adjusted reorganization. OR Pathological reality-denying maladjustment |
|-incrédule; | |
| Protest, angry efforts at recovery, weeping; | Disorganized behaviour; |
| Appeals for help; | Ineffective futile action. |
| Accusations, ingratitude, hostility; | |
| Phantasies, dreams, denial symbols. | |

**GRIEF (feelings)**

| Anxiety, Pain of Loss; Disappointment; Hope |
| Anger, Protest; Depression; |
| Yearning, Despair (alternating) | Despair |

**OTHER RESPONSES**

 behaviour: Succouring others who grieve (Green)
 feeling: Absence of grief; indifference (Deutsch)

Bowlby acknowledged the similarity between his thought and that of Robertson. Robertson's notion (1953a) that separation led to "protest" behaviour was congenial to Bowlby's thinking. Bowlby explicitly identified his own three-phase theory of Bereavement (Yearning, Disorganization, Reorganization) with Robertson's three phases of Separation (Protest, Despair, Detachment).
All that has been said, however, applies equally to infants and young children of over six months. When for any reason they lose their loved object the three phases of mourning described are experienced. At all ages, we now see, the first phase of mourning is one of Protest, the second one of Despair, and the third one of Detachment. That Robertson and I had described as typical for young children has a generality greater than we knew. (Bowlby, 1961a: p. 338)

**Phase I: Yearning**

Bowlby says that the main thrust of the first phase of mourning is yearning, an urge to recover the lost object. The two main observable features of the first phase of mourning are weeping and anger; these are to be understood as instinctive or biological expressions of the primitive urge to recover the lost love-object, identical with the instinctive response of an infant to the temporary disappearance of his mother.

(i) **Weeping.** When an infant first misses his mother his immediate response is to cry; his mother usually responds by returning.

There seems no reason to doubt that it is this response system that is motivated in the human adult who is bereaved. A situation of sudden loneliness evokes in him an ancient instinctual response ... when he weeps the bereaved adult is responding to a loss as a child does to the temporary absence of his mother. (1961a: p. 333)

He adduces evidence in support from Fenichel and Darwin.

(ii) **Anger.** Just as there is a sharp increase in aggressive behaviour in infants separated from their mother-figure (it apparently assists in her return and her reluctance to go away again) so there are therefore good biological reasons for every separation to be responded to in an automatic instinctive way with aggressive
In the course of our evolution, it appears, our instinctual equipment has come to be so fashioned that all losses have been assumed to be retrievable and are responded to accordingly. (p.333)

Associated with the weeping and anger designed to cause the recovery of the lost object there are seen expressions of hostility to comforters, and indeed accusations and reproaches are directed not only at third persons (doctor, nurse, family and friends) but also at the deceased person and at the bereaved self. Bowlby sees all such blame, ingratitude and hostility as expressions of the effort to undo the loss, to recover the lost one and to maintain union. Rage does, as it were, increase hope and assurance that reunion can be effected. The appeal to others for help is not help to endure the loss but help to recover the lost one. The would-be comforter accepts the reality of death but his aim to bring the bereaved into that reality may be a thankless and frustrating one. In conclusion, every response of the bereaved in this stage, protest, weeping, anger, accusation, rage, ingratitude, appeals for help, phantasies and dreams, are directed to the recovery of the lost loved one.

**Phase 2: Disorganization**

Behaviour based on the belief that the dead person is still alive and that reunion is possible leads the bereaved person to repeated painful disappointments. As these are increasingly frustrated by reality they gradually become extinguished. Despair may set in and behaviour, previously set on reunion, becomes disorganized. Lindemann (1944) describes this restlessness, aimless activity, continual
search for something to do, and painful incapacity "to initiate and maintain organized patterns of behaviour". The subjective aspect (grief feeling) of this state of disorganization is, according to Bowlby, depression. "The depressed individual . . . is the one whose behaviour is no longer organized." He experiences the world and himself as poor and empty and without esteem.

This concept of depression seems very useful. The person who cannot adequately control his environment, whose goals have dissolved in a restless apathy, and whose behaviour patterns are inchoate, responds with depression. Bowlby sees it as a primitive biological response, like separation anxiety, which is natural to man. He says it as a concept applicable to geese and other creatures and one that is capable of enabling us to discern more clearly which mourning responses are shared with other species and which are found only in man.

The disorganization of behaviour which is associated with depression is seen to have an adaptive function. The patterns of interaction with the lost one are now inappropriate and maladaptive; new ones can only be developed via the painful road of disappointment, disorganization, depression, and deep dissatisfaction with the world and the self. He must accept the destruction of large areas of his personality and behaviour in order to organize towards new goals, new satisfactions, new experiences of success which enhance esteem in the newly forming self.
This seems to be the most satisfying part of Bowlby's discussion. Whether depression does have a biological base remains to be proved. Nevertheless the idea of the relationship between disorganization and depression is fruitful and permits the integration of other evidence. For example, the traditionally recognized relationship of depression to guilt and self-condemnation is capable of being understood in this context. The place of guilt in behaviour-change needs further elucidation. Bowlby's concept suggests that the experience-sequence of disorganization-depression-guilt-dissatisfaction is an essential process in detaching "the survivor's memories and hopes from the dead" which Freud described as the task of mourning.

A number of psycho-analysts and psychiatrists have expressed the view that capacity to tolerate disorganization-depression is essential to mature development. Only the rigid, unadaptable and anxious person cannot bear disorganization or the reality of self-condemnation; excessive anxiety in the presence of disorganization-depression causes the erection of defence barriers and the development of maladaptive protection. Chronic neurotic and psychotic reactions to bereavement may have their origins in the resolute rejection of the dissolution of the old pattern and in the refusal to accept the condemnation and frustration of disorganization which are the necessary prelude to change. (Bowlby, p.336) referred to several ways in which the bereaved person may fail to accept the distress of disorganization-depression after bereavement and so fail to carry out the reorganization in relation to new love objects and new goals:
(i) the person may continue to live as though the lost person were present or recoverable. He may take no satisfaction in the present reality but maintain himself in a context of mementoes, fantasies and behaviours that are a tolerable substitute for the past. Linked with this may be feelings of anger and reproach towards the dead person. This is the road leading to chronic depressive illness of the Miss Havisham variety.

(ii) the person may lead a superficially adjusted way of life but have separated off from the main psychic life all the emotions and responses directed towards the lost person. Being repressed in the unconscious, they give rise to neurotic symptoms and "strange" behaviour. Many "normal" people in society carry with them their unrecognized but potent emotionally-charged memories of unresolved ambivalence and unintegrated hostilities, pains and guilts associated with bereavement, and especially with bereavements of later childhood and youth.

Phase 3: Reorganization

The third phase of "healthy" mourning is one of reorganization of life around other love objects and goals, modified by the reality of the loss. There persists in this phase some behaviour oriented towards the lost person which however does not immobilize the person in the past but enables him progressively to shed his attachments to the lost one in ways that are acceptable to those inextinguishable attitudes of love and loyalty to the deceased that are compatible with a full acceptance of the death: for example, holding a
religious belief that the departed person continues his existence in another world, together with a hope of reunion which, being confirmed by popular religion, is therefore socially acceptable; maintenance of the dead person's values and goals by actively pursuing their fulfilment, as in the case of a widow who carries on her husband's business or ensures the wishes of her husband in the education of the children. In such ways an effective love-relationship with the lost person can be maintained in ways that do not hinder adjustment to real demands of life.

Bowlby emphasised that the main motivation in an advanced stage of pathological mourning is a persistent seeking of reunion with a permanently lost object. That is, the person has never moved out of the first phase. He has rejected the discomfort of disorganization and depression and returns again and again to the fruitless search for the lost person. This may take psychotic forms; an alternative pathological adjustment is characterised by repression and ego-splitting with unusual behaviour and ideas held alongside an apparently well-adjusted pattern of life.

Bowlby emphasised the biological model which gives shape to his theory. He sees phases 2 and 3 as adaptive processes. In his conclusion he wrote:

Points I have stressed particularly are the intimate relationships of grief and separation anxiety, the urge to recover the lost object that is dominant throughout the first phase of mourning, the weeping and aggressive acts that are a part of it, and the roles of disorganization and subsequent reorganization that are the main processes occurring in the second and third phases.
Throughout it has been my aim to discern the potentially adaptive function of the processes concerned, a potential that is realised when the object can be recovered but which cannot be realised in the statistically rare cases when recovery is impossible.

In drawing attention to mourning processes in lower species I have sought to emphasise the primitive biological processes that are at work in human beings, whilst at the same time recognizing that there are probably also features of mourning specific to man. (1961a:p.338)

Bowlby's three-phase theory does not seem to do justice to the evidence of the dynamic, purposive activity of the bereaved person in carrying out the "work of mourning", or the severance task by which he actively accomplishes his emancipation from the affective bonds which attach him to the lost object. Bowlby's interpretation of the evidence conceives of the symptoms of grief as biological responses to stimuli which the bereaved person makes without having control over the kind or quality of his responses. Perhaps his thinking has been too largely influenced by the studies of "separation anxiety" of infants and by the ethological studies of loss and bereavement in animals. His discussion of the theoretical issues is richly illustrated with evidence of the great variety of animal and human bereavement behaviours, but his theory seems to be little more than another way of categorizing bereavement behaviours which is no more useful than several others.
ADAPTION AND CHANGE.

The same edition of the International Journal of Psychoanalysis which published Bowlby's comprehensive survey and theory of mourning based on instinct (Bowlby 1961a) also published the conclusions of an inquiry into the nature of mourning by psychoanalyst George Pollock (1961). He distinguished successive different stages of the mourning process in himself and in members of his family and subsequently in others.

As the mourning continued it became apparent that different aspects of the process could be distinguished. These stages consisted of a series of reactions occurring in a temporal sequence having distinct degrees of acuteness and chronicity and seemingly divided into component parts. (Pollock 1961:p.346)

Stage 1. Shock results from the first upset in ego equilibrium when the emotional orientation to the deceased is disrupted. It may so overwhelm the ego that it leads to panic, with uncontrolled shrieking, wailing and moaning: "an acute regression to an earlier ego-organizational level".

Stage 2. Grief reaction follows, of which the physical aspects were described by Darwin (1872) as being marked by muscular hyperactivity, with aimless, restless walking, hand wringing and pulling of hair and clothes.

The person then moves into a phase of deep sorrow and despair expressed in motionlessness and sighing, with flaccid muscles and a "long" face. He cites evidence from
Lindemann concerning fatigue and anorexia associated with the psychic pain and tearful lamentations. This, says Pollock, is a regression to the earlier pleasure-pain principle operation. As greater ego integration occurs, reality-principle functioning and secondary process thinking return with the resulting amelioration of the psychic pain. (1961:p.347)

The main experience of this stage is the frustration which arises because the lost object no longer fulfills the need of the mourner. Pollock identifies the "animal-like" crying of the early phase of mourning as the expression of the primitive "cry of alarm signal", derived from the cry of distress that accompanies separation of an infant from the mother.

Pollock sees mourning work as essentially the same as the biological operation of adaptation. Fantasy-making and day-dreaming concerning the deceased person can interfere with the mourning work and in instances where the death of the object is not realistically appreciated, the object may continue to exist as an unassimilated introject with whom internal conversations can be carried on. (1961:p.348)

Stage 3. Separation reaction. His use of the term seems different from that of Bowlby and others who describe "separation anxiety" as the immediate response to loss. (Freud 1923, 1926; Bowlby 1951, 1961a; Ainsworth 1965).

Pollock seems rather to be referring to the work of mourning itself, that is, the ego's task of detaching the libido from the loved object. He speaks of the ego-adaptive task in mourning as requiring "a re-orientation in the perceptual sphere involving both self and object.". A "total internalization" of the lost object must take place in order that
the early anxiety experience of separation be resolved. Where there are tensions arising from negative feelings or non-neutralized aggression, the integrative task of reconciling external reality with internal structures is difficult.

The principle means of internalization are introjection (the method) and identification (the end-result). When there is total assimilation or identification, the mourning process is short. Despite the presence of the pain of grief, reality can be perceived and dealt with appropriately. On the other hand, when there is poor integration between self and not self, the lost object may be retained by some process of hallucination, and separation is not effected.

Where there is poor ego integration, the hyper-cathexed internal object may be projected and hallucinated as an external figure. The hallucinatory process in this instance is a manifestation of what happens when instinctual-tension is not discharged because the real object is lost, and we have a primitive type of ego organization. Separation is not accepted and the lost object is hallucinatively retained. (Pollock, 1961:p.349)

It is as though, despite the death of the loved object, the bereaved person still responds to the introjected but un-assimilated object. Because of the lack of full identification and ego integration, negative attitudes towards the lost object, now attached to the persisting introjected image, lead to symptoms of melancholia. There continues a secret internal "communication" with this object. When the deceased person is retained as one who can be spoken to and envisioned, and the death is denied, the process of mourning is frustrated.
Pollock emphasises that anger at being left by the deceased person and at being frustrated is a part of the separation reaction. Whereas children express frustration and rage, adults defensively displace their hostility onto others or direct it to themselves, where guilt feelings mingle with grief and lead to typical expressions of depression and "guilt-expiating rituals".

He sees "separation anxiety" as expressed in such behaviours as attachment to the coffin and keeping the deceased person's possessions and room furniture intact, as Queen Victoria did after her husband's death. This denial of death or refusal to let the person die takes many forms.

The principle difficulty in accepting this kind of theorising is its emphasis on the notion of instinctual energy operating in what Bowlby disparagingly calls the "hydrodynamic theory of instinct" (1961a:p.324). One has continually to translate the technical phraseology of such sentences as: "The task of mourning consists of internal object decathexis with the freeing of energy for later recathetic activities" (p.352). There are probably other ways of describing the process of detaching feelings from the lost person and attaching them to others.

Another difficulty is that already referred to in regard to Bowlby and Parkes, the deceptiveness of describing "stages" which gives the impression that a natural and instinctual sequence of events is being described, which will be worked through by the bereaved person. Although Pollock described various components of the three "stages", the
distinction between stages and the idea of progression are hard to maintain in the face of the complexity and variety of empirical evidence.

To recapitulate briefly, the acute stage of the mourning process refers to the immediate phases following the loss of the object. These phases consist of the shock, grief, pain, reaction to separation, and the beginning internal object decathexis with the recognition of the loss. The reaction to separation brings with it anxiety as the perception of the loss in time and space is integrated, as well as the anger reaction.

As the acute stage of the mourning process progresses, the chronic stage gradually takes over. Here we find various manifestations of adaptive mechanisms attempting to integrate the experience of the loss with reality so that life activities can go on. Adaptation in the chronic stage of mourning involves the further integration of newer reality demands which include newer functional need gratifications and demands. The ego is able to withstand the more immediate effects of the loss of the object, and to begin the reparative aspect of the more lasting adaptation. (Pollock, 1961: p. 352)

Pollock has brought together a wealth of clinical evidence enhanced with observations from animal studies. Despite his welcome affirmation on mourning "as a process of adaptation", his three-stage theory and his psychoanalytic dynamism do not lead us to a fully satisfying understanding of the processes of the work of mourning nor of the effect of the intervention of the psychoanalyst in the mourning work.

There is another way in which the process of psychoanalysis illuminates the nature of the work of mourning. Freud himself hinted at the similarity between the general task of psychoanalysis and the task of the bereaved person in doing his mourning work. Wetmore (1965) asserted that the central activity of psycho-analysis is accomplishing effective grief work.
One of the most important goals during the psycho-analytic process is the patient's attainment of the ability to grieve effectively, since without a prolonged period of effective grief there can be little permanent change or lasting personality reorganization. (1963:p.97)

Wetmore says that the child cannot grieve effectively and therefore cannot relinquish the earliest essential object-relationships. In this he is in agreement with Deutsch who wrote:

My hypothesis is that the ego of the child is not sufficiently developed to bear the strain of the work of mourning and that it therefore utilizes some mechanism of narcissistic self-protection to circumvent the process. (Deutsch,1937:p.13)

The repetition compulsion arising from these early attachments continues to dominate the personality until the ego knows itself to be strong enough to tolerate the separation anxiety and face the work of grieving. After a period of therapy during which a great deal has been made conscious and the ego has been strengthened by the acceptance of the therapist, the ego can develop "the courage to discard its infantile behaviour patterns". He explains that the very goal of psycho-analysis is "the freeing of the patient from his repetition compulsion". In so far as a person distorts the present in terms of past experience he is suffering from neurotic illness; his neurosis consists in his infantile demands and his particular ways of seeking satisfaction in them.

Therapy takes place when the patient is able to respond to the pressures of the therapeutic relationship which demand that he accept the reality beyond his own closed little world, and relinquish his attachment to the elements in that
inner world. Wetmore approves of Fairbairn's description of treatment as arising from the conflict between the unreal world of the patient and the real world of the therapist. Fairbairn describes treatment as resolving itself into a struggle on the part of the patient to press-gang his relationship with the analyst into the closed system of the inner world through the agency of transference and a determination on the part of the analyst to effect a breach in this closed system and to provide conditions under which, in the setting of the therapeutic relationship, the patient may be induced to accept the open system of outer reality. 

(Fairbairn, 1941)

The grief work that Wetmore sees to be essential for healthy development and which is accomplished in psychoanalysis, is occasioned by a particular kind of psychic bereavement experienced in infancy; that is, the loss of those objects which gave him essential satisfactions and which, while he received those satisfactions, confirmed the infant in his assurance of omnipotence.

The concept of infantile omnipotence was developed by Ferenczi (1913). He asserted that in the primary state of subjectivity of infantile existence, when he does not distinguish between self and the external world, the infant knows himself to be omnipotent. As reality brings about frustrations and restrictions, disappointments and failures in achievement, he must come to a more realistic understanding of the world and his relation to it. In his omnipotence, his survival seems to depend on his control of those objects which satisfy his needs. As reality presses upon him and separation from his beloved and dominated objects seems imminent (and is indeed essential for maturity) he tends to perpetuate the
infantile object-relationship through the neurotic fantasy that nothing has changed and that he still possesses those objects which assure him of survival, security and satisfaction. If he can maintain the fantasy of omnipotence and attachment he will never need to face the reality. Anger arises as the fiction of omnipotence is admitted; anger is essentially the aggression that arises with the frustration of not getting one's own way. If the fantasy of omnipotence is to be maintained, anger may need to be repressed.

This is the general theory of the infantile origins of neurosis and its similarity to the experience of bereavement by death can be discerned. Jetmore's idea is that therapy brings about a vital encounter between the person and his past separation anxiety, and enables him to accept the severance of his infantile object-relationships, to dissolve his fantasies and to accept reality.

In the psycho-analytic process, the patient is encouraged, both by the method and by the 'attitude' of the therapist, to relive his psychological development, and, as the past is relived, to discover that he can experience the separation anxiety that so much effort and energy have gone into avoiding, and to grieve effectively. May we not consider the entire psycho-analytic process, from the long and tedious recall to the final burst of grief which, at last, accepts the loss of the phantasy and of the infantile object-relationship, as a mourning one? (Jetmore,1963:p.99)

Without accepting the whole body of psycho-analytic doctrine, we may usefully contemplate the possibility that the psycho-analytic insights about the processes of therapy may enable us the better to understand the therapeutic processes going on in counselling with a bereaved person.
As the ego grows under the acceptance of the therapist and its particular repetition compulsion is made conscious through the analysis of the transference, it reaches a point where for the first time it can tolerate the anxiety and grief against which it has been forced to defend itself. The experience of tolerating anxiety further strengthens the ego, so that at last it can make its compromise with reality and grieve away the object-relationships. (Netmore, 1963, p. 100)

Translating this into terms of counselling with the bereaved, we may discern several processes:

1. The counsellor, by the relationship he creates with the bereaved, confirms and strengthens the self-esteem of the bereaved.

2. In that relationship the bereaved increases in confidence and in self-affirmation to the place where he can explore the experiences and feelings of his bereavement.

3. The anxiety arising from injury to his self caused by the death and from the alarming truth of his own ambivalent attitudes are found to be tolerable and he is able progressively to release the defences which protected him from the threat of being overwhelmed or annihilated.

4. His self-confidence and self-esteem are further enhanced by these experiences of success so that at last the reality of the loss can be accepted, realised and contemplated without fear.

5. Detaching himself is painful but it allows new attachments to be formed which are themselves the means by which his maimed self grows out again.
Wetmore emphasises the necessity of the period of strengthening the ego to enable it to let go of infantile objects. He calls this letting-go "effective grief". The ego of the infant is incapable of this kind of activity. The ego of the mature adult is capable of it. The ego of the neurotic person must be strengthened before the work of separation can be done.

The courage to perceive what has been lost, its symbolic significance, and the ability to examine one's ambivalence about the object become prerequisites for effective grief-work. (p.101)

He makes the interesting observation that "anxiety is the forerunner of effective grief, as if a period of anxiety toughens the ego so that it can let go of infantile objects." Schein (1968) in developing his theory of personal change through interpersonal relationships, considered that guilt-anxiety has an essential part in making a person ready for change.

The concept of mourning as adaptive behaviour lies behind the thinking of Fleming and Altschul (1959) in a report of a study by a group of analysts of the effects in adult life on bereaved people in childhood of a parent. Such a loss is especially significant, for the bereaved is deprived of the one who supplies experiences necessary for normal growth and development. The response of the child is likely to be maladaptive. He may become an adult with marked immaturity in self-image and in development of ego-ideal and superego structures. Reality-testing, impulse control and self-object awareness were inadequate for adult functioning in many of the cases studied. They manifested ego deficiencies more appropriate to various stages of childhood development.
A significant feature of this maladjustment was defensive denial of the reality of loss at the time of bereavement. In the one case which Fleming and Altschul described in detail, this denial of the loss was manifested in psycho-analysis in denial of the significance of the analyst himself and in "insistence on repeating with the analyst the fictional relationship with the lost parent."

The subsequent resistance to transference was inimical to the establishment of a therapeutic relationship as a vehicle for therapy. A protective illusion enabled the patient to refuse to acknowledge the painful fact of parental death and to resume the work of mourning. A relationship with the therapist was a threat to this illusion.

Therapy was accomplished (over a period of 5 years with many hundreds of hours of analysis) when the repressed grief and ambivalence towards the parents were activated. This was done by means of analysis of her initial resistance to the transference relationship. After one hundred hours of therapy she learned of the analyst's plans for a vacation. Her subsequent feelings of helplessness and depression opened her to talking about her parents and the meaning of their loss. Little by little she acknowledged the pain of their loss and her negative feelings.

She was able to accept the death of her parents without ambivalence and guilt and to gain a new self identity with an orientation in present time. (Fleming and Altschul, 1969:p.428)

In their discussion these authors likened the ordinary process of growth and maturation to mourning work in that it is accomplished by a series of adaptations to
separations. Freud (1923) stated that "the character of the
ego is a precipitate of abandoned object-cathexes". The
objects to whom the ego is related do not die but in normal
growth maturity is accomplished by a succession of separations
or experiences of detachment from previous relationships.
"The step forward is in terms of change and giving up rather
than losing something."

It might be added that the step forward is in
terms of the formation of new relationships which accompanies
the surrendering of old ones. The detachment seems like a
death to the self. Just as the breaking of an adolescent
love affair may seem like the destruction of oneself to the
rejected lover, so the making of a new relationship means
the restructuring of the person as he enters the new relation­ship.

The view of the present writer is that the anxiety
of bereavement arises from the threat to the self of the
bereaved person. Rochlin (1953) emphasised, in his study of
a child deprived of his mother who sought solace and security
in his mother's fur coat, that the anxiety deeper than the
loss of emotional sustenance is that of the disintegration
of the self. The loved object is necessary not so much for
sustenance as for existence. Without it, he is not what he
was. Then separation threatens the self with cataclysmic
disintegration, as in some bereavements, the bereaved will
do anything to hold the lost person in the present in order
to preserve his own integrity and entity. Fleming and
Altschul stressed the denial of reality in response to this
danger. They and Deutsch (1937) and others have observed
the consequent absence of affect which preserves the illusion and hence the integrity of the old self. The illusion can be maintained as long as reality, in its disconfirmations, does not cause too much discomfort. When it does, the double task must be undertaken, to acknowledge that the old self is dead and to begin, at the point of acknowledgment, to shape a new one in accord with reality.

The importance of the threat to the self's existence experienced in bereavement is expressed in Lipson's study of denial and mourning (1963), in which he observed that a common consequence of denial of death is "ego splitting". The traditional psycho-analytic understanding of a person's response to object-loss is that he effects a "temporary introjection of the loved person," (Abraham, 1924). Fenichel distinguished two processes of mourning: "the first being the establishment of an introjection, the second the loosening of the binding to the introjected object." (1945: p.394). A prerequisite to the introjection is the acknowledgment of the loss. Lipson gave examples of bereavement behaviour which, he claimed, illustrate simultaneous introjection (and therefore acknowledgment of loss) with denial of the loss. The bereaved person may oscillate between two convictions, one that the person is dead and the other that he is living. This ego-splitting he saw as an interruption to mourning:

It is my conclusion, then, that the initial reaction to the loss of a loved one is denial accompanied by a splitting of the ego. This splitting of the ego is a reflection of the actual psychic state of affairs in that the ego is faced on the one hand with a highly
cathedected mental representation of the loved object, and on the other with an absence of perceptions of the object. The splitting is a compromise that acknowledges both realities. (Lipson, 1963: p. 107)

Lipson observed that both denial and introjection are "attempts to preserve the object." Introjection is a step on the way to relinquishing; denial, however, is a total rejection of the need for relinquishment. Introjection is an adaptive method of preserving some relationship with the lost person; denial is a maladaptive method of preserving a relationship. Lipson, referring to denial, added, "perhaps its more basic function is to preserve the ego."

Perhaps it could be asserted that every bereavement behaviour has the purpose of preserving the ego from disintegration or fatal injury. It may be truly described as adaptive behaviour. At peril is the integrity of the person. The bereavement may be likened to a massive amputation. The person will never be the same again. The readiness to change into someone different can be acquired only by painfully acknowledging the change in the self that has already taken place and by accepting new interpersonal associations which nourish the growth of his new self organism.
Influenced by the work of Bowlby and Robertson and by his own investigations of bereavement behaviour, Parkes (1969) developed his thinking on Separation Anxiety in an article published in the British Journal of Psychiatry Publication No. 3, *Studies in Anxiety*. In this paper he clarified many of his theoretical notions about bereavement behaviour.

He defined separation anxiety as the subjective accompaniment of awareness of danger of loss. As it is defined as a response to the threat of loss, he admits that it is not obviously a major element in bereavement but asserts that separation anxiety is the predominant affect in bereavement until the permanency of the loss is established and accepted. Bowlby came to essentially the same conclusion: that, although the majority of adults well adjusted to reality are not to be expected to respond to bereavement as though it were a temporary loss, in fact, when the knowledge of death is brought to them, they react with the same instinctive weeping-and-anger of a child calling his mother to return.

When he misses his mother the infant's response is to cry. This is a behaviour pattern that man shares with many lower species and which is adaptive: when the infant creature cries, his mother usually responds by returning to him. There seems to be no reason to doubt that it is this response system that is activated in the human adult who is bereaved ....
In the course of our evolution, it appears, our instinctual equipment has come to be so fashioned that all losses have been assumed to be retrievable and are responded to accordingly. (Bowlby, 1961a: p. 333)

Parkes accepts wholeheartedly this thesis about bereavement initiating in separation anxiety. He asserted that Bowlby's evidence from studies of children and from separation and bereavement behaviour of several different species "carries weight", although he admitted that "much of it is anecdotal in form." He sees separation anxiety as issuing in
(a) pangs of grief, characterised by yearning and pining for the lost person
(b) mourning behaviour, crying and searching for the lost person.

For several years Parkes had been closely associated with several substantial empirical studies of bereavement behaviour.

(i) "Cast Note Study". Of a total of 3,245 adults admitted to psychiatric units during 1949-51, he identified 95 (2.9 per cent) whose illness came on within six months of a significant family bereavement. 30 of the 94 were bereaved of a spouse, six times as many spouse-bereaved patients as would have been expected by chance. This Case-Note Study revealed a good deal else that confirmed that bereavement has an important part in contributing to mental illness. He reported on this study in 1964 and went on to several further areas of research. (Parkes 1964c).
This study aimed to investigate atypical reactions to bereavement. 21 (4M, 17F) bereaved patients at Bethlem Royal and Maudsley Hospitals were interviewed in 1958-60, most of them having been seen soon after entering psychiatric treatment. Each was asked to tell in his own words about the bereavement. (Parkes 1965).

(iii) "London Study"

22 unselected London widows under the age of 65 were interviewed several times (at the end of the first month of bereavement, and again at the third, sixth, ninth and thirteenth months) to find out how they were coping with the stress of bereavement. (Parkes 1971).

From the evidence of these studies and that of Lindemann (1944) and some others, Parkes developed his special emphasis on the initial bereavement behaviour of "searching" rather than, as Bowlby does, on angry weeping and protesting.

These studies show that when an adult human being learns of the death of a person to whom he is attached he tends to call for and to search for that person; at the same time, his awareness that such a search is useless, reinforced by lifelong restrictions on the expression of "irrational" behaviour and the knowledge that fruitless searching is painful, cause him to avoid, deny, and in many ways restrict the expression of the search. The resultant is a compromise, a partial expression of the search which varies in degree from person to person and even, within a single person, over time. (Parkes, 1969: p.55)

He does not minimise the importance of Bowlby's observation of weeping and anger, but he says that a bereaved person may have tears and anger for other reasons than the
bereavement. Searching, on the other hand, is specific to
grief of loss. Searching "is thought to be an essential
component of grief and central to an understanding of the
process."

It is instructive to observe how Parkes developed
somewhat similar categories to those of Robertson and Bowlby
in describing the experience-sequence of adult grief.

<table>
<thead>
<tr>
<th>Robertson</th>
<th>Bowlby</th>
<th>Parkes</th>
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<td>(1953a,b)</td>
<td>(1961a)</td>
<td>(1972)</td>
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1. Protest
   Yearning (urge to recover lost object)
   Alarm: Searching

2. Despair
   Disorganization
   Mitigation: Anger-Guilt

3. Detachment
   Reorganization
   Gaining new Identity

In characterizing the first phase of grief
behaviour as "searching", Parkes quoted from Robertson's
discussion of "protest" behaviour.¹ The behaviour that
Robertson saw as angry "protest" and Bowlby described as
"yearning" and an urge to recover the lost object, Parkes
described as "searching" for the lost person.

Each of the components described in the
preceding page is here - alarm, protest,
crying and searching. But note that what
Robertson is describing is not just the
effects of losing mother; it includes
the effect of being lost oneself.
(Parkes, 1972:p.43)

Parkes goes on to draw the conclusion that as the child is
"lost" and in "unfamiliar territory", he is driven to

¹ See p.42 above. This passage of Robertson (1953a) is quoted by Parkes (1972:p.43)
"searching" behaviour which aims to ensure the return of the lost person.

Parkes emphasised that "searching" implies not merely motor acts, movements towards possible places where the lost one may be found, but also "mental set" perceptual and ideational components by which the perceptual processes are readied to discern and structure any suggestion of a sign of the object sought. As an illustration he gives the following:

A woman is searching for her missing son. She moves restlessly about the likely parts of the house scanning with her eyes and thinking of the boy; she hears a creak and immediately associates it with the sound of her son's footfall on the stair; she calls out, "John, is that you?" (1969:p.56)

This illustration demonstrates the difficulty we may have with Parkes' notion. It implies an active, conscious search which would be recognized by an observer as bizarre. There is considerable evidence to show that many bereaved persons tend so to concentrate attention on the thought of the bereaved that they may think they see them for a moment in a stranger passing by, or in a moment of forgetfulness they may call out or speak to the deceased or think they hear them when a board creaks. This kind of misperception is common in the early days of bereavement and it may well be assumed that there is an unconscious "searching". Nevertheless, the description of a person as moving "restlessly about the likely parts of the house, scanning with her eyes" seems like the picture of psychotic delusion or a parody of the normal and rather painful and embarrassing experiences of mis-perception. It seems that in considering the evidence,
Parkes has bent it in the direction of his 'searching' hypothesis and disregarded other possible explanations.

He presented evidence from the three empirical studies to support the assertion that 'searching' is a behaviour sequence with the following components (Parkes, 1972: pp. 46ff.):

1. Motor hyperactivity: restless movement about and scanning the environment.

Almost all of the widows felt "restless and fidgety". Other evidence, including that of Lindemann, confirmed that restlessness and muscle tension are commonly observed in the early stages of severe bereavement. Parkes quoted Lindemann's account with warm approval:

The activity throughout the day of the severely bereaved person shows remarkable changes. There is no retardation of action and speech; quite to the contrary, there is a rush of speech, especially when talking about the deceased. There is restlessness, inability to sit still; moving about in an aimless fashion, continually searching for something to do. There is, however, at the same time, a painful lack of capacity to initiate and maintain normal patterns of activity. (Lindemann, 1944: p. 10 quoted by Parkes, 1972: p. 57)

Parkes set the words "continually searching" in italics and affirmed that Lindemann was in error. "The searching behaviour of the bereaved person is not "aimless" at all. It has the specific aim of finding the one who is gone." (Parkes, 1969: p. 57). Because the bereaved person seldom admits to having so irrational an aim, his behaviour seems aimless. But his real desire is to find the lost person so he has no satisfaction in doing anything else.
It seems probable that the restless activity is connected with the sense of meaningless. In a case of severe bereavement such as that of a widow, it is likely that most of the previous patterns of activity were associated with the deceased. His loss means that almost every normal habitual action leads to a painful sense of futility.

2. **Preoccupation with the memories of the lost person and thinking intensely about him.**

There was considerable evidence for this. Besides being absorbed in thinking about the deceased, many bereaved persons spoke of having a clear visual image of him. Parkes commented: "It is postulated that maintaining a clear visual memory of the lost person facilitates the search by making it more likely that the missing person will be located if, in fact, he is to be found somewhere within the field of search."

It could also be postulated that pre-occupation with the memories of the lost person arises because the unsatisfied yearning (not searching) for him who has for long satisfied important needs is always experienced with sorrow and disappointment. These needs must now be satisfied elsewhere but until means of satisfaction is found the pain of acute disappointment focuses attention on memories of the deceased.

3. **The development of a perceptual "set" for the lost person;** that is, "a disposition to perceive and to pay attention to stimuli" that suggest the presence of the person and to ignore those that are not relevant to this aim.

This need not be explained as due to "searching" for the lost person. It arises from the intense pre-occupation with the image of the deceased because of the pain of unsatisfied need.
4. **Focussing of attention on those parts of the environment which are associated with the lost person** and where the person is likely to be. Many widows admitted to feeling drawn to visit favourite places or to return to valued possessions of the deceased.

5. **Calling for the lost person.**

Parkes provided many instances of behaviours which he claimed to be evidence of this: for example, ambiguous sensory data were perceived as the lost person; sounds in the house were perceived momentarily as being caused by the presence of the still living person; many had a comforting sense of the presence or company of the deceased; some widows frequented places or were drawn to objects (e.g. a chair) associated with their husbands; some sought him in spiritualist meetings or felt drawn to the hospital or cemetery; many admitted to weeping; some cried out, addressing their dead husbands.

Despite this body of evidence of bereavement behaviours, it is not convincing to assert that it all points to searching for the lost person. Even though several (4 of 22) widows admitted to consciously "walking around searching for him" or to "wishing to find him", almost all the behaviours purporting to be evidence for "searching behaviour" may be explained readily in other ways. Although Parkes admitted that "Implicit in the act of searching is disregard of the permanence of the loss", he requires us to accept that while the bereaved person is searching, she feels and acts as if the lost person is recoverable, although she knows that this is not so.
There is ample evidence that in bereavement unconscious motivation is important, by which means the bereaved person defends himself from a too painful reality until he has built new patterns of behaviour and thought and begun to establish a new self-image. In due course he can contemplate the loss with a sufficient measure of acceptance, and the defences, useful to him in the early stage of acute disruption, can be laid aside. There seems no need to set up a single unifying principle such as "searching" by which all bereavement behaviour can be comprehended and related to a primitive biological or instinctual basis. Both Bowlby and Parkes are wedded to a similar but different "biological theory of grief". Parkes says that his theory "has been developed over the last decade but has not required major modification." (1972:p.28). Another interpretation of the evidence leads to the conclusion that his theory may not be required at all.

In the concluding paragraphs of "Separation Anxiety", Parkes, having reiterated that bereavement is characterised by the behaviour of "searching" and by the subjective component of "pining" or separation anxiety, asked, "What is the function of this behaviour?" He dismissed Freud's understanding of "separation anxiety" as inadequate.

Freud has spoken of the 'signal' function of separation anxiety in alerting the individual to the threat of loss. Searching clearly goes further than this in providing the individual with a repertoire of behaviour which maximises the chances of reunion with the lost object. (1969:p.66)

Freud actually defined separation anxiety as "reaction to the danger of losing the object." (1926:p.286).
Although Freud saw the similarity between this experience of an infant separated from the mother figure and that of an adult bereaved of a significant person, he did not identify them, as both Bowlby and Parkes have, to a large extent, done. Freud described "the work of mourning" in quite different terms.

Parkes asserted that in a young child suffering from separation anxiety and having no means of distinguishing between temporary and permanent loss, the function of searching is "obvious". That is, the behaviour consequent to separation anxiety is intended to cause the lost person to return. "In the human adult, however, who knows, or should know, when a loss is permanent, it can have no such function." This remark seems entirely to contradict all that has been claimed in the previous pages of the article, where he affirmed that the bereaved person is searching in order to ensure the restoration of the lost person. Now the author himself affirms that the bereaved person is not really searching in order to bring about the restoration of the lost person. Rather, he is detaching himself from the lost person as each effort to find the lost one fails.

Grief is commonly described as the process by which a person detaches himself from a lost object, yet here we have an important component of grief which seems to have the opposite function, the restoration of the object.

We know, however, that even in animals, unrewarded searching does not persist forever. With repeated failure to achieve reunion, the intensity and duration of searching diminish, habituation takes place, the "grief work" is done. It seems that the human adult has the same need to go through the painful business of pining and searching if he is to "unlearn" his attachment to a lost person. (1969:p.66-67)
In this passage we have a succinct statement of the "work of mourning" as described by Freud. It might have been made without all the intense effort to prove that bereavement behaviour is characterised by 'searching' and 'the urge to recover the lost object'. Both these concepts seem to be somewhat misleading. It seems that the "work of mourning" (to use Freud's term) or "grief work" (as Lindemann aptly re-named it) may be understood without recourse to the rather cumbersome "biological" hypothesis of Bowlby and Parkes.

Subsequent to this interpretation of bereavement behaviour as being characterized by "searching", Parkes wrote a full length book, *Bereavement: Studies of Grief in Adult Life* (1972), incorporating the results of all his research and the fruit of his reflection. In this book he developed a comprehensive theory of bereavement behaviour on the basis of his earlier conclusions about the importance of separation anxiety and his conviction that the principal characteristic of grief is "searching". He delineated five processes or stages in the progress of grief; they may be best understood as the five "faces" of grief.
IX
FIVE FACES OF GRIEF.

Reference has already been made to the researches of Parkes. (i) The "Case Note Study" (1964c), (ii) the "Bethlehem Study" (1965) and (iii) the "London Study" (1971) formed the basis of a "biological theory of grief" and in particular of his conclusions about the significance of Separation Anxiety as the origin of the primary grief response of "Searching". He continued his own research in (iv) the "Harvard Study" in collaboration with Glick, Weiss, Caplan and others at the Harvard Medical School. 68 unselected widows and widowers of Boston were interviewed 14 months after bereavement and the results compared with interviews of a matched control group of married men and women. The bereaved were distinguished from the non-bereaved by

(i) the evidence of more emotional disturbance such as depression, restlessness, insomnia, loss of concentration

(ii) the greater frequency of complaints of physical symptoms indicating anxiety and tension

(iii) the higher incidence of hospitalization: the number of bereaved who spent time in hospital was four times as many as the number of non-bereaved

(iv) the greater number seeking advice for emotional problems from ministers and psychiatrists (not physicians)

(v) the increased use of tranquillisers, alcohol and tobacco by the bereaved after their bereavement. (Parkes 1972:pp.21-22 and 201-204). This study was reported by Parkes and Brown in 1972.
In addition to these most valuable and substantial investigations, Parkes also brought together evidence from other sources (apart from the results of the decade of fruitful cooperation with Bowlby and the colleagues at the Tavistock Institute): for example (v) various statistical studies of the link between bereavement and mortality (Young, Benjamin and Wallace 1963; Rees and Lutkins 1967; Parkes, Benjamin and Fitzgerald 1969); and between bereavement and general health (Marris 1958; Hobson 1964); and between bereavement and certain diseases (Parkes, Benjamin and Fitzgerald 1969; Schmale and Iker 1966; Schmale 1968). (vi) the work of Maddison (1968, 1969, 1970, 1972) and his colleagues (Maddison and Viola 1968; Maddison and Raphael 1970, 1971; Maddison and Walker 1967; Maddison, Viola and Walker 1969) who, in their most substantial study, compared the health of 353 Australian and American widows under 60 with that of control groups of married women.

These results were similar to the results of the "Harvard Study". 28 per cent of the bereaved indicated marked deterioration of health, compared with 4.5 per cent of the control group. The bereaved showed more symptoms of nervousness, depression, fears, nightmares, insomnia, trembling, loss of appetite, loss of weight, fatigue and reduced working capacity. These symptoms have long been recognized as associated with bereavement. The widows also showed other symptoms less readily linked with bereavement: headaches, dizziness, fainting, blurred vision, skin rash, sweating, indigestion, vomiting, menstrual disturbance, palpitations, chest pains, shortness of breath, infections and aching (Maddison and Viola 1969; Maddison and Walker 1967).
Parkes' book *Bereavement: Studies of Grief in Adult Life* (1972) has brought together the results of more than a decade of substantial research. As John Bowlby's foreword says, "It is certainly the first book of its kind, and for many years to come is likely also to remain the best." From the point of view of the present inquiry, the question being asked of Parkes' book is, Does it deepen our understanding of bereavement so that in counselling the processes of normal mourning (the task of severance) may be facilitated and morbid sequelae of bereavement may be minimised?

He considers that grief can be regarded as an illness. Like illness, it is characterized by discomfort and disturbance of function; society treats the bereaved person as someone temporarily disabled. Common language likens bereavement to a 'blow' and grief to a 'wound' which must be allowed to heal. It is the only "functional psychiatric disorder whose cause is known, whose features are distinctive and whose course is usually distinctive". Although it is usually described by psychiatrists as "reactive depression" its most prominent feature is "separation anxiety". The "pining or yearning that constitutes separation anxiety is the characteristic feature of the pang of grief". For this reason, he asserted that if traditional psychiatric diagnosis is to be used, it should probably be categorized as a "subgroup of the anxiety states" rather than a "reactive depression". Furthermore, he observed that grief is not a state but a process, a "succession of clinical pictures", a movement from numbness, through pining to depression. Nearly every case of grief shows the common pattern and sequence.
In addition, according to Parkes, the loss sustained in bereavement is usually not simple. It is seldom clear exactly what is lost. Death of a husband may mean loss to a widow of a friend, co-worker, sexual partner, financial provider, audience, gardener, chauffeur, bed-warmer, accountant, depending on the roles of the husband in her life. There may be consequent loss of income, loss of status, loss of house or occupation, as well as loss of support and of love. Two other consequences are associated with these losses:

1. **Stigma**: friends fall away, social occasions become less frequent, invitations fail, embarrassment or pity or strained and distant feelings may colour relationships with people. Many ordinary sources of support disappear as though her company was tabu and she was to be avoided. Alongside this is

2. **Deprivation** of essential love relationships which previously nourished self-esteem and sense of personal worth. The needs of personal intimacy, creature comfort, personal feedback and security are not satisfied as they were.

Parkes, even in drawing attention to these elements of bereavement, failed to emphasise their true significance in the progress of the person towards adjustment. The observations were made but there is little attempt to integrate these ideas into his theoretical system. It seems that the dislocations in the self-image, the disruption in the inter-personal relations, and the disturbance in life-values and self-appointed goals are the very stuff of the bereavement experience. The symptoms, which Parkes was at pains to categorize seem superficial; the self-structures
which have suffered injury and have to be reformed by painful processes are of deeper concern. At one place in his discussion he briefly illuminated this dimension and said that the basis of grief is resistance to change.

In the ongoing flux of life man undergoes many changes. Arriving, departing, growing, declining, achieving, failing - every change involves a loss and a gain. The old environment must be given up, the new accepted. People come and go; one job is lost, another begun; territory and possessions are acquired or sold; new skills are learnt, old abandoned; expectations are fulfilled or hopes dashed - in all these situations the individual is faced with the need to give up one mode of life and accept another. If he identifies the change as a gain, acceptance may not be hard, but when it is a loss or a 'mixed blessing' he will do his best to resist the change. Resistance to change, the reluctance to give up possessions, people, status, expectations - this, I believe, is the basis of grief. (1972: p.11)

It is disappointing that the author did not pursue his inquiry in the direction indicated in this last sentence. The evidence of "healthy" bereavement behaviour and pathological bereavement behaviour demands understanding of the nature of the changes in the self occasioned by the bereavement and the ways in which the self must become reformed and reorganized.

Using the evidence of the researches already referred to, Parkes described the progress of grief:

1. **Bereavement is a stress-situation** which causes the characteristic neuro-physiological reaction of alarm. This is an intense and primitive brain and nervous system response to an extreme situation of danger. Observations of the somatic and psychological concomitants of grief confirm this: restlessness, nervous tension, sleeplessness, loss of
appetite, dryness of mouth, headaches and similar symptoms of autonomic disturbance have been observed by several researchers. These are all signs of strain which occur in different kinds of stress situations other than bereavement.

Parkes referred to the observations by Cannon (1929) of the physiological preparation an animal makes in response to danger. Sympathetic stimulation and parasympathetic inhibition prepare the organism for instant action, be it "fight" or "flight". He mentioned too the crisis studies of Caplan (1955, 1961, 1964) and others which show that major life stresses disrupt customary modes of behaviour and require the person to abandon old patterns of behaviour and affective bonds and to create new ones. Caplan observed that moderate stress causes rapid learning and change in behaviour; severe stress has a numbing and overwhelming effect, which may lead to panicky rigidity or chaotic disorganization. In bereavement, the immediate response is often a numbness of all feeling and an experience of unbelief or unreality like a suspension of judgment. This numbness may last for some hours and days. It is like a kind of emotional anaesthetic which enables the bereaved person to continue some measure of living without being fully aware of the pain of loss.

Parkes asserts that a person's response to bereavement will depend on several factors: the characteristics of the stressor (the severity and significance of the grief); the person's coping techniques; his perception of the situation; his tolerance of anxiety. He might have added some others: his tolerance for disorganization; his perception of himself; his tolerance of guilt; his family and social
support systems; the quality of his openness to emotional reality in himself and others; his self images and values.

2. **The principal and characteristic feature of grief is "searching" behaviour.** The immediate response to grief is alarm behaviour with its accompanying quality of pining or separation anxiety, which is followed by a primitive biologically based response of "searching" for the deceased.

I would contend that the searching behaviour of the bereaved person is not "aimless" at all. It has the specific aim of finding the one who is gone. (Parkes, 1972: p. 47).

The approach in this book (1972) is similar to that of the article published in *Studies in Anxiety* (1969), which has been discussed at length. He sees the searching behaviour of bereavement as "the appetitive behaviour that mediates attachment to a human being". It is biologically determined towards the set-goal of "attachment behaviour".

The goal-situation to which these behaviour patterns normally give rise is the optimum proximity of the loved person. When this is achieved the appetitive behaviour ceases. But if the loved person is permanently lost, appetitive behaviour will tend to persist and with it the subjective discomfort that accompanies unterminated striving. This is what is experienced as frustration. (Parkes, 1972: p. 55)

Patterns of behaviour which once involved the presence of the dead person but which were not examples of love attachment behaviour can soon become re-structured; a person can soon learn to cook a meal for one instead of two. When, however, true attachment behaviour is sought, which demands physical proximity for its satisfaction, there can only be the pain of frustration and unsatisfied longing.
It is this that accounts for the persistence of the impulse to search long after habits such as laying the table for two have been unlearnt. . . . To the griever the only happening that seems important is the return of the one who is lost. And in social animals, from their earliest years, the principal behaviour pattern evoked by loss is searching. (Parkes, 1972: p. 56)

Parkes insists that the behaviour of the lonely widow can best be understood as the result of her being driven instinctively to more "searching"; a more satisfying interpretation of her experience can be had by seeing her behaviour as expressions of her various attempts to deal with the pain of loneliness and of unsatisfied longing. Somewhere in the night the reality of loss is accepted; somehow in the new associations of home and work and social life a new kind of self-organism is being formed which is structured about other relationships, until the need for affective bonds and for self-esteem are satisfied by other persons and activities.

3. Parkes' discussion of anger and guilt attempts to incorporate them into his overall theory of "searching". Irritability and anger are part of the 'protest' designed to cause the lost person to return; they express the feeling of insecurity in a hostile world. He says that they are part of an intense impulse to aggressive action. The idea that the dead person is not recoverable is a danger to be repulsed. Relatives who encourage the widow by expressing the hope that her pain will pass are met with hostility as though they were obstructing the search and its success. Similarly, guilt or attitudes of self reproach confirm the "searching" hypothesis:
In agonizing over events which were often quite trivial they seemed to be looking for a chance to castigate themselves as if by accepting blame they could somehow reverse the course of events and get back the missing spouse. (1972:p.84)

His interpretation does not satisfy. Many observers have noticed that these large negative emotions play a considerable part in bereavement. To explain them away as expressions of the instinctive "searching" behaviour seems to belittle their significance and leave them uncomprehended.

4. Another important process that operates, according to Parkes, is mitigation of the pain of loss. As the appetitive behaviour is frustrated there results an intensifying of the searching behaviour until, by a misperception of some sensory stimulus or by the acceptance of an idea that the dead person is invisibly near, the bereaved person has an experience in which he believes he has found what he is looking for.

This theory of mitigation is used to explain a whole range of experiences which tend to ease the pain of loss by granting some kind of mental contact with the lost person.
- the belief that the dead person is present or near or within the bereaved
- misperception of a stranger at a distance as the lost person (illusions)
- hallucinations
- irrational but 'comforting' behaviour, as though the lost person were present in some way or may soon return (e.g. rocking an empty cradle, setting a place at table).
- preoccupation of thought and imagination with the deceased
spiritualist activity to "communicate" with the dead
- dreams in which the lost person is present

In attempting to discern how a bereaved person is able to free himself from the compulsive searching and the continuous pain of frustration, Parkes postulates that he carries out a process called "worry work". This term was coined by Janis (1958) to describe how a person who believes himself to be in danger uses imagination to contemplate and face the danger, to make plans to meet it, and to alter his view of the world and to give up some of his assumptions and expectations in accordance with the dangerous reality he anticipates.

We have seen that a major change such as bereavement cannot be fully realised at one time. The bereaved person continues to act, in many ways, as if the lost person were still recoverable and to worry about the loss by going over it in his mind. This activity has been termed 'grief work' by Freud (1917) and it can be assumed to have the same function as worry work in preparing the bereaved individual for a full acceptance of the loss. (1972:p.75)

It is very doubtful if this does justice to Freud's idea of the "work of mourning". It seems clear that hidden behind the naive phrase "to worry about the loss by going over it in his mind" is the elusive mystery of healing of bereavement grief that we seek to uncover. Later he adds: "Presumably appraisal of a trauma normally enables a person to establish in his mind, as realistically as possible, the true external situation so that he can make appropriate plans to cope with it." (p.76).
His conclusions are expressed thus:

It seems, then, that several components go to make up the process of grief work:

1. There is preoccupation with thoughts of the lost person, which, I suggest, derives from the urge to search for that person.

2. There is painful repetitious recollection of the loss experience, which is the equivalent of worry work and which must occur if the loss is not fully accepted as irrevocable.

3. And there is the attempt to make sense of the loss, to fit it into one's set of assumptions about the world (one's "assumptive world") or to modify those assumptions if need be. (1972:p.77)

It seems that the excellence of the empirical researches needs to be matched by creative thinking about their significance if a more satisfying theoretical understanding of the work of mourning is to be found.

5. The last process that Parkes refers to is that of gaining a new identity.

He alludes to the need for a widow to learn new rules, and a new repertoire of problem solutions as she assumes a new identity. In giving up the old identity she may pass through a time of disorganization, aimlessness and apathy, marked by feelings of depression. She will experience many and extensive changes in her view of herself as she accepts the loss of a significant part of her self and grows out again as a new person in a new environment. Identification with the mind and values of the deceased gave stability and confidence to some widows. In this way they, in some sense, took into themselves significant elements of enduring quality of the deceased and took over roles he had vacated. Others found
their new identity emerging from new life situations, a
different social milieu and different role models from those
that previously influenced them.

In describing the five stages of grief, Parkes drew
together evidence from a number of clinical studies of adult
grief and his "system" is far more complex than the three-
phase descriptions of Robertson and Bowlby. Nevertheless, he
is dominated by his method of categorizing symptoms in phases,
seeking to structure his observations on the neuro-biological
stimulus-response model. Although he discusses "grief work" he
does not seem to give sufficient attention to what the
mourners are accomplishing and describes their behaviour in
terms of successive manifestations of symptoms.
THE TASK OF SEVERANCE.

(i) The Dynamics of Interpersonal Relationships.

Psychotherapeutic practice has given rise to numerous theories of personality and of the self which emphasise interpersonal as well as intrapsychic processes. Haley, for example, and other interactional and transactional practitioners (Berne 1969; Glasser 1965; Haley 1963, 1967; Haley and Hoffman 1967; Satir 1964, 1967) have concluded from their clinical experience that behaviour may be better understood not as a response to internal pressures or to external stimuli but as an integral part of the matrix of interpersonal relationships. The model of the self to be preferred in understanding behaviour is that of an open system of interpersonal relationships, with a hierarchical structure.

The concept of system owes much to the impulse of Norbert Wiener's cybernetic concepts of "information exchange" and self-regulation through "feedback". Jean Piaget has attempted to define the main elements of "structures" observed in several sciences:

As a first approximation, we may say that a structure is a system of transformations. Inasmuch as it is a system and not a mere collection of elements and their properties, these transformations involve laws: the structure is preserved or enriched by the interplay of its transformation laws, which never yield results external to the system nor employ elements that are external to it. In short, the notion of structure is comprised of three key ideas: the idea of wholeness, the idea of transformation, and the idea of self-regulation. (Piaget,1971:pp.4,5)
These principles imply a departure from the study of isolated phenomena such as lists of "symptoms" and a trend towards investigation of synchronously functioning unified behaviour systems.

This model of the self as an open system of interpersonal relationships is the most useful means of understanding bereavement and other "pathological" behaviour. Virginia Satir has demonstrated the significance of interpersonal interaction of the family in the maintenance of the "mental illness" of one member:

To understand the meaning of the symptom, I have to see how it fits into the family system. I believe that every piece of behaviour in a family is logical to that system. That's why I tend to see the whole family during the first meetings. Later on, I may take out the different units and see them separately, but I always make it clear that I am doing this within the framework of the family as a whole, and I never pull out any unit in terms of which is the sickest. (Satir, 1967: p. 98)

Haley and Hoffman have expressed the dynamic social interaction that characterizes personal experience of the schizophrenic patient in a vivid figure of speech:

To see a schizophrenic with his family is like seeing a fish in water for the first time, after one has only seen him stranded on the shore gasping and trying to fly with inadequate, fin-like wings.
(Haley and Hoffman, 1967: pp. ix-x)

So-called psychiatric symptoms are increasingly seen not as evidence of a diseased person but as behaviours appropriate to an interpersonal system. This concept of structuralism applied to interpersonal relations was fruitful in the study of schizophrenia by Bateson, Jackson, Haley and Weakland in 1956. They asked themselves what kinds of inter-
personal relationships and communications would induce behaviour that could be labelled schizophrenic. The schizophrenic, they thought, "must live in a universe where the sequence of events are such that his unconventional habits will be in some sense appropriate." (Watzlawick, Beavin and Jackson, 1967: p.212). So they were led to postulate the theory of "the double bind" which describes the qualities of his personal relationships with another person. The "illness" which develops is his response to a pattern of communication from others. The classic view of mental illness as a group of diseases characterized by their syndromes of symptoms has been challenged by this concept of the self as a system of interpersonal relationships. Some mental "diseases" are increasingly being understood as strategies which a person invents in order to live in an unlivable interpersonal situation.

This concept is not dissimilar to that of some other theoretical constructs or models of the self conceived as systems. Boulding (1956) postulated that a person's behaviour depends on his internal "image" of reality by means of which he predicts behaviour outcomes and acts accordingly. He emphasised the processes of confirmation and disconfirmation of the image by the environment and the consequent alteration in the image by a "feed-back" process. Miller, Galanter and Pribram (1960) extended Boulding's concept of the Image by defining the "Plan", the means by which the Image moves into action, as "any hierarchical process in the organism that can control the order in which a sequence of operations is to be performed." (p.16) Epstein (1973), having examined the classical statements of the self from James to Rogers, concluded
that an appropriate concept of self would be a system of hier-
archically organized concepts, developing out of experience, 
especially out of "social interaction with significant others", 
which has the function of organizing the data of experience and 
facilitating attempts to fulfil needs of the organism. Frank 
(1963) gave us the deft concept of "the assumptive world", 
a system of expectations with an in-built "feed-back" mechanism 
using emotions to call attention to unexpected or non-congruent 
outcomes of behaviour. A similar idea had been developed by 
Kelly (1955) who developed a theory of "personal constructs" 
which he defined as comprised of beliefs, assumptions and 
evaluations a person has about some objects in his social 
world. He taught his patients how to remake their "personal 
constructs" and how to test and confirm them in practical 
behaviour terms.

The model of the self as a dynamic system is more 
useful to psychotherapy if the subsystems are seen as predictive 
images concerning interpersonal relationships. It is in personal 
encounter that the self is differentiated and the sub-systems 
of the self are formed.

Bowlby emphasised that the key to understanding 
bereavement behaviour is in the model adopted to represent the 
process of object relations.

All who have discussed the nature of the pro-
cesses engaged in healthy mourning are agreed 
that amongst other things they effect a with-
drawal of emotional concern from the lost 
object and commonly prepare for making a 
relationship with a new one. How we conceive 
their achieving this change, however, will 
depend on how we conceptualize the dynamic of 
object relations. (Bowlby,1961a:p,319)
Sullivan (1953) saw psychiatry as dealing with interpersonal situations. For him, the vehicle of therapy was the person-to-person relationship which is the secure ground from which a patient may experience himself as a person and so may comprehend and respond to objective reality. In "The Psychiatric Interview", addressing psychotherapists in training, he declared, "If you are to correctly understand your patient's problems, you must understand him in the major characteristics of his dealing with people." (Clinebell, 1966: p. 101). Perhaps it may be said of Sullivan that he was limited (as Haley has suggested) by the concepts and language of his time, which had grown out of the study of the psychology of the individual.

Bennis and his colleagues in the introduction to "Interpersonal Dynamics" (Bennis, Schoin, Steele and Barlow 1968) deplore the failure of the social sciences to study adequately the relationships that arise in interpersonal communication.

There is as yet no single comprehensive theory of interpersonal relations .... the scientific study of interpersonal relations lags woefully behind the other areas of social research. (Bennis et al, 1968: p. 3)

They quote G. Allport: "It is only the merger that can profitably be studied." Martin Buber wrote: "A soul is never sick alone, but always through a betweenness, a situation between it and another existing human being." (Clinebell, 1966: p. 100)

Certain first principles concerning the organization of the structure of interpersonal relationships may be stated;
Its motivation is derived from or directed towards some primary goal or function, which necessitated the origination of the relationship and the presence of which is necessary for the relationship to continue. The relationship and the behaviour it comprehends are expressions of the interrelated persons fulfilling needs.

The cybernetic principle of optimum self-regulation points to a second principle that any behaviour is the person's optimum response to the pattern of his felt needs in that situation and relationship. There may be faulty external and internal methods of communication. There may be a conscious desire for one thing and an unconscious desire for another and opposite thing. The frustration may be painful. Nevertheless, the behaviour is the best response the person can make to meet his needs in the circumstances.

The third principle is that each behaviour is a response to another person perceived as a complex matrix of need-satisfying roles. The complex of needs in one seeks satisfaction in behaviour which is a response to the complex of need-satisfying roles perceived to belong to the other. The nature of the need-satisfaction depends on the kinds of roles attributed to the other:

1. Community Role. The other person is viewed as having some kind of status in the community, for example, a foreman, a shop assistant, a policeman. The relationship one has with this person in this role or status is capable of satisfying some element of one's need. The other is seen as a 'persona' acting a more or less significant part in one's life drama. Goffman (1959) developed this concept at length and his study
is illuminating despite the static nature of the interpersonal structure which he draws. He seems to pay little attention to what Cartwright called "the neglected variable of power" (1962: p. 414) which may be delineated as the influence operated by the capacity to provide need-satisfaction.

2. **Familial Role.** The other person is perceived as having a status similar to that of a member of one's family, such as that of a father or a sister; the relationship is capable of influencing one to behaviour which satisfies a need in regard to that relationship.

3. **The Self Role.** The other person is seen as another self like one's own with whom one may enter an interpersonal relationship so as to maximise need-satisfactions. Behaviours range widely over the gamut of moral significance. The other person may be the object of cynical manipulation or may be the means of an intimate "I-thou" relationship which satisfies highest level moral and personal needs.

Other studies throw light on role-relationship.

McGregor (1962: pp. 422-431) described a "hierarchy of needs", physical, social and self-affirming, which find optimal satisfaction within the complex matrix of personal relationships.

Kelman (1962: pp. 509-517) discerned three processes of social influence - compliance, internalization and identification - which are related to the concepts of complementary needs and roles.

In these and similar attempts to conceptualize the self, the essential nature is discerned in the functioning of the interpersonal relationships. In so far as other objects
are capable of satisfying some level of need, the organism enters into some kind of personal relationship, which is assimilated into the hierarchy of relationships that comprise the self.

(ii) Injury to the Self-Image.

Bereavement seems to mean the dissolution of part of one's own self, that is, of that part of one which consists of one's relationship with the dead person. This is an injury or psychic trauma to the self-system which may be slight or massive, depending on the quality of the personal relationship with the deceased. It may be likened to the physical trauma of the loss of an organ such as a limb. In physical loss the pain of the wound must heal and the person must recreate his life with activities that are satisfying, but do not require the lost limb. In bereavement, the pain of the relationship-loss must be healed, and new relationships must be created which do not depend on the presence of the dead person.

The total system of self is comprised of these relationship sub-systems, some of which are unavailable to awareness. Unlike the loss of the physical organ, which cannot be organically restored, the loss of the relationship from the total self-organism can be compensated for by the development in time of new relationships. The loss of a large and significant sub-system of the person means that the change will be correspondingly large. Whether the loss is large or small, the previous self can never exist again and the new self will be different.
An analogy of bereavement is seen in the damage to body-image in brain-damaged patients with hemiplegia following a stroke. Friedlander (1966) summarised the results of several reports on the characteristic loss of body-image experienced by such patients. A study by Ullman of 67 stroke patients revealed that 54 reported the transient feeling that the hemiplegic limb was separated from or did not belong to the body. Nathanson et al found that 28 out of 100 consecutive patients with complete hemiplegia explicitly denied their hemiplegia (anosognosia). Babinski reported anosognosia present in 26 per cent of 300 patients. The term means lack of knowledge of one's symptoms and was introduced by Babinski in 1914.

The condition varies in severity. Sometimes there is denial of illness generally; sometimes specific denial of the hemiplegia (Babinski reported that one patient interrupted the consulting doctors discussing her case in her presence and said, "Why should I have treatment. I am not paralysed."); and sometimes merely a degree of inattention to the paralysed organs. There is some evidence that patients who give explicit verbal denial show less affect than others who merely look away from their hemiplegic side, not attending to it.

Several elements in the anosognosic syndrome as described by Weinstein and Kahn (1955) are seen with striking similarity in bereavement behaviour:

(i) neglect and/or denial of disability
(ii) disorientation for place and for time
(iii) reduplicative delusions
(iv) confabulations
(v) paraphrastic naming
The present writer's observations with several hemiplegic patients noted the denial of the hemiplegia; or, if the fact of obvious disability were brought to the patient's attention, the denial of its importance. It was minimised as of small significance. The patients seemed unable to conceive that the consequence of disability would be a loss or change of job. They showed an optimism contradicted by their own present condition.

This denial expressed itself in two striking ways:

(a) drawings of familiar objects such as tree, house, person were made which showed omission of a whole side of the drawing or of essential structures such as wall of a house.

(b) when walking across a room the patient would commonly walk directly towards an intervening object so that if he stayed on that course the hemiplegic side would strike the object. At the last second, by an adroit and almost imperceptible movement, the object was narrowly avoided. It is as though the patient says, in walking full into a chair, "That side doesn't exist" and that just before collision another, realistic, message says, "Move to avoid that chair or you will be hurt and your non-existence theory will be publicly exploded."

Another feature noted in hemiplegic patients was the generalised depression similar to that observed in some bereaved persons. The person sits still and is disinclined for any kind of action or interaction; he may express feelings of depression and sadness concerning various aspects of his
life (not the hemiplegia) and show signs of self-reproach and loss of self-esteem. He may also display hostility to some significant persons, a doctor or member of the family or employer. He may also show restlessness and dissatisfaction with ordinary activities.

This pattern of denial and depression and their associated behaviours is strikingly similar to that of bereavement.

Weinstein and Kahn (1955) examined 52 patients with explicit denial of illness and another 52 who showed implicit forms of denial. They concluded from a study of pathological, clinical, neurological, E.E.G., spinal fluid, behaviour and pre-morbid personality characteristics that those who denied the illness were predominantly proud, independent, conscientious and responsible people who considered illness as a sign of weakness or defect.

The outstanding characteristics of patients in this group (explicit verbal denial) concerned their (premorbid) attitude towards illness and the mode in which this had been expressed. All had previously shown a marked trend to deny the existence of illness. They appeared to have regarded ill health as an imperfection or weakness or disgrace. Illness seemed to have meant a loss of esteem and adequacy. With one exception, they were regarded by the informants as strong, "independent" people who were able to shake off or ignore their own troubles and counsel others. Attitudes towards work were also consistent. All were characterized as conscientious and responsible people. They had a great deal of drive and compulsive energy. The need for prestige and esteem was a prominent motivation in many interpersonal situations. The word 'pride' was almost invariably used by informants. Patients had tried in the great majority of instances to avoid becoming indebted or
accepting help from others. It seemed important for them to regard themselves as healthy, successful, and 'independent' people. (Weinstein and Kahn, 1955)

Here is a picture of a person whose self-image is constructed of many subsystems of interpersonal relations in which he sees himself in a certain relationship to others. The hemiplegia has caused the demise of these many relationships which comprise his self-image. This destruction may be so widespread throughout his self-system that it is intolerable. Life can only be sustained with some measure of self-esteem by a direct denial of the widespread trauma. Little by little the self-systems can be re-structured around new relationships based on more accurate self-images and as this new growth takes place the reality of the physical loss can be gradually admitted.

Similarly, bereavement may be described as an injury to the self-image. In the case of an intimate and long-lasting relationship, the bereaved person may experience the loss of a large part of himself. This loss is comparable to a serious injury to the body which results in the loss or paralysis of an essential organ such as a limb. Serious bereavement may result in such a gross disconfirmation of one's situation-definitions and frustration of one's expectations of self and others that it can lead to a massive disablement. The bereavement is to be seen not just as the demise of one who is totally other, but as the tearing out of vital parts of the self-image of the bereaved person himself.

It is not too fanciful to use the image of "Siamese twins". The death of one can mean the death of the other if
a large part of essential organs are held in common. However, if it is possible for a surgical severance to be made and for the wound to heal over and new tissue to grow, the surviving twin, after a period of severe disturbance and disorientation of self-image, may find a new life without his partner.

The bereaved person experiences the pain of injury within himself. Shock, numbness, unbelief and anger mingle with confusion and panic as alarming disconfirmation of self-image is experienced. If a satisfactory severance from the lost love object is to be accomplished, the injury and its pain must be acknowledged and explored.

Clinical evidence suggests that if this severance is to be made satisfactorily, negative feelings associated with the deceased must be acknowledged and resolved. It may require considerable effort and courage to bear the pain of this encounter with real parts of oneself. Only as this is accomplished can new relationships and behaviours be securely grafted on so that there develops a new kind of person who did not exist before.

Lindemann's list of morbid reactions may be understood as the response of a person who is unwilling to accept the injury to the self-image but who has a need to accomplish the severance task and to develop a new self-image. One major kind of response is to deny the injury and to attempt the impossible task of continuing to live as before. Hence such symptoms as overactivity, absorption in the image of the deceased, acquisition of the deceased's symptoms, and breakdown in relations with others.
Many bereavement activities show an unreal determination to deny at any price the reality of the loss of part of himself. There may be set up a conflict which causes the person to oscillate between denial and affirmation, between rejection and acceptance, between fantasy and realisation. Bit by bit, as Freud said, affirmation and acceptance and realisation take the place of denial, rejection and fantasy. These two opposed responses exist side by side in varying degrees.

The seriously bereaved person suffers a disruption in his sense of identity. He is not the person he was and the confusion and frustration associated with this loss of identity give rise to his hostility to anyone who may be connected with his hurt. Loss of social patterns, alteration in his personal relationships, actions detrimental to his economic security and the deeper experience of depression arise from the numbing experience of partial death to his own self.

These morbid reactions are increased if the severance task cannot be accomplished. The task may be inhibited if there are powerful negative attitudes of resentment and guilt associated with the deceased. The self-esteem can tolerate some forms of morbid denial more easily than the threat of negative and condemnatory feelings. The physical death of the loved person necessitates the systematic severance of widely dispersed structures of the self which were created out of the relationships with that person. It is as though the severance demanded by external reality cannot be tolerated while negative feelings associated with the deceased dominate the inner reality.
(iii) The Processes of Change.

A useful model for conceptualizing the way changes take place in bereavement is that developed by Schein. In his essay (1968), "Personal Change through Interpersonal Relationships", he wrote that there are many types of changes in behaviour resulting from interpersonal relationships, but the main issues are: how the types of change can be classified, how the process of change can be conceptualized, and how the mechanisms occurring in change can be identified. For the understanding of the process of change he describes three stages: unfreezing, changing, refreezing. These terms are derived from Lewin's (1951) three stage process of change: unfreezing, moving, refreezing; they are reminiscent of the Robertson-Bowlby-Parkes' trinity of phases of grief.

The satisfactory resolution of bereavement requires change and reorganization of the person's life, particularly in the areas of interpersonal relationships. Schein's model of change is described in terms of the circumstances and conditions which bring about the change. He sees things from an external point of view. Following Lewin, he envisages a system whose forces he can observe and manipulate towards desired ends. His evidence drawn from various experiments in behaviour change (for example 'brain washing', ideology correction, industrial training in human relations) has resulted in his developing an abstract and impersonal model, but it is a useful means of interpreting the very diverse kinds of behaviour observed in bereavement.
The resolution of bereavement is a process of change experienced by a person who has to surrender cherished activities, aspirations and gratifications and must reorient his life in terms of the new context in which the rest of his life must be lived.¹

Schein's model is conceptualized as follows (Schein, 1968:p.339):

The Process of Influence and the Mechanisms Underlying each Stage.

Stage 1. Unfreezing: creating motivation to change

Mechanisms: (a) Lack of confirmation or disconfirmation
(b) Induction of guilt-anxiety
(c) Creation of psychological safety by reduction of threat or removal of barriers

Stage 2. Changing: developing new responses based on new information

Mechanisms: (a) Cognitive redefinition through
(1) Identification: information from a single source
(2) Scanning: information from multiple sources

Stage 3. Refreezing: stabilizing and integrating the changes

Mechanisms: (a) Integrating new responses into personality
(b) Integrating new responses into significant ongoing relationships through reconfirmation.

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Personal communication P. Pentony. ¹
Schein takes the view that change is resisted because it implies that previous behaviours and attitudes must now be rejected. To a bereaved person it may be painful that he must go on living a 'normal' life as though the loss meant little to him. It may seem that he is required to reject the previous life style associated with the deceased and so, by implication, the deceased himself. This apparent rejection of the loved person is perceived as threatening to the self-esteem of the bereaved and is therefore intolerable. Hence the change and the severance task are delayed.

The event which precipitates unfreezing is the bereavement. It is accompanied by lack of confirmation or "disconfirmation" of many aspects of the self-system. Schein wrote of a "gradual atrophy", and this is probably true of the disconfirmation of bereavement despite the sudden and absolute fact of physical death. During the bereavement experience which follows the death, the old self-system of the bereaved suffers dissolution; there is a numbing experience of shock followed by ideas of meaninglessness and futility. Everything the bereaved person attempts exposes the trauma to his own person. C. S. Lewis described this "unfreezing" experience of disconfirmation:

I think I am beginning to understand why grief feels like suspense. It comes from the frustration of so many impulses that had become habitual. Thought after thought, feeling after feeling, action after action, had H. for their object. Now their target is gone. I keep on through habit, fitting an arrow to the string; then I remember that I have to lay the bow down. So many roads lead through to H. I set out on one of them. But now there's an impassable frontier-post across it. So many roads once: now so many culs-de-sac." (Lewis, 1961)
The second phase in unfreezing is "guilt-anxiety" induced as a person reacts to disconfirmation and is aware of inadequacy or failure or deterioration of the self. If the change in self-image demanded by the disconfirmation is so painful that it cannot be readily accomplished, the person's behaviour may manifest the "double-bind" behaviour. The confusion and pain may be evaded by means of denial; it can never be resolved fully until the essential change in self-image is undertaken.

In Schein's understanding, guilt-anxiety is an essential pre-requisite for change to take place. It is an uncomfortable experience arising from the conflict between self-expectations and real consequences of behaviour. Change will occur as the person attempts to reduce or remove and avoid guilt-anxiety.

The bereaved person may remain for some time in the pain and confusion of this stage of unfreezing. The clinical symptoms described by Lindemann and Parkes, for example, the absorption in the image of the deceased, the feelings of anger and guilt, the denial of feelings, the acquisition of morbid symptoms, can be understood in terms of Schein's model of "unfreezing".

If disconfirmation and/or guilt anxiety are too high, the change target will either leave the situation, or, if this is not possible, will become defensive and more rigidly cling to his present equilibrium. He will deny the validity of, or fail to perceive, disconfirming cues, and will repress feelings of guilt anxiety. (Schein, 1968: pp. 342-343)

The third phase in unfreezing is the opportunity for the person to enter a place of "psychological safety" in which
the threat of change is diminished and the barriers to change are lowered. Until this can happen, only neurotic pseudo-change is acceptable to awareness. In the place of "safety", cognitive redefinition, scanning and identification can facilitate change, permitting the new self-system to form.

The counselling relationship will often provide this place of psychological safety. The change agent (friend, counsellor, doctor, minister) not only provides this relationship but also confirms the changes that begin to take place. Schein points out that the change agent can also influence others to accept the changes and to permit and confirm them as the new self-system is formed. In bereavement, this acceptance by the family and friends of changes in self-image by the bereaved person is essential to satisfactory adjustment.

Change can only begin to take place, says Schein, when these three elements of unfreezing - disconfirmation, guilt-anxiety and psychological safety - are in a state of optimum balance. If the change is inherently anxiety-provoking because it brings with it the unknown, or if it is seen to have consequences the person is unable to bear (both of which may pertain to the bereaved person) the change agent may try to reassure him, try to help him bear the anxiety accompanying the change and attempt to show that the change may be more palatable than he has feared.

Thus, when a person enters a very supportive therapeutic relationship, he may find that he can begin to explore disconfirmatory experiences which happened long ago but which for the first time he can allow himself to plumb the real meaning of. In other words, it is not always necessary for the disconfirmation to occur in the psychological present.
All of us have accumulated a history of disconfirmations which however never led to change because there was insufficient psychological safety to permit us to really pay attention to the cues. Once we are in a supportive safe relationship, these early cues can lead to significant change. (Schein, 1968: p. 343)

In bereavement, the change sought is that the bereaved person acknowledge the loss and accept the new identity he must make for himself without the lost person. If it is understood that the change that must take place is within the self-system of interpersonal relationships of the bereaved as a consequence of the death of the loved person, Schein's model is illuminating not only for recent bereavement but for those childhood and adolescent experiences of loss which have unsatisfactory consequences in later life.

(iv) Bereavement and the Resolution of Ambivalence.

To understand what the mourning is accomplishing it is necessary to perceive what is happening to the self as experienced by the bereaved person. If the self is conceived as a hierarchical system of interpersonal relationships, the bereavement, which is perceived by a third person as a separation between deceased and bereaved, is experienced by the bereaved as a severance of a living part from his total self and indeed the demise of his old self as he had known it. All that part of him which was in relationship with the deceased he must permit to fall away. This severance is difficult if the previous relationship formed a large part of his self. Not only is the pain of unsatisfied desire severe but the task of growing out a new sub-system of the self is considerable and takes time and effort.
In order for the severance to take place there must be acknowledgement and acceptance of its necessity. The relationship which was once deliberately created must now be deliberately severed or dissolved. Clinical experience shows that this severance is not tolerable if there are negative feelings of resentment or guilt associated with the deceased. Both these negative forces press for some kind of action by which they may be resolved. Resentment is an attitude of hostility directed towards an object and can only be resolved by the resentful person acknowledging it and actively expressing forgiveness and esteem. Guilt is an attitude of hostility directed towards the self and can only be resolved by the person acknowledging it and actively appropriating forgiveness and self esteem.

The necessity for resolution of these negative feelings is absolute and it seems that the bereaved person cannot permit the severance of the relationship from his self while the negative feelings associated with it remain. For the severance to be acknowledged, the negative feelings must be first resolved.

In the absence of the deceased, this can probably only take place with the assistance of a third person. A friend, counsellor, doctor, minister or other significant person who can permit expression and acceptance of the negative feelings seems essential if the severance required by the bereavement is to be accomplished.

The experience of the bereaved persons whose case histories are outlined shows not a series of phases like those
of a medical disease but a variety of behaviours occasioned by the necessity of experiencing the pain of loss, acknowledging the negative feelings, accepting the severance to their own selves and undertaking the growth of new areas of the self.

Mrs. D. had a history of unsatisfactory relationship with her husband and her co-workers. She had always done all she could to please them and to be accepted by them. At the same time, she manifested rigid attitudes of disappointment with other people, of condemnation of them and of demanding that they change and become more moral and more religious. To the counsellor's question, "What lies behind this disappointment with other people?" she replied, "I suppose I must tell someone some day." When she was 12 years old it was arranged for her by her parents to meet her 9 years old sister on a street corner and escort her home. It was the sister's birthday and a party was planned. When the sister did not arrive at the time expected Mrs. D. was in anxious conflict because she had an appointment with her music teacher. In some distress, she went off to her lesson. Meanwhile the sister apparently arrived at the street corner and began to make her way home alone. On the way she was killed by a truck. When Mrs. D. arrived home expecting the party, the house was in tragic confusion. No one explained to her what had happened. Her pain and fear and confusion were multiplied when she learned the truth and found that her father blamed her for the death. She experienced a terrible and bitter sense of rejection and remorse. The loss of her sister and the blame and self-reproach mingled inextricably with deep resentment towards the father for what she felt was an
unjust accusation. In the twenty-five years since, she had daily remembered and sorrowed for the events of that day but had never spoken of it to anyone. The father still refused to see her or her children.

In counselling, she enacted a bitter scene of hatred and hostility towards the father and in expressing her desire to forgive and accept him, experienced also a measure of self-acceptance and forgiveness. Having opened up the way to awareness of these conflicting and negative feelings, she was able to explore the meaning of the sister's death and to come to an acceptance of it and of the reality of her own present circumstances. Subsequently she began to rebuild her relationships with people as she became increasingly aware of a new self-image as an acceptable person. At the same time her need to project her negative feelings diminished and she became more accepting of others. This changed their attitude to her and her self-esteem was enhanced increasingly.

Mrs. D's sad experience of rejection and resentment was linked with that painful day of bereavement. The deep anger felt for her father had never been acknowledged. It was intolerable to her very religious convictions. The reverse was true. She displayed, especially towards men, a loving and submissive attitude. That there was in her a contrary and ambivalent state was intolerable to awareness. When her sister died, she was required, as are all bereaved persons, to explore and accept the meaning of the loss and the severance of an important part of her own self-image. This severance task she could not accomplish because of the impossibility of acknowledging the negative feelings of resentment and guilt associated with the
bereavement. In counselling, she was enabled to enter and acknowledge these negative attitudes, and so to accept the task of self-severance required by the bereavement. As the new self-system was organized she was able to release new objective attitudes to others, increasingly free from resentment and projective condemnation.

Mrs. L. was a woman in her mid-forties when her son of 10 years, the second of three children, died of carcinoma after a long illness. Despite some periods of hospitalization, he was nursed for most of this time by his mother at home, where he died. The mother's immediate response in the hour of his death was to leave the body for her husband and the visiting clergyman to deal with. In this and other activities at the time of the funeral and afterwards, she displayed what her religious friends considered to be admirable restraint and courage in not manifesting undue emotion. In the following three years she spoke of her grief at frequent intervals to a number of friends, especially at times of anniversaries of events connected with the deceased. Most of her friends became impatient with her and some told her "You ought to be over it by now." She felt that the family could never be the same. Several times she said, "Four's not a family." A number of times in this period she expressed misgivings that she had demanded too much of the dead son, been too ambitious for him and so caused him some unhappiness or frustration. There were significant expressions of self-reproach. With one friend who counselled her she revealed that the doctor prescribed a hysterectomy for her. She could not
bring herself to have it done. "That part of me belonged to him," she said.

It seems that in this period she was denying the loss that had taken place in her own self and in the family. The son's death meant that the previous family could never be again, and she felt herself unable to be part of "another" family. Her old self was intimately related with the dead son. That old self could never function again. The fact of death required a deliberate act of acknowledgement of the severance in her own self. She seemed to be attempting to maintain the unsatisfactory fiction that she could not change.

At the same time, there was change taking place in her life style. Before the bereavement she had worked and saved every penny for some future "rainy-day" or for the children's education. She had long spoken of extending the house to allow more space for the five in the family. This was a dream for the future. Some months after the bereavement she began to spend freely. The house was extended, carpeted, air-conditioned and modernized; she began to speak more of living in the present than in the future.

Mrs. L. was compelled by her physical condition (and encouraged by her counsellor-friend) to accept the inevitable surgery. After successful surgery, she manifested rapid changes in life style. She spent money on clothes and family vacations; she ceased to "break down" at "anniversaries" and seemed to have accepted not only the son's death but her own new person and new life. The completion of this 4 year process seemed to be in taking the family for an overseas vacation.
Presumably at the hysterectomy she allowed the introjected presence of the son to be severed from her and felt able to accept that the old self with its life-style and expectations was truly cut away. She was able to develop new self-images without guilt and hence to create new personal relationships. She was able to cease remaining what she was not and to begin becoming what she was. The period of conflict was marked by both affirmation and denial; various behaviours showed compromise between the desire to retain the previous self and the need to recognize the necessity of severance of those old images of the self.

Mr. R. was taught in childhood always to suppress his feelings. He finds it extremely difficult to recognize his own or other's feelings. He is perceived as depressed with solemn mien and drooping lids. He sought advice about the relationship he had with his wife, and with her adolescent son of her deceased first husband. He explored his early childhood relations with a twin brother who dominated him all his life until he was killed in the war. The brother was extremely cruel to him, calling him insulting nicknames. Although he was bitterly hurt his parents were oblivious and the hurt was never expressed.

The exploration of the bereavement experience permitted a release of some negative feelings towards himself and the brother as well as towards members of his present family. Subsequently he found a measure of satisfaction in practicing how to get into touch with and express his feelings. In these attempts he began to increase in self-esteem and to create new and more satisfying relationships with his wife, with her son and with their children.
Mr. R.'s frozen affect was released somewhat as he reflected on the negative attitudes he had to the dead brother and to himself in relation to the brother. As he did so he was able increasingly to acknowledge the severance of that relationship and its irrelevance to his present self-system. He began to enjoy developing a new self-image with more positive attitudes to himself and to members of the family.

Mrs. N. is married some 10 years with no children. In a woman's discussion group she came into touch with her lack of desire for children and dislike of the feminine role. She condemned herself for this and is in truth petite, elegant and very feminine. At 6 she learned her father rejected her and wanted a boy; also that her parents blamed her for endangering the mother's life by seeking to be born in a breech presentation. She always played boys' games and hated dolls. She had deeply felt need for parents' appreciation and used to beg mother for assurance of love. Her father's frequent absences from home on business she interpreted as rejection.

At 14 the maternal grandmother died after 6 years of illness during which she was cared for by the mother (except for the last few months when the mother and grandmother separated with bad feeling). The mother expressed her irritation at having to nurse her mother. When the grandmother died of a coronary attack the mother blamed the daughter for the death. The girl loved her grandmother and felt that her grandmother was the only person who cared for her. She was bereft at her death and desolated at the accusation.
A narrow pietistic and moralistic religious upbringing deepened her in years of depressing self-condemnation.

After the grandmother's death the mother went "insane" and had periodic psychotic episodes thereafter.

Mrs. N., when invited to act what she would like to say to her mother, expressed extremely violent feelings of hatred, hurt and self-pity. Then she said, "I never cried for my grandmother" and began to weep.

In subsequent interviews (in all 3) she enacted an incident as a 6 year old when her grandmother forbade her to play with a neighbour's boy and she had violent anger for the grandmother. She told the imagined grandmother, "I hate you. I wanted to kill you. I wanted to stamp on your grave, to smash you and hit you." Then, acting the part of the grandmother, she said, "I'm sorry. I didn't understand. I want to be different." She also re-enacted several significant incidents of rejection and rebuke by parent figures in her later years (employers) and explored several other experiences of rejection, and her rejection-proneness.

Mrs. N.'s painful experience of condemnation and rejection were intimately linked with her grandmother's death. The self-injury she sustained in the bereavement could never be assimilated while such painful affect was unadmitted. The counselling provided what Schein called an area of psychological safety in which she could experience the meaning of her own bereavement-injured self, and actively acknowledge the negative feelings associated. Subsequently, she found a new job, blossomed as an increasingly confident and relaxed person,
accepted leadership in a youth group, decided on an ovariectomy and clearly took up the delayed task of reconstructing her self-system.

(v) Integrating the Changes.

Bereavement is an unwanted, unrehearsed and uncomprehended change in the self-system. The death demands the dissolution of all those sub-systems of the self associated with the departed and means the virtual death of the old self as it was, and the necessity to create a new self.

The grief of bereavement is experienced as a complex of unpleasant feelings arising out of the pain of unsatisfied desire at various levels of need, depending on the quality and depth of the relationship which is now severed:

I have longings that are unsatisfied. Only the deceased can satisfy me so I can never be satisfied. I feel lonely, rejected, disappointed. I cannot tolerate the thought of severance and of permanent dissatisfaction. I dislike the feeling of internal disruption and injury to myself. I am angry at whoever caused this. I feel guilty about a number of things concerning him and I condemn myself for the imperfections in my attitudes to him. I have resentments concerning him that I can never now express or have him understand. I wish he were here so that I would not feel this pain, sorrow, guilt, resentment, frustration and anxiety. Only his presence could comfort me.

This conflict continues until the bereaved person begins to acknowledge the reality of the separation and to reorganize the self about relationships with living persons and real objects. In order to do this, the task of severance from the self of those sub-systems of the self dependent on the deceased must be accomplished. The grief work is this task
of severance. It is accomplished by resolving the negative attitudes relating to the bereavement and by accepting the catastrophic change in the self-system and by "growing-out" new sub-systems of the self from other interpersonal relationships. The bereavement becomes tolerable only when the self has become radically altered and has, in fact, become a new self.

Just as the new response must be able to fit in with other parts of his personality, so the new person must be accepted and confirmed by his significant others. Schein observed that "for any change to become a stable part of the person, it must, at some level, become integrated with other parts of himself and be acceptable to those whose opinions and reactions he values." (1968:p.363). The significant others who relate to the bereaved person must be ready for and convinced of the desirability of the changes coming about in the bereaved. The suggestion of relocating residence or remarriage may be very congenial to a bereaved person developing his new self-image but may cause strife with family members not so well adjusted. The counsellor may need to work with the family also and teach them to accept the changes taking place so that the personal and interpersonal reintegration may be confirmed.
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