THE ROLE OF GRIEF IN PSYCHO-ANALYSIS

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The purpose of this paper is to re-emphasize the importance of psycho-analysis as a process, placing special emphasis on the importance of the grief work and the peculiar characteristics which differentiate it from all previous experience. The grief-work which occurs in the unique environs of the psycho-analytic situation and ' seals ' the cure will be referred to as effective grief, since it seems to me to differ from the daily recurring grief work described by Freud (1917).

It is my hypothesis that the child cannot grieve effectively, and therefore cannot relinquish the earliest essential object-relationships. This means that the repetition compulsion must continue in full command of the personality until the time when the ego discovers that it can tolerate the postponed separation anxiety and, so strengthened, can face the work of grieving. This mastery of original grief is essentially different from the working through of ordinary day-to-day grief, as described by Freud and others.

With experience, first as a patient and increasingly as a therapist, I have been intrigued with the role that grief and effective grief-work play in recovery during treatment. It has become clearer, as I hope the elaboration which follows will show, that one of the most important goals during the psycho-analytic process is the patient's attainment of the ability to grieve effectively, since it is my feeling that without a prolonged period of effective grief there can be little permanent change or lasting personality reorganization. Since I am talking not only of sadness, mourning, or the reaction to present loss which reawakens reaction to past loss, but of a unique emotional response experienced, perhaps, only in the psycho-analytic process, I have chosen, for the time being, the term ' effective grief ' to describe and differentiate it. The patient reaches a point in therapy when the particular response is available to him after a great deal has been made conscious and after the ego, strengthened by the acceptance of the therapist, has developed the courage to discard its infantile behaviour patterns.

Simple grief-work does not require a special ego state; it results in the transfer of libido from one object to another with the same concomitant intensities and distortions. Effective grief-work takes place only after the ego has undergone certain strengthening experiences; it results in a deintensification of the original object-relationships and of all of the operations of the id.

At one point in my psycho-analytic training it occurred to me that my colleagues and teachers must be keeping a closely guarded trade secret, a secret that they neither discussed, wrote about, nor taught. I went so far as to imagine that since, to me, the subject of the secret was the essence of the psycho-analytic process, it was guarded to prevent its becoming a subject for intellectualization, so that it could be discovered by the analysand in all its intensity in order to ensure recovery. This did not turn out to be the case: there was no such secret; there was, however, a very neglected aspect of the psycho-analytic process. This neglect is still very puzzling, for it seems to be the crux of the matter.

What is this matter with which we are concerned in our daily work? Is it not a process, employing a certain scientific method, which has as its goal the freeing of the patient from his repetition compulsion? Is not the degree of illness the extent to which he distorts his present living in terms of his past experience? Is not neurosis the degree to which the present is misconceived, distorted, and reacted to, as influenced by the phenomena of transference and of the repetition compulsion? This degree varies from distortion and misconception that negate the present to relative freedom from the distorting influence, not of the past itself, but of those factors in the past which give rise to the need to repeat earlier behaviour patterns. The patient

comes to the analyst to get rid of something. As Nunberg (1949) states, ' By health, the patient means something different from what the physician does, namely the gratification of all kinds of desire, impulses, expectations, hopes and so on. . . . Thus the wish for recovery contains, in the unconscious, two contrasting roots, one that emanated from the ego and hopes to gain control over the instincts, and the other coming from the id, which hopes for gratification of the instincts.'

Fairbairn (1941) uses different words when he 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 '. It is only when such a struggle ensues in all its intensity that growth in the therapeutic situation can take place. And so the troublesome symptoms and ways of behaving that cause difficulty in living inevitably plague the patient as he listens to his thoughts while relating them to the doctor. As the patient talks, he begins to repeat in thought and feeling all the patterns of behaviour he has ever used in relating to the significant persons of his past and present, until all his neurosis, that is, his infantile demands and his particular ways of seeking satisfaction of them—his own unique repetition compulsion—seems now confined to the person of the analyst.

Isaacs (1948) notes that ' the patient's relation to the analyst is almost entirely one of unconscious phantasy, and it is the making conscious of this phantasy that much of the treatment is concerned with, for in doing so it is found that the analyst not only has come to symbolize the most superficial and most recent objects but, also, as these displacements and sublimations are understood, the most primitive objects as well.' When the phantasy is made conscious and the patient can see the distorted and irrational elements in his thinking, is he cured? Of course not. He knows a great deal more about himself, but he is powerless to stop his repetitious behaviour. In fact, it is often at this point that he becomes more intent than ever upon satisfying his neurotic demands. What then is required of him? To answer this we must look again at the possible source of power that unconsciously propels him in his irrational, repetitious behaviour patterns.

Silverberg (1948) succinctly states that it is fundamentally human not to admit that there is something that one wants but cannot have, and explains the repetition compulsion and its component, transference, on the basis of such a feeling. It seems to be the universal experience that one makes a '. . . persistent attempt to deny the presence of those frustrating and restricting forces which have compelled the transition from the state of infantile omnipotence to the sense of reality, and makes a persistent attempt to undo that transition and to traverse it in a reverse direction. In all of its variety and multiplicity of manifestation, in all the attitudes and behaviour which are its expression, transference may be regarded as the enduring monument of man's profound rebellion against reality and his stubborn persistence in the ways of immaturity.' Ferenczi (1913) formulated the hypothesis that infants begin existence in a state of subjectivity, without distinguishing between self and the world external to it, and this produces a state of omnipotence which is modified with difficulty, through disappointments and failures in achievement and through education into a more objective appraisal of the world and the individual's relation to it. Balint (1952) further elaborates the omnipotent position by stating that satisfaction of all need is crucially important because of the infant's absolute dependence on the object. He then lists three conditions necessary for the existence of omnipotence: (i) certain objects and satisfactions can be taken for granted; (ii) no regard or consideration need be paid to the object; and (iii) there is a feeling of extreme dependence; i.e. the object and the satisfaction by it are all-important. Survival depends upon maintaining control over the object, then, and the continuous feeling of omnipotence will be continuous reassurance that the object is still controlled, and survival thus guaranteed.

The separation which the infant fears as meaning death, and which when imagined or imminent gives rise to anxiety, is as inevitable as physical growth; and in an effort to avoid anxiety caused by change from the known to the unknown, the infantile object-relationship is perpetuated through unconscious displacement. The phantasy is that nothing has changed from the time when he possessed those objects that represented satisfaction, security, and survival: as long as the illusion of omnipotence is so perpetuated he will never have to face the reality

of the separation that is so threatening. He would seek those objects whose symbolic representation reminds him of his infantile feeling of security and omnipotence, and would treat them in such a way as to maintain the illusion of his power which, paradoxically, was greatest when he was most helpless and most passive. Later in life, when the ' separation ' or ' separateness ' has lost all its destructive possibilities, he continues the phantasy which, for the rest of his life, will exert its neurotic influence through the unconscious.

It would be impossible to discuss the role of grief and grief-work, both simple and effective, in the psycho-analytic process without quoting liberally from Freud's concise and thoughtful description in ' Mourning and Melancholia ' (1917). ' Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an ideal and so on. . . . In what, now, does the work which mourning performs consist? . . . Reality testing has shown that the loved object no longer exists, and it proceeds to demand that all libido shall be withdrawn from its attachments to that object. This demand arouses understandable opposition.... This opposition can be so intense that a turning away from reality takes place, and a clinging to the object through the medium of a hallucinatory wishful psychosis. Normally, respect for reality gains the day. Nevertheless its orders cannot be obeyed at once. They are carried out bit by bit, at great expense of time and cathectic energy, and in the meantime the existence of the lost object is psychically prolonged. Each single one of the memories and expectations in which the libido is bound to the object is brought up and hypercathected, and detachment of the libido is accomplished in respect of it. Why this compromise by which the command of reality is carried out piecemeal should be so extraordinarily painful is not at all easy to explain in terms of economics. It is remarkable that this painful unpleasure is taken as a matter of course by us. The fact is, however, that when the work of mourning is completed the ego becomes free and uninhibited again.'

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 of the infantile object-relationship, as a mourning one?

Melanie Klein (1952) describes what seems to her necessary for ego change before the repetition compulsion can be altered: ' I suggested . . . that one of the factors which bring about the repetition compulsion is the pressure exerted by the earliest anxiety situations. When persecutory and depressive anxiety and guilt diminish, there is less urge to repeat fundamental experiences over and over again and, therefore, early patterns and modes of feeling are maintained with *less tenacity*. These fundamental changes come about through the consistent analysis of the transference: they are bound up with a deep-reaching revision of the earliest object-relationships and are reflected in the patient's current life as well as in the altered attitudes toward the analyst.'

Helene Deutsch (1937) notes that whenever grief in the adult takes an abnormal course, the severity of the abnormality is due to the intensities of ambivalence toward the lost object and that the abnormal course may appear as melancholia, anxiety, absence of grief, and suicide. She concurs in the hypothesis 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 . . . the fate of the omitted grief is the question of chief interest for us in the analytic history.... If grief should threaten the integrity of the ego, or, in other words, if the ego should be too weak to undertake the elaborate function of mourning, two courses are possible: first, that of infantile regression expressed as anxiety, and, second, the mobilization of defense forces intended to protect the ego from anxiety and other psychic dangers. The most extreme expression of this defense mechanism is the omission of affect. It is of great interest that observers of children note that the ego is rent asunder in those children who do not employ the usual defenses, and who mourn as an adult does. . .

' 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 as long as the affective process of mourning has not been accomplished '

(and is still a part of the repetition compulsion).

' Whatever the motive for the exclusion of the affect—its unendurability because of the ego's weakness, as in children, its submission to other claims on the ego, especially through narcissistic cathexis . . . or its absence because of a previously existing conflict with the lost object; whatever the form of its expression—in clearly pathological or in disguised form, displaced, transformed, hysteriform, obsessional, or schizoid—in each instance, the quantity of the painful reaction intended for the neglected direct mourning must be mastered.

' In any case the expediency of the flight from the suffering of grief is but a temporary gain, because, as we have seen, the necessity to mourn persists in the psychic apparatus.' *As long as this grief is not mastered, the repetition compulsion is in full command, forcing one to act as if the object had not been lost.*

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 infantile object-relationships.

Mourning, as Freud describes it, is for everyone a daily experience on some level of consciousness. The result of grief-work meant to him, I gather, withdrawal of the libido from this object and transference of it to that new one. Such a transfer is not in itself effective in bringing about a change in the personality. Effective grief-work results not only in giving up the object, but in a deintensification of the drive which determined the person's neurotic attachment to the object. The libido is not just transferred, but the inherent quality of the attachment is changed. In fact, it may not be transferred at all but only deintensified, as with incorporated objects where the nature of the attachment is altered rather than severed. The object is contained within the mourner without the previous neurotically determined attachment to it. That is, the incorporated object is seen more realistically and retained in a new relationship with the mourner, the object now devoid, or more nearly so, of wish-fulfilling distortion. This distortion may diminish *ad infinitum* as the grief process continues.

Lindemann (1944) describes the symptomatology and management of acute grief, noting that ' it is a definite syndrome with psychological and somatic symptomatology, that may appear immediately after a crisis; it may be delayed; it may be exaggerated or apparently absent. In place of the typical syndrome there may appear distorted pictures, each of which represents some special aspect of the grief syndrome and, by appropriate techniques, these distorted pictures can be successfully transformed into a normal grief reaction with resolution.' He notes that there is a tendency to avoid the syndrome at any cost, to refuse visits lest they should precipitate the reaction, and to keep deliberately from thought all references to the deceased. Anxiety and physical exhaustion—indicative of efforts at repression—guilt, hostility and morbid identification, seem to be pathognomonic of loss. He notes that ' patients with a history of former depressions and with obsessive personality make-up are likely to develop an agitated depression ', rather than a normal grief reaction.

Abram Blau (1955) mentions depression as a way of attempting to maintain the phantasy of possession, just as Searles' (1956) provocative paper on ' The Psychodynamics of Vengefulness ' gives us data about the flight from grief and describes another defence, that of vengefulness, which serves psychologically to hold on to the object as if it had not been given up. Depression, too, can be an effort to avoid grief by holding on to the object.

' Melancholia,' said Freud, ' is in some way related to an object-loss which is withdrawn from consciousness, in contradistinction to mourning, in which there is nothing about the loss that is unconscious.' So often the lost object is perceived by the depressed person and grieved for but without relief, for what is not perceived is the symbolic importance of the object.

Mrs A., a 44-year-old wife and mother, was severely depressed because she felt that her life was empty without the love of a physician who had been particularly helpful to her. She surveyed, under pressure, the realistic factors in the situation and saw that divorce and remarriage were impossible, even if it should transpire that he returned her feeling, of which she had grave doubts. The ' little girl ' quality of her attachment with idealization of the object in order to increase her feelings of security became clearer. Her depression did not lift until she began to see how she had cast the doctor in the idealized role of her father, who had died suddenly when she was five, and with whom she still had imaginary reassuring conversations.

Mr B., a 50-year-old lawyer, became enamoured of a secretary who had worked in his office for many years, feeling that he could not live without her. The fact that she did not love him pained him but did not decrease the intensity of his longing for her. Again, his depression did not decrease until he began to see her as a symbol of all his infantile desires which had been repressed, and to realize that it was her motherly quality which had attracted him.

In neither case was it clear what had precipitated the sudden reliving of the phantasy with a real person cast as the idealized object, but each had been subject to increasing frustration and hurt from a spouse.

Mr C. sought help for his severe anxiety when he found that his wife was dying of a malignancy. His capacity for grieving was great, and, though grief-stricken, he was not depressed. It became clear to both of us that, whenever he thought of separation from his wife, he found himself remembering his childhood and times of separation from his mother, and that his present grief contained elements of grief about earlier separations. Not all the factors involved in his readiness to grieve have become clear, but it does seem that the conscious connexions between the present and past objects made his grief effective and played a part in preventing his being depressed.

Freud says of melancholia, 'So we find the key to the clinical picture; we perceive that the self-reproaches are reproaches against a loved object which have been shifted away from it on to the patient's own ego.' Mrs A. and Mr B., in the examples cited, divided their reproaches between the guilty self and their respective mates with a resulting dichotomy of the good and bad external objects. As long as this position was maintained there was no chance of giving up either object. Mr C., on the other hand, was aware of his disappointment in his wife and of his guilt-tinged anger and so was freer to grieve through the separation.

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. Melanie Klein (1940) felt that the child went through states of mind comparable to the mourning of the adult and that this early mourning was revived whenever grief was experienced later in life. To return to the example of Mr C., it would appear that it is indeed true that early periods of mourning, or rather, periods of hurt when he did not consciously mourn or effectively grieve, were revived by his wife's illness and death, and revived because he, as a child, had not been able to solve them 'by carrying out the behest imposed by the testing of reality', and that only now, in his adult life, could he meet the requirements necessary for accepting reality, both in the past and in the present. She also stated that in the depressed position of infancy '. . . the object which is being mourned is the mother's breast and all that the breast and the milk have come to stand for in the infant's mind: namely, love, goodness, and security.' Neurosis is inevitable; the form it takes is determined by many factors. 'In normal development,' she says, 'these feelings are overcome by various methods.' Again, it is her view that when, in the infant, the depressed position is reached, the ego is forced to develop methods of defence which are directed against the pining for the loved object. These defences are against admitting that the object and its symbolism of love, security, and power are lost.

Mr E., who sought treatment during separation from his wife prior to her getting a divorce, felt that he could not live without her and prayed to God and to me to get her back for him. His mood during this early period was depressed and he was persistently manipulative. 'She was mine,' he said, 'why couldn't I do anything I wanted to her? She is my life.' He was unaware of the neurotic quality of his possessive control of her, which seemed quite natural to him, and was really perplexed that she did not return his 'deep love'. He had repeated with her the all-or-nothing relationship he phantasied he still had with his mother. He exhibited, in his four hundredth hour, the essence of his infantile omnipotence, meeting all Balint's requirements, and made a last ditch stand in the transference to perpetuate his omnipotence with me. His depression was a defence against grief, a refusal to mourn, and a reluctance to feel the hostility which would lead to the experience of loss.

Freud states that the occasions giving rise to melancholia for the most part extend beyond the clear case of a loss by death, and include all those situations of being wounded, hurt, neglected, out of favour, or disappointed which can reinforce an already existing ambivalence. Effective grief work during psycho-analysis arises from the loss of a phantasy which included protection against all those hurtful experiences. In my experience, 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. Klein feels that destructive impulses are the primary factor in the causation of anxiety since

the infant feels that whenever the mother disappears she has been destroyed by his sadistic impulses. He is afraid not only that she will not return to satisfy his needs, but that some feeling in himself is responsible for her not returning. Not having his needs met is cause for anxiety, as is the feeling in himself which might bring this about.

Anger is the admission of the loss of the fiction of one's omnipotence, since inherent in anger is the realization that one is not getting what one wants. The repression of certain kinds of anger also serves to maintain the omnipotent position.

We may ask why the infant on weaning cannot give up the breast and its symbolic representation. The child is not psychologically equipped to grieve effectively, for reasons already mentioned, nor for that matter is the adult, until certain emotional experiences have strengthened the ego. This orientation leads one to the conclusion that there is no grief experience to compare with the effectiveness of the psycho-analytic one in freeing the individual from the neurotic attachments of childhood. If, by the time there is the potential to grieve effectively, the incorporated objects are unknown and the primary external objects displaced, where else but in psycho-analysis can these be made conscious? And where can the emotional charge of all the investments in unattainable goals and objects be invested in one person, a person who could tolerate the inevitable separation following such an attachment?

It would seem that, at least to be effective in deintensifying the infantile demands, grief-work accomplishes the giving up of the symbolic representation of the objects embellished by all the wish-fulfilling characteristics given them to avoid the pain of reality. The child wants something, cannot have it, is frustrated, becomes angry, feels anxiety, and cries, giving it up and choosing another object, but always with the same persistence and intensity, so that the problem and tension are moved into another area. Effective grief-work must result in a lessening of the persistence and of the wanting, so that reality factors, such as availability, desirability, and symbolic significance of the object, are taken into account. Only if this happens can the repetition compulsion and its manifestation in transference be interrupted. This is the last and most fateful stage of the process, upon the intensity of which depends the outcome of all of the work that has been done before, and without which little has been effected in the interest of permanent growth.

These ideas, born of psycho-analytic experience, postulate that all neuroses develop because the infant cannot grieve effectively, but must build systems of defence against the acceptance of reality, i.e. the necessity for giving up object-relationships. Neurosis then becomes the inevitable direction of growth that can be changed only by effective grieving as the final stage in the psycho-analytic process.

Freud writes of grief as passing off after a certain time without traces of gross change. Is it not that change takes place only when effective grief-work has occurred? It is only during true grieving that the defences of a lifetime are relaxed, and whenever thereafter grief is inhibited or repressed, all defences, although less intensely, return, and symptoms recur. This suggests that grief-work never accomplishes its goal completely, but, once made available, may continue throughout life, bringing increasing freedom from infantile neurotic goals as it increases recognition of reality and the most appropriate responses to it.

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