Note: The Editorial Board made a special request that the author write this essay, and he kindly agreed.

Mourning

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The mere mention of the word "mourning" floods the mind with visions of tears and funerals and sounds of wailing and sobbing. Images of crying men and women, rituals of cremation, or of a body being lowered into a freshly dug grave, and tear-soaked words of condolence are among our immediate associations to the word. That it should be so is understandable, for loss of a loved one by death is the most potent trigger of the emotional reaction called mourning.

Used in a broader fashion, the term "mourning" also refers to the chain of sentiments aroused by any loss, big or small (1). This can range from the loss of physical health to that of material wealth. Surgical amputation of a limb can stir up a mourning reaction just as one's car being stolen can. Less dramatic events also have the potential of mobilizing the emotional sequence associated with mourning. A missed appointment with an out-of-town friend, a misplaced Montblanc pen, and an unexpectedly bad result in a college admissions test are all capable of causing us to mourn.

MANIFESTATIONS AND VARIABLES

Such a broad conceptualization of mourning has commonalities with its narrower usage. In either instance, mourning comprises of a set of emotions that unfold over time when one is faced with a loss (2-4). Shock and *disbelief* ("But I met him just last week and he appeared fine!") are the immediate responses. These are soon replaced by *emotional pain* and a desperate sense of *longing*. Depending upon the gravity of the loss, there might be *physiological disturbances* accompanying this stage. Pacing, sighing, clutching one's chest, pulling at hair, rubbing hands, loss of appetite, and disturbed sleep are often evident. As time passes, the turmoil seems to settle. The lost person is talked about in exalted ways and all his or her blemishes are glossed over; a lost object is an *idealized* object, mused Freud in his seminal paper "Mourning and Melancholia" (5). A mentality of *bargaining* also sets in: "Had I only done this or that, this loss might not have happened". Fleeting

moments of *self-blame* appear, although sustained feelings of guilt are not typical of ordinary grief. More often one encounters irritability and even *anger* at the occurrence of the loss in the first place. Sooner or later, this too passes. A sense of profound *aloneness* and *sadness* now takes over. The bereaved finds himself or herself *fluctuating* between heartache, pining for the departed one, dull indifference, and the dawn of resigned acceptance of the changed life situation. Gradually the rays of *hope* appear on the psychic horizon and the potential space for a substitute begins to open up. The night, it seems, is turning into day.

Lest this description appear too schematic or stylized, let me hasten to add a few caveats. *First,* grief comes in waves. It waxes and wanes. Just when recovery seems at hand, one is hit by a fresh upsurge of sorrow. Grief is hardly a linear process. The phases described here are useful largely for didactic purposes; human experience is always more complex than a catalogue of symptoms. *Second,* no mourning is ever complete and, by implication, no lost object of our affection is ever totally given up. It only is moved to a different place in one's heart. The pain diminishes, to be sure, and emotions do not get readily mobilized. The wound turns into a scar but the story remains.

A *third* caveat pertains to the fact that mourning is a process that takes its own time; it takes, for instance, about two years to recover reasonably from the loss of a truly loved one or from the breakup of a serious romantic relationship. The process, like the healing of a bodily wound, cannot be rushed. However, it can be delayed if certain complicating factors happen to be on the scene. Mourning over death, for instance, is prolonged if the death was unexpected, occurred in violent circumstances, was the result of suicide, and if the death left many unsettled accounts, so to speak, between the deceased and the bereaved. Moreover, the greater the impact upon the day-to-day reality of the bereaved, the harder it is to resolve the grief. The sudden death of a wage-earning head of a household is thus more difficult to mourn than the passing away of an elderly grandmother who was long-suffering from terminal cancer.

Mourning over the death of a child is profoundly difficult, if not utterly unfathomable. Not only is the occurrence contrary to the natural order of things (e.g., grandparents die first, then parents, then children, and so on), it is tantamount to a murder of dreams and hope for the future. Parents are left with the burden of "survivor's guilt" and find grieving to be a life-long nightmare. The pain is greater when the offspring lost happens to be an adolescent. Having brought the child to the threshold of adulthood and then to lose him or her is truly devastating. The fact that parents are often at cross purposes with their teenage children further complicates mourning such a loss.

COMPLICATED GRIEF

When grief does get stuck or complicated, the manifestations of ordinary mourning get prolonged over time. The tendency to become teary, feel that the deceased is not really dead, or both, normally experienced for a few days or weeks, now extends over months and years. The language changes associated with the acceptance of death (e.g., "Uncle Elvin *is* fond of sweets" changing into "Uncle Elvin *was* fond of sweets") get delayed and the dreams typical of early mourning (e.g., seeing the dead person alive, rescuing him or her from a life-threatening situation) continue long past a first few months.

More significantly, new symptoms appear. The most important among these is a peculiar attitude about the physical possessions of the deceased. Under ordinary circumstances, things left behind by someone dead are (unknowingly) divided into three categories: things that are thrown away (e.g., a toothbrush, socks), things that are given away to the poor (e.g., old clothes, shoes), and things that are kept and passed on as family heirlooms (e.g., jewelry, diplomas, private journals, unfinished manuscripts). Moreover, this disbursement is neither too quick nor too delayed; it usually takes a few weeks to a few months. In complicated grief, however, one notices a disregard for time in this context. One either gets rid of the deceased's things immediately (in a magical attempt at denying the significance of what has just happened) or hangs onto them forever, finding oneself haplessly unable to discard these items.

Another development is that things that ought to have been thrown away (e.g., dentures, old underwear, a glass eye, a half empty bottle of cold cream) are kept and, strikingly, held onto in a very strange way. They can neither be used nor thrown away. They cannot even be seen. Looking at them stirs up extremely painful emotions of anxiety, pain, and sadness. These things no longer remain mere physical artifacts; they become what Volkan has called "linking objects," i.e., things that connect the bereaved with the deceased in unspoken and mysterious ways (6).

In light of this, it is not surprising that the deceased's grave becomes a nidus of complex feelings on the part of the bereaved. In normal grief, the feelings one has towards a loved one's grave include tender respect and a peculiar mixture of wistfulness and a sense of reunion. Visits to the grave occur around the anniversary of the death, religiously dictated occasions, and when new members get added to the family via weddings and births (7); over the course of time, the frequency of such visits diminishes. However, when grief has become complicated, the grave acquires greater emotional charge. One either avoids visiting the grave altogether (and even forgetting its location) or becomes "addicted" to it, going there again

and again. A displaced form of this is the phenomenon of “obituary addiction” (6), whereby an individual with unresolved grief feels compelled to check out the obituary section of the newspaper every day. Not finding the name of a loved one who has died long ago provides an unconscious reassurance; it is almost as if that person is still alive.

One thing this description leaves unaddressed is the cause or, to be accurate, the causes, of a grief remaining unresolved. Certainly the depth of attachment one has with the deceased and the external and internal jagged edges left over by his or her departure contribute to the difficulty in mourning. What, however, goes contrary to common sense is that unresolved aggression, if not actual hostility, towards the deceased plays a significant role in "freezing" the process of grief. The dynamics of this are as follows. When there are unspoken hostile and destructive affects and fantasies directed at someone who dies, letting him or her go becomes tantamount to “killing” him or her; this results from the condensation and telescoping of the repressed anger with the reality-dictated necessity of the aggression implicit in moving away from an object.

ASSESSMENT AND TRIAGE

Since, regardless of specialty, every physician comes into contact with situations of grief and mourning, it is important to spell out some essentials of evaluating an individual in such circumstances. First and foremost, upon hearing that someone’s father or mother or brother or sister or son or daughter has died, the physician must not restrict his or her attention to the medical aspects of the occurrence. Questions must be asked about the expected versus sudden nature of the death, the circumstances surrounding it, and the impact that this death has had upon the bereaved’s day-to-day existence. Next, one should inquire about the funeral and explore the degree to which the bereaved participated in it. The fate of the ashes (if the deceased was cremated) or the location of the grave and the emotions that it arouses (if he or she was buried) should also form a focus of gentle but firm inquiry. The same applies to the physical possessions of the deceased. How quick or how delayed was their disposition? What objects are in the bereaved’s possession and what sort of feelings are attached to them? Raising such questions would allow a glimpse into the progress or blockage of mourning processes. As this conversation is taking place, the physician must also make a mental note of the changes in language that occur with a deeper acceptance of someone’s death (see above).

While known to most physicians, one simple fact can hardly be overemphasized: normal grief does not require medical intervention. It is, by definition, a normal

process. The attitude that all human suffering is not illness must be maintained; some pains are integral to life. This does not mean that individuals in this state of normal grief might not end up at a physician's door. When this happens, curiosity should be directed at the lack of social and familial support that has led to "medicalizing" a normal process. Parallel to such investigation, the clinical approach should consist of empathic remarks, imparting of information regarding the nature of normal grief, and a relatively hands-off policy, coupled with reassurance of availability should matters become more difficult. If, however, there is growing evidence that the grief is becoming complicated (prolonged emotional distress, unchanged language, difficulty disposing the deceased's physical possessions, and so on) then active therapeutic interventions do become necessary.

TREATMENT

The foregoing has implications for the sort of help one needs to offer to those with unresolved mourning. Listening to their anguish must, of course, be respectful and empathic; loss, after all, is not a pleasant affair. The therapist, regardless of whether he or she is in the mental-health field or not, should allow ample psychological space for the bereaved to elaborate their story. It is advisable to not meddle too much with sharp, intellectual comments. What the suffering of grief needs most is "witnessing" (8). Listening patiently and making occasional, brief, and affirmative remarks which demonstrate that one understands the pain of the patient is generally sufficient. The therapist may help the patient to talk in greater detail and encourage the bringing in of the deceased's photographs for the therapist and the patient to look at together. This would facilitate the emergence of hitherto repressed memories and release pent up emotions.

Such credulous listening and affirmative stance should, however, not eclipse a certain amount of therapeutic skepticism. In listening to someone with pathological grief, one must keep one's "third ear" open for the verbal and nonverbal cues of a hostile attitude in the patient towards the deceased (9). Such hints and allusions should be gathered silently at first. In other words, the tragic motif of grief must be allowed to run its course before one begins to point out that the patient has actually been somewhat ambivalent about the deceased. It is only with the conscious recognition and acceptance of negative feelings towards the dead person that the patient can fully come to grips with his true psychic reality. This step is necessary for the proper resolution of grief.

A less known technical ingredient of "re-grief therapy" (10, 11) is the use of linking objects described above. The therapist not only encourages the bereaved to talk more and more openly about his or her feelings of loss but also encourages

him or her to bring "linking objects" to the office. Encountering them, touching them, holding them, and reminiscing about them (and, through these, about one's complex feeling toward the lost person) helps thaw the frozen grief. That inanimate objects should help revive and resolve emotional reactions about someone who himself or herself has now become inanimate is an amazing paradox that, in the midst of tears, can bring a smile of gratitude to our faces. Such, as they say, is life!

SOURCE INFORMATION

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REFERENCES

1. Klein M. Mourning and its relation to manic-depressive states. Internat J Psychoanal 1940; 21:125-153

2. Parkes CM. The effects of bereavement on physical and mental health. Brit Med J 1964; 2:274-279

3. Parkes CM (1972). *Bereavement: Studies of Grief in Adult Life*. New York: International Universities Press.

4. Kubler-Ross E (1970). *On Death and Dying*. New York: Macmillan.

5. Freud S (1917). Mourning and melancholia. *Standard Edition* 14:237-258.

6. Volkan VD (1981). *Linking Objects and Linking Phenomena*. New York: International Universities Press.

7. Akhtar S, Smolar A. Visiting the father's grave. Psychoanal Q 1998; 67:474-483

8. Poland W (1996). *Melting the Darkness*. Northvale, NJ: Jason Aronson.

9. Reik T (1948). *Listening with the Third Ear: The Inner Experience of a Psychoanalyst*. New York: Grove Press.

10. Volkan VD. A study of a patient's re-grief work through dreams, psychological tests, and psychoanalysis. Psychiatric Q 1971; 45:255-273

11. Volkan VD, Cilluffo AF, Sarvay TL (1975). Re-grief therapy and the function of the linking object as a key to stimulate emotionality. In *Emotional Flooding*, ed. Olsen P T, pp 179-224. New York: Human Sciences Press.