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I follow'd rest; rest fled and soon forsook me;
I ran from grief; grief ran and overtook me.

—Quarles, *Emblems* (1635)

The shadow of death haunts man even when he does not think about it. With the expansion of consciousness characteristic of our age of awareness, the transience of our existence is brought home with greater force, particularly since the survival of the race has become an ever present concern. Yet man manages to deny this ultimate reality—his mortality—with illusions of perpetual youth, reliance on advances in technology, and naive belief in magical solutions.

Only the giants of our globe, according to Gorki, are able to live as if death did not exist while living in fear of it. The average human being has the task of finding a midpoint between denial of death and obsessive fear of it. It is noteworthy that the greatest intellects as well as the mentally ill show a marked preoccupation with death. The former transform their obsession into a creative quest for immortality; the latter suffer the anguish to the point of incapacitation. On the other hand, helping professionals, as well as average men, keep themselves busy avoiding confrontations with such questions as the impermanence of our existence.

Modern man does not place easy trust in religious systems to aid him in this dilemma; rarely does he believe in life in the hereafter. Grief, sorrow, and bereavement are inseparable companions of the human condition.

The health professions have recently addressed themselves more vigorously to the emotional impact of death and severe illness. Assistance to the dying patient and his family, as well as the rehabilitation of the physically injured or handicapped and those maimed by war or accidents, have finally emerged as central issues in modern psychiatric practice. And with good reason. Every patient soliciting help has many grounds for deep grief.

Bereavement has been defined as the "loss of a loved one and separation from others on whom we depend for sustenance, comfort, and security" (Erich Lindemann). The data on bereavement are staggeringly abundant and diverse; its sources are manifold. It is necessary to restrict the scope of incidents of bereavement dealt with in this chapter. However, the reactions to the specific losses discussed—primarily, but not only, through death—may be usefully applied by the practitioner to other incidents.

Whenever an individual suffers a loss—be it his homeland, his language, an ideal, a treasured material possession, a part of his own body, or particularly a beloved person—he normally undergoes a period of grief and mourning of varying intensity until he recovers the energy he invested in the lost object. The process of mourning is very painful. It is a travail that reconciles him to the loss and permits him to continue his life with unimpaired vigor, or even with increased vitality. A similar process takes place when one is confronted with a disappointment, failure, the loss of a love

object through rejection, divorce, abandonment, and the like.

Grief is a common human experience, for life does not spare any of us those events, major or minor, that cause sorrow. Normally grief, even over a very serious loss, is more easily resolved when shared; a person usually has some intimate friends or family members with whom he is able to share his pain. But beneath the surface of consciousness remains a core of deep sorrow that the bereaved person has to work through alone. Profound sorrow is silent.

In Agee's novel, *A Death in the Family,* after the heroine's husband is suddenly killed in an automobile accident, her father warns her that it will take time for the loss to sink in, and then it will get worse. He continues:

> It'll be so much worse you'll think it's more than you can bear. Or any other human being. And worse than that, you'll have to go through it alone, because there isn't a thing on earth any of us can do to help, beyond blind animal sympathy.

What a grief-stricken person needs is "common sense," love of life, and what we are accustomed to call ego strength, that is, endurance, courage, and the ability to face up to things.

An individual who possesses the stamina for confronting a severe loss only rarely turns to a professional to aid him in going through this process. Those who seek help are sometimes very lonely people who have the sense to

look for someone to share their grief with them, or they may display various aspects of the pathology of mourning, but the majority come for other reasons.

Pathology of Mourning

To paraphrase Parkes, grief may play as important a role in psychopathology as do inflammatory reactions in medicine. The inability to engage in mourning after a loss gives rise to a number of pathological manifestations. These may be psychological, physiological, or mixed in nature. The psychological reactions range from chronic reactive depressions, agitated depressions similar to those observed in menopause or middle age, and emotional anesthesia (Minkowski, Paris[1]), to intractable melancholia. Addictions and acting out may also be precipitated by bereavement. In delayed mourning hypochondriasis plays a special role; it may be looked upon as a kind of strategy to master paranoid feelings that are linked with denial of the death.

On the physiological side there are to be found conversion symptoms, psychosomatic disturbances, and identification with the physical symptoms of the deceased. Some individuals seem to develop the same physical condition that caused the death. Somatic delusions have also been recorded. Thus, a young man who lost his mother during adolescence and did not

mourn her death developed the menopauselike symptoms that she presented prior to her death, including crying spells regularly accompanied by hot flashes. A woman whose late husband had suffered for years from Parkinson disease developed a Parkinson- like tremor, gait, and masklike face.

Reactions to bereavement are difficult to classify because they cover such a wide range of pathological manifestations. Peretz distinguishes the following reactions to loss: (1) "normal" grief; (2) anticipatory grief; (3) inhibited, delayed, and absent grief; (4) chronic grief (perpetual mourning); (5) depression; (6) hypochondriasis and exacerbation of preexistent somatic conditions; (7) development of medical symptoms and illness; (8) psycho-physiological reactions; (9) acting out (psychopathic behavior, drugs, promiscuity); and (10) specific neurotic and psychotic states.

Before focusing on some specific types of loss, I shall discuss the general psychodynamics of mourning. In order to complete successfully the process of mourning, one must have the capacity to form object relationships of a differentiated type and to deal with ambivalence.

The Mourning Process

Just as "being in love" is a prototype of human psychosis (Freud), so, too, are various manifestations of mourning. Both are common experiences in which the distinction between normality and abnormality is effaced. After all,

there is nothing normal about nature. In reaction to the dead particularly, man still demonstrates an array of irrational beliefs and attitudes that fall within the range of normality. Some of these are culturally determined, some may be considered atavistic, handed down to us through folklore and, perhaps, through channels unknown to us. Thus, we often feel that the moment the soul leaves the body it is everywhere, sees everything, and is aware of our every thought. The first impulse is not to think anything bad nor to say anything derogatory about the dead. *De mortuis nil nisi bonum.*

The essential aspects of mourning are not clearly understood, particularly the kind of psychophysical pain that accompanies the pangs of conscience; but to undergo the process effectively, one has to have the capacity to face the feelings of hopelessness and helplessness evoked by the finality of death. “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,” said Freud."’ Some of it can be explained by the fear of the vengefulness of the spirit or ghost of the dead. A vengeful image of the dead only too often terrorizes those who had an intensely ambivalent relationship with the departed and who repressed or denied their hostile feelings, particularly obsessive, compulsive characters. But it would be a mistake to think that hysterically defended bereaved persons are free from such tortures.

When the relationship was more or less mature and well integrated, the loss, however hard it may be to bear, has a different quality of pain. One may miss a person intensely, and feel the full impact of the loss—psychologically, economically, or in status, as in the case of a widow—and one may have feelings of slight remorse. Nevertheless, there is little need to expiate one's guilt, to justify one's past behavior, apologize to and appease the dead. One is able to deal more realistically with a real loss because of the relative absence of unconscious guilt.

I shall describe the process of mourning in a 34-year-old woman who lost her extended family—her parents, a brother three years older than herself, a sister two years younger, a grandfather, and a host of cousins, uncles, and aunts—during the German occupation of the Ukraine in World War II. Their neighbors rounded them up and shot them, under the supervision of the German invaders. The woman, a nurse, who lived thousands of miles away with her husband and three-year-old son, received word of the catastrophe in a letter from a friend of the family.

Although she had read and heard about Nazi atrocities, the thought that her family might be wiped out had never entered her mind. Such things might happen, but not to *her* family. Immediately after reading the letter, she felt stunned. "Something snapped in my head," she said. "It was as if a curtain had fallen down on a part of my brain and chopped off part of it."

Since she had not visited her childhood home for many years and had been out of communication with her family from the beginning of the war, news of the tragedy changed nothing in her life. And yet something changed drastically inside her. She became extremely fearful and irritable at home. At work she could take care of people "better than before," she said, "because I was able to shut out everything when I was with a patient; but at home I felt empty." She had previously read a great deal, but from the moment she learned about the extermination of her family, she was unable to concentrate on reading. She would sit in front of an open book as if submerged in deep thought, but would not be able to think about anything. To think meant to think about the fate of her family, which she was afraid to do. She knew, she said, that she had to follow in the footsteps of all the members of her family as they moved toward their collective grave, but she was unable to do so. Whenever she started to think about what had happened to them, she felt she would either lose her mind or kill herself. She avoided any discussion of the holocaust.

She became self-absorbed at home, unresponsive to the needs of her husband and child. For a time she felt incapable of being a good mother and entrusted the care of her son to a spinster sister-in-law, only to reclaim him later. Traveling to and from work she would often enter an empty subway car and scream at the top of her lungs. She was gripped by a kind of inner-directed attention, "as if I had to hold myself together and not think." The only

time she allowed herself some pleasure, such as dining out or going to the theater, was when a stranger was there to enjoy it with her; then she could feel that she was doing something for another person. She entertained thoughts of divorcing her husband because she felt she had nothing to offer him. During this period she began to suffer from headaches, low back pain, and anxiety attacks during which she felt as though she would faint or die. She developed a number of phobias, including fears of crowds, elevators, high places, and also of going alone anywhere except to work. Meanwhile, she continued to work at peak efficiency. Thus, three years elapsed before she sought help.

In treatment, after a short preliminary period, she started to review her relationships, one after another, with her dead relatives. She would identify herself totally with whatever member of the family she was concentrating on, repeating his or her gestures, speaking in the same way, and behaving so as to please that member. Referring to this process as “going through purgatory or the last judgment,” she said, “I have to give each of them an accounting of what we lived through together.” For a long time she felt she had to expiate her guilt.

The patient had been brought up in a closely knit family whose members were not supposed to experience negative feelings, let alone utter them. In treatment she harbored suicidal thoughts when she became aware of

her anger toward the dead for "abandoning" her and her envious attitudes toward her siblings; the uncovering of her death wishes for them so shocked her that she became even more desperate. When these wishes became clear, she felt that she was a danger to everyone close to her. She said that she was responsible for the deaths in her family; Hitler had simply carried out her wishes. She feared that her husband, son, and therapist would suffer a similar fate through her evil influence. She experienced a strong need to be punished. She burned herself while cooking or lighting a cigarette. In her dreams the deceased were alive and often angry with her. Whether awake or dreaming, she feared their retaliation.

Apparently each person she mourned was first sequestered in her mind, isolated as a unit of behavior, and then accounted to, as if still living, in order to obtain forgiveness. She conducted endless imaginary conversations with each of the departed before reaching the point where their deaths became a reality for her. Until then they maintained a life of their own within her.

Schematically one may distinguish the following stages in mourning:

1. *Complete identification with the deceased* —becoming like him and envisaging him as an authority, either totally benevolent or tyrannical, who directs the life of the survivor. Some persons stop at this level, maintaining a sort of symbiosis with the departed and fulfilling his wishes until the end of their days. This solution, achieved through unconscious mechanisms,

permits one to avoid guilt and responsibility for the death. The deceased is installed as a foreign body that governs the mourner's life.

2. *Splitting of the identification.* This takes place while reflecting on the relationship with the deceased, a process that leads to fragmentation of the "foreign body." The first consequence is a conflict between submission and rebellion.

3. A *detailed review of the relationship,* with a somewhat detached appraisal of one's own conduct toward the lost object. The self-evaluation encompasses a painful working through of myriads of minute elements and a complete scanning of one's life. There can be no glossing over in this process; shallowness is incompatible with mourning. The result of "digging in" is that one emerges as an integrated, enriched, and revitalized person.

In essence the process of mourning is not unlike the analysis of transference. The latter is also, in a sense, a kind of mourning as one struggles to give up dependence on parental figures and integrate the ambivalences of life. The issue is not so much the elimination of ambivalences as learning to live with them, for life is fraught with conflicts. There is good reason to equate effective living with the mastery of polyvalence.

What is particularly difficult about undergoing the process of mourning is the need to face the ultimate reality of life—*death*—with the full realization

of one's helplessness to evade its finality. One dreams of eternal youth and denies one's own demise in countless ways, but real mourning affords no hiding place from this existential truth.

The rituals prescribed for funerals, which many include under the term "mourning," vary from culture to culture, but they express a common theme. They are all oriented toward appeasing and showing respect for the dead. These ceremonials tend to retard the mourning process and intensify the mood of bereavement, often artificially.[2] The intensification is accomplished through collective mourning, which initially serves to facilitate catharsis. Thereafter ensues a period in which the mourner is expected to conform to the restrictions imposed by societal or tribal customs, particularly for widows.

Collective mourning gives the bereaved an opportunity to shed tears, which they might not be able to do when they express their sorrow privately. Collective mourning reached its epitome following the assassinations of President John F. Kennedy, Martin Luther King, and Robert Kennedy. Never before the advent of television had an entire nation been joined together in expressions of bewilderment, sorrow, indignation. These successive cathartic experiences afforded some participants the opportunity to reflect on the transience of glory, or its acquisition through death, as well as for mourning the loss of their own loved ones.

Melancholia

Melancholia may be viewed as an extreme form of mourning, sharing its symptomatology—lugubriousness of mood, ritualistic rigidity, and many superstitions—but lacking the actual work of mourning as outlined above. Melancholia seems to be a sort of pseudomourning because of the inability to work through a situation, which, as already pointed out, is the essence of mourning as a dynamic process.

Instead, there is a clinging, demanding dependency, an insistence on passive gratification that is impossible to meet. Particularly trying for the people around the melancholic person is the incessant complaining. Three W's—of Woe, Whine, and Wail—prevent the patient from taking stock of what has happened and what might be done about it. Thus, a closed circle is maintained, and this may be termed the *constipation of mourning.*

There are, however, transitional forms of mourning with similar symptomatology that are less intractable than melancholia. These forms include the agitated depressions of menopause," in which it is impossible to trace the pathology to early introjects that were excluded from awareness. These exist throughout life, unchanged and unaffected by experience. The existence of such introjects, experienced as *not me,* is maintained mainly by repression and dissociation, reducing the integrative capacity of the ego and producing a latent tendency to depressive reactions. This accounts for a more

or less chronic state of discontent with oneself as well as a tendency toward reaction-formation coupled with strong oral fixation. Under the influence of a new loss (object loss or any other), a decompensation takes place; anal defenses crumble and oral traits, such as envy, greed, avarice, and impatience become predominant. As Abraham pointed out, envy may be oral and anal in character; it is usually both. The patient is preoccupied with what others have and devalues everything that he has or is. He blames others or fate for his deprivations. The self-reproach is actually an accusation directed at whoever deprived the patient of what was promised him at the cradle. Some individuals weep over real losses, others over lost opportunities or things they never had.

Melancholic patients often present a caricature of the introjected, feared, malevolent person and are incapable of relating their behavior to any previous experience. Memory traces are lacking. If there is any recollection, it is only of undifferentiated feelings; there is an absence of a formulated thought about a loss. That is why it is important to inquire about early deaths and, in general, about those who were important in the patient's formative years.

The melancholic syndrome is perplexing in that not only is a painful experience retained, but also it seems to be actively intensified, with the persistence and effort worthy of a Sisyphus. Attempts to dissuade the patient

are useless. The absurdity is accentuated by shameless self-vilifying ideation, and the patient reacts impatiently to any effort to console him. He feels misunderstood, which indeed he is.

In instances where the ego is sufficiently intact and a connection can be established with an isolated introject, it is possible to obtain good psychotherapeutic results. It is important to find out as much as possible about the significant persons in the patient's early childhood in order to determine the source of the pathogenic influence. Of particular significance are his first encounters with death, whether of a human being or a pet. Although the patient's lamentations may strain the therapist's patience and foreclose his sympathy, the capacity for insight and the readiness to examine the relationship and confront the ambivalence with the therapist's help make it possible to integrate the not-me into the personality. This accounts for the new energy that becomes available after the completion of mourning.

Some of the above mentioned reactions are present during the process of mourning, but without the tenacity seen in melancholia. That is why it is essential that the therapist be familiar with all the manifestations of melancholia; otherwise it is impossible to sustain interest in helping the patient overcome the passive submission to pain, which teaches him nothing and maintains his restlessness, confusion, and perplexity. Patients invariably regress in proportion to the degree of their helplessness.

The pain of the melancholic well illustrates that suffering by itself does not generate wisdom. Protracted suffering exhausts the energy of the patient and the tolerance of the helper.

Emotional Anesthesia

Minkowski coined the term "emotional anesthesia"[3] to describe the feeling state of young survivors of the concentration camps. When interviewed after World War II, they had no affective response to those who had perished around them, including those closest to them. One must differentiate the state of these survivors from total apathy; they were quite enterprising and were able to care for themselves and take advantage of any opportunity offered to further their immediate existence. Of course, there was an underlying depression.

In 1944, when I interviewed five children who survived the concentration camp at Majdanek, I was struck by the total absence of affect in them. For example, a nine-year-old boy described the death of his mother, who suffered from tuberculosis, in a matter-of-fact way; his face and voice betrayed no emotion whatsoever as he told his story:

> We all knew what she was going to do. She was going to throw herself into the river. She wanted to do it before but we wouldn't let her. This time we let her go. She went and drowned herself. Later in the day the Germans came to our home and killed everybody. I hid under the bed so they didn't see me. A Polish neighbor came to the house afterwards and took me home

with her. She kept me as long as she could and then turned me over to the Germans. She had no choice.

Massive denial came to his rescue, permitting him to mobilize energy for survival.

Denial in Somatic Loss and Disability

Although actual loss, severe disablement, or disfigurement of a part of the body is not, as far as we know, accompanied by a specific mental constellation, clinical experience indicates that it stimulates so intense and massive a use of denial that this defense assumes a pathological quality/ A person with a severe physical handicap often denies it on a conscious as well as an unconscious level. Shame and fear of humiliation or pity arc among other attitudes that are consistently observed in the severely handicapped.

For example, a young man with such severe paraplegia of the lower extremities that he could not walk without the aid of crutches, said during his first interview that he did not regard himself as a disabled person but as a "disembodied mind." Another young man uttered no complaint about the leg he had lost in an automobile accident—he thought he had resolved this problem by learning to use a prosthesis—but he solicited help in recovering his memory, which had begun to fail him after the accident, so that he could concentrate on his studies. A third patient, a paraplegic who was confined to a wheel chair and lacked control of his bladder and bowels, complained only

about his stutter. If this speech defect could be overcome, he said that he would be a happy person.

Similar pronouncements have been made by many other patients with severe physical disabilities. As a rule they do not want to talk about their handicap or to have others confront them with it. The more intelligent the individual, the more intense his efforts to guard himself against any intrusion into this aspect of his experience.

The temporary or limited use of denial may be useful and even desirable for slowing down confrontation with a loss that is devastating to one's self-esteem or that threatens to shatter one's mental equilibrium. Used in this way, denial is most frequently associated with shame, humiliation, and guilt and indicates a proneness to dissociative processes. Before confrontation of the patient with the nature or full extent of the disability, it is *first* necessary to help him develop or consolidate the ego strength necessary to tolerate it.

On the other hand, the predominant and permanent resort to denial is always psychologically depleting and crippling. It suggests a commitment to a more or less double form of existence—-that is, the incorporation of two distinctly separate images: one of a wholesome and healthy individual and the other of a disabled or disfigured self, which is, as a rule, actively hated, personified, and rejected. The stronger this conflict, the stronger is the

subject's feeling of injustice, deprivation, and discrimination.

Before the patient can give up his denial of the disability, he must face his handicap. This, so far as we know, can be accomplished only through the laborious and painful process of mourning. Since the ambivalence of the feelings seems to be stronger in the case of severe physical disability than in any other loss, the mourning is almost inevitably more prolonged and more painful, but it leads to reconciliation with the disability. Through this process a state of calm is achieved as one becomes capable of *making a distinction between oneself and the disability.* The disability then becomes depersonalized. In place of a split self-image, integration takes place; there emerges a unified personality with more or less limited equipment.

One should also bear in mind the deep narcissistic blow that physical injury inflicts on the ego. This is familiar to psychoanalysts who work with patients who have undergone mutilating operations, even when these affected only internal organs. The extent to which a physical defect disfigures a person is an important consideration. Particularly devastating to self-esteem are facial injuries.

In order to come to terms with the disability, the patient has to face the intense despair and grief that underlie his feelings toward his handicap; he also has to face an exceptionally intense castration anxiety. Despair nourishes

a need for revenge. Most frequently there is no one to blame. Superstitions have given way to a scientific understanding of this predicament, as is the case in congenital disabilities. As Thomas Mann observes in *Royal Highness,* which deals with the life of a prince born with an atrophied arm, the worst kind of misfortune is one for which no one is to blame.

The working through of a severe loss through the mourning process serves to diminish or alleviate shame, which invariably follows a loss of self-esteem. As with the physically handicapped or disfigured, shame may be markedly present in widows and widowers, in many of the dying aged, and in the parent who has lost a child. They feel stigmatized and ashamed, as if "marked by destiny," compared with more fortunate people. They also experience a sense of guilt, of being punished for their transgressions.

Grief has to be shared if it is to lead to hope. Only once have I heard a handicapped person express his grief spontaneously. It was soon after an accident in which he lost his right hand. "I miss my hand as one misses a sweetheart. I feel a yearning for it, as if it were a person." This was said by an immigrant peasant, whose right hand was his breadwinner. This I consider to be a normal reaction to a loss, one without recourse to denial.

The existent literature on the rehabilitation of the physically disabled-stresses the necessity of accepting the disability. However, there is nothing

acceptable about a disability or the equally tragic loss of a beloved person; at best one may become dispassionate about it.

Loss of a Parent

There is a consensus that the loss of an important person cannot be mourned in early childhood since the child's ego is not equipped to deal with the task of separating itself from the object. As a rule the child continues to maintain a living representation of the deceased, usually an idealized image. The finality of death is inaccessible to a small child. For example, after one mother had finished explaining to her four-year-old daughter that her father had "gone to heaven," the little girl asked, "When will daddy come back?"

In treating adults who lost a parent in early childhood, one notices over and over again that the parent continues to live in their minds. In most cases two contrary and independent attitudes are maintained. One is an acknowledgment of the death and adaptation to it; the other is a denial of the death. In that context psychoanalytic literature refers to the splitting of the ego.

A lawyer who had lost his father at the age of six did not begin to mourn him until he entered reanalysis 42 years later. He completed his first analysis ten years earlier without deep mourning for the parent. There was a mere acknowledgment of the death at the time. The father was talked about as a

dead person. The patient reported how he recited the Kaddish by rote at the age of six without understanding a word of it and how, during the year he attended synagogue, older Jews admired him and whispered, “Poor orphan, so young.” As they shook their bodies, he imitated their movements. Feeling accepted and at one with them gave him a sense of importance. He idealized his father and cherished his memory.

During the second analysis the patient began to confront himself with the meaning of his father’s death and the realization that his father had never died for him. Very painful memories emerged and were expressed with tears, despair, and anger. Left with a “halfcrazy” mother, he had to take care of her so that she wouldn’t go completely mad. “I couldn’t even go crazy,” he cried out. “I had to control myself.” When he went to work at the age of 11, his mother, he said, “kept waiting for me to come home, and if I came home late she would go out of her mind and abuse me both verbally and physically.” In recalling the Kaddish, he said, “I wasn’t praying to God; I was talking to my father. I told him, ‘I do this for you. What are you going to do for me?’ The patient cried bitterly, “Father left me with *his job*—caring for mother.” For years he had talked in this way to his father, even though his grandmother told him that his father was watching over him and taking care of him.

The patient had always gesticulated like an old Jew; many had noticed and commented on that behavior. Usually he responded to these remarks as

to a pleasant joke, saying that imitating the old Jews he had met in the synagogue strengthened memories that preserved the bond with his dead father. In the reanalysis, during the period of working through oedipal guilt and the concomitant castration- anxiety, and also his relationship to his mother (then dead eight years), a curious identification with her behavior and style of speaking was noticeable.

In short, there is abundant evidence that a parent's death in childhood is accompanied by denial of the death, rigid avoidance of feelings that accompanied the event, unconscious identification and often idealization of the deceased parent, and fantasies of being reunited with him.

The Dying Patient (Anticipatory Mourning)

The dying patient has to face the ultimate reality—the loss of his own life. Not infrequently, as he struggles to reconcile himself with the irreconcilable, he is surrounded by people waiting for his end to come. And often he feels guilty of imposing on them. Usually those around him, afraid of their own death, incapable of controlling their disturbed feelings over the imminent bereavement, or guilty over their own death wishes, avoid the dying patient in defense of their own feelings.[4] But if one wants to help the dying patient, one needs to be able to transcend this self-protective shield and become other-oriented, to alleviate his fear of abandonment and his

aloneness, which are more frightening than death itself.

The absence of that other-oriented *quality of presence* deprives the patient of the possibility of sharing his grief. Very often family and friends—and doctors—are unable to respond to this psychological need. They "sign off" emotionally long before the death occurs. Their guilt and helplessness make the patient feel guilty, ashamed, envious, and bitter.

Even though they know they are going to die, human beings can hardly imagine the end of their own lives. Freud said: "In the unconscious, every one of us is convinced of his own immortality." A patient condemned to death by an incurable disease does not want to know he is dying. He wants the environment to deny death, and he hopes against hope that he will pull through, perhaps by some miracle. He wants to be given some hope.

A 52-year-old woman dying of cancer of the stomach wanted to talk about literature, to keep her mind on something else. Her husband and daughter avoided her because of their own fears and arranged for friends to visit her during her last weeks. When I made myself available to discuss anything she chose, including her illness, she evaded the topic. She did not want to hear that her life was endangered.

Other families begin the process of mourning long before the death occurs. In cases where the patient doesn't know that he is suffering from an

incurable disease and those closest to him have to bear the burden alone, they are likely to come to the psychiatrist for help. He has to help them confront the situation, give them support and sometimes hope.

Conclusion and Treatment

Rarely if ever do patients mention difficulties in mourning as a presenting problem. Usually the bereaved complain about other difficulties, such as inability to concentrate on work, depression, disinterest in life, anxiety states, suicidal thoughts, and the like. As the classification cited above indicates, there are few psychiatric conditions that may not mask a delayed, unfinished, or absent mourning. Such a view may be challenged as an extreme oversimplification, for it virtually reduces the whole of psychiatry except schizophrenia to the pathology of mourning. Nevertheless, it is no oversimplification to assert that every human being has to face death in those close to him and his own death, and that the human condition is afflicted with sorrows, to which the schizophrenic is no less immune.

Hence, in addition to mastering the entire therapeutic armamentarium of modern psychiatry, every therapist has to develop skills in dealing with such matters. This makes an enormous demand on the psychiatrist. Since protracted complaining is frowned upon in our culture, those who indulge in it meet with pity, if not open contempt, even among the helping professions.

In order to develop appropriate responsiveness and to enable patients to undergo mourning when necessary, the therapist has to come to grips with his own fears of death and the defenses he has erected against them. Appropriate responsiveness springs from *empathy* and a *quality of presence,* both of which are *other*-oriented, and a readiness to face the countless forms of human unhappiness. As Bertand Russell expressed it, "One needs, as the key to interpret alien experience, a personal knowledge of great unhappiness; but that is a thing which one need hardly set forth to seek, for it comes unasked" (p. 253).

Stefan Zweig, with his deep understanding of human nature, is even more instructive in *Beware of Pity.* His hero found that once gained, an insight into human nature grows, in some mysterious way, so that "he to whom it has been given to experience vicariously even one single form of earthly suffering acquires by reason of this tragic lesson, an understanding of all its forms, even those most foreign to him, and apparently abnormal" (p. 78).

These thoughts point to suffering as the royal road to insight, wisdom, and empathy. It may be superfluous to observe that suffering per se does not generate wisdom, as is clearly demonstrated in cases of melancholia. But suffering that is accompanied by insight and gradual emancipation from narcissistic self-involvement leads to empathy that, in turn, contributes to the resolution of grief. With that comes a compassionate attitude toward others

and a new commitment to life.

All of the bereaved need a great deal of compassion. But there are two kinds of compassion. One is accompanied by anger and pain—a form of self-protection and vulnerability that evokes angry feelings toward the object of compassion and wants him out of the way. The other is compassion free of self-centeredness—an empathic consideration for another person's feelings with a readiness to respond to his needs without having to shield or spare one's own sensibilities and without making someone else's suffering one's own burden.

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[1] Personal communication.

[2] An anecdote related by Rabbi Solomon Tarshansky of New York illustrates this artificiality. In many parts of the world it has been customary to hire mourners to keen at funerals. One *shtetl* boasted of a woman who excelled in that profession. She was renowned for her artistry in "carrying on" and inducing others to cry with her. But one day she refused to

"perform" at the funeral of a wealthy townsman, and the disappointed customer asked her, "How come? Don't you need money any more?" She answered simply, "Today I cannot cry. My sister just died." With grief in her heart, she was unable to pretend sorrow.

[3] Personal communication.

[4] Anticipatory grief of the dying patient is perhaps best described by Tolstoy in *The Death of Ivan Ilyich*, it is an excellent study of a 45-year-old official, facing a lonely and agonizing death from cancer, whose wife and children are unwilling or unable to relieve his agony in the slightest measure.