

# The Treatment of *Established* Pathological Mourners



**Vamik D. Volkan, M.D.**  
**Daniel Josephthal, M.D.**

# **The Treatment of Established Pathological Mourners**

**Vamik D. Volkan, M.D.  
Daniel Josephthal, M.D.**

e-Book 2018 International Psychotherapy Institute

From *Specialized Techniques in Individual Psychotherapy* edited by Toksoz B. Karasu and Leopold Bellak

All Rights Reserved

Created in the United States of America

Copyright © 1980 by Toksoz B. Karasu and Leopold Bellak

## Table of Contents

[The Phases of Grieving](#)

[The Clinical Picture of Established Pathological Grief](#)

[The Psychodynamics of Established Pathological Grief](#)

[Splitting](#)

[Internalization](#)

[Externalization](#)

[Differential Diagnosis](#)

[Depression](#)

[Fetishism](#)

[Psychosis](#)

[The Suitability of Patients for Re-grief Therapy](#)

[A Description of Re-grief Therapy](#)

[Transference: Therapeutic Efficacy](#)

[A Case Report](#)

[REFERENCES](#)

## The Treatment of Established Pathological Mourners

There is much in the psychiatric literature about the similarities and differences between uncomplicated grief and the reactive depression that follows the death of someone close and important to the mourner. Freud (12) showed long ago how both “mourning and melancholia” may be initiated by such a loss, and how both include painful dejection, a loss of interest in the world outside the self, a decrease in the capacity to love, and the inhibition of any activity not connected with thoughts of the dead. What distinguishes mourning from neurotic depression is the disturbance in self-regard that appears in the latter state. In uncomplicated grief the mourner can loosen his ties to the representation of the dead through the work of mourning, or can form the kind of loving identification with it that promotes his growth. In depression, however, the mourner experiences disruptive identification with it, and the ambivalent relationship he had had with the one now dead becomes an internal process; the yearning to keep the representation and at the same time to destroy it is felt as an issue of one’s own—a struggle between cherishing and doing away with one’s self.

Further accounts of the complications of grief appear in the literature. For example, the initial absence of a grief reaction is mentioned by Deutsch (7), and the chronicity of what are generally thought of as “normal” grief manifestations by Wahl (48). However, differentiation between varieties of complicated grief and depression over loss by death is not always made, and these diagnostic terms are commonly used interchangeably. The study of adult mourners carried out at the University of Virginia has demonstrated the existence of a type of established pathological grief with a clinical picture and underlying psychodynamics which are unique, persistent, and different from those of either a normal but protracted grief reaction or a neurotic depression. It is, in fact, a common psychiatric

problem.

After the death of someone greatly valued, the grief-stricken relative or friend goes through consecutive phases of mourning. One might anticipate that when the process develops complications these might include fixation in any one of these phases, but clinical research shows that fixation usually occurs at one specific phase—that in which the mourner is in a limbo of uncertainty about the death and yearns to bring the dead to life. The situation is complex inasmuch as along with the longing to restore the dead is a dread of ever seeing him again. These conflicting emotions result in the picture of established pathological grief with its characteristic underlying psychodynamic processes. Once diagnosed, this condition may be successfully treated by a method of brief psychotherapy called re-grief work (39, 41, 46, 47).

### The Phases of Grieving

The psychological phenomenon involved in the process of grieving over the loss of someone who had been important to one's self is one, the course of which can be represented graphically as though it were the course of a physiologic process seen longitudinally. Indeed, Engel (8), in asking whether or not grief might lie called a disease, suggested that it resembled the working-through of a healing wound. Just as a wound can become infected or form keloids, so can the course of grieving become complicated.

It begins when someone is lost, or when his loss is seen as imminent. This external event affects the internal milieu of the mourner, triggering a psychological process. Freud (12) described how this process runs its course over an interval of time. As the work of mourning goes on, memories and expectations connected with the one who died are brought to the mourner's mind one by one. When they are hypercatheted and examined, it becomes possible to detach the libido that had been invested in the deceased, and when the mourning is completed the mourner's ego becomes "free and uninhibited

again.” However, a closer look suggests that the end of the grieving process is not so easy to identify, since the internal image of the lost one remains with us to a certain extent all our lives—and may sometimes be externalized with a degree of communication with that person continuing. When one is asked to recall a dead relative, for example, his image is usually readily available to the mind’s eye; what is more important is that such an image may impress itself on the mourner in moments of need without conscious recall. For example, a woman who has completed the healing of the wound caused by her father’s death may find herself preoccupied with his image at the approach of her wedding day, as she longs for his approval of this important step in her life. Nonetheless, the grieving process does terminate for all practical purposes when the image of the dead person is not required in any absolute and exaggerated way to maintain the mourner’s internal equilibrium, although it may from time to time be reactivated, as in anniversary reactions (29, 30). The healed wound is, as it were, at least covered over by scar tissue, but it never altogether disappears; the feelings about an internal relationship to the one who is lost continue.

Once initiated, the phases through which mourning over the death of someone important proceeds are recognizable. Although these have been described somewhat differently by different writers, it is clear that they were all observing similar manifestations. Engel (9) divided grieving into three stages: a) shock and disbelief; b) a growing awareness of the loss; and c) restitution, the work of mourning. Schuster (31) focused further on the stage of shock and disbelief, Bowlby (1) also identified three phases of grieving, although he and Parkes (5) later worked out a schema with four. They describe the first phase as a brief phase of numbness that may last from a few hours to a week and be interrupted by outbursts of extremely intense anger and distress. The second phase is one “of learning and searching for the lost figure” that lasts for some months, even years. The third phase is one of disorganization and despair; and the fourth, one in which reorganization appears. Pollock (28, 31) made a special contribution to the psychoanalytic understanding of this reorganization

(adaptation) when he went beyond Freud's original notion of the transformation into ego loss that occurs with the loss of a loved object—or even of an ideal—by showing that the ego uses the adaptational process of mourning for its own healing. “Mourning processing, like working through, is internal work to restore psychic balance (32, p. 16). Using the term mourning in a broad sense to include reaction to losses other than those occasioned by death, he holds that to be able to mourn is to be able to change. People also mourn their own impending death; people aware of having incurable cancer, for example, go through similar phases if time allows and they are psychologically capable (17).

This paper refers only to the mourning of *adults*, its complications and therapeutic management. Psychoanalysts debate the possibility that infants or small children faced with loss grieve in the manner of the adult. In his review of children's reactions to the death of someone important to them, Nagera (23) concludes that such losses interface with development. Our own experience suggests that Wolfenstein (50) was accurate in saying that adolescence constitutes a necessary precondition of the ability to mourn. A painful and gradual decathexis of the living parents is accomplished in adolescence and serves as a model for the adult type of grieving.

As noted, our clinical research (39, 40, 42, 43, 44, 45), which was conducted with a hundred patients during eight years, confirmed our belief that the fixation typical of established pathological mourning occurs mainly in the phase Bowlby and Parkes (5) describe as one of “the yearning to recover the dead” and, to use a term of Kubler-Ross (17), to “bargain” for his return. When such yearning is crystallized, it is inevitably accompanied by dread of such a return. Manifestations of earlier grief stages—denial, numbness, or angry outbursts—may appear also, as well as occasional periods of disorganization usually more typical of a later phase. If the fixation we describe is extended we are, however, justified in diagnosing “established pathological grief.”

### **The Clinical Picture of Established Pathological Grief**



Although the pathological mourner has intellectual appreciation of the historical fact of the death, he clings to chronic hope that the lost will return, even after the six months or a year that usually disabuses the normal mourner of any such notion. The pathological mourner's dread of such an eventuality is as strong as his hope. This situation can persist over time without alteration, or the picture may be overlaid by others.

Wistful longing is not abnormal; Parkes (25), for instance, speaks of how a widow yearning for her dead husband may imagine hearing his footfall at coming-home time for a year after his loss, and even "hallucinate" his appearance. In the established pathological mourner, however, longing becomes such a strong preoccupation that it dominates his daily life and keeps him ongoingly involved in the conflict produced by the ambivalence of deciding whether to bring the dead person back or to kill him, i.e. expunge him from consideration. Many pathological mourners become interested in reincarnation (40), the sophisticated sublimating this interest in a related hobby or scientific hypothesis. Some compulsively read obituary notices, betraying not only anxiety over their own death but trying to deny the one they mourn by finding no current mention of his death, while at the same time recalling how such mention as it appeared earlier had the finality of "killing" the lost one. This kind of preoccupation can become extremely morbid, as in the case of one patient who changed his dead wife's burial place three times in as many years, one move taking her coffin some distance away and another bringing her "nearer home." When he came to our attention he was planning a fourth move. His preoccupation with his dead wife's image was ambivalent, clearly reflecting the painful struggle that this religious man had had being faithful to his marriage vows over the many years in which she had been a suffering invalid. He had longed for liberation from her tragic situation, and after her death he went through cycles of trying to draw her close to him and then to put her away.

Some established pathological mourners think they recognize their lost one in someone they see alive. A son pathologically mourning a father dead for years

may be struck by a resemblance perceived in some stranger passing by, and rush forward to peer at him over and over to see if this can indeed be his parent. This act represents an effort to return the dead to life; when the illusion is recognized as such it serves the wish to “kill” him. The mourner may make daily reference to death, tombs, and graveyards in ritual ways that obviate painful affect, but it is unusual for such a mourner actually to visit the grave. For example, a 20-year-old college student still, a year-and-a-half later, mourning the sudden death of a grandfather she described as “the most important person in my life” was surprised when she was asked if she had ever gone to his graveside. Like most people with established pathological mourning, she was quick to find an excuse. She doubted that she could find it in a cemetery as “big” as the one in her small town. Her preoccupation with her grandfather was nonetheless evident in her daydreams about him and her search for him in an affair with a married man 30 years her senior.

The therapist of such a patient gets the impression that the one being mourned is in a sense alive as far as the patient is concerned and still exerts his influence. The patient uses the present tense, stating confidently, “My father likes to go to the movies.” One patient joked nervously during our first interviews, cautioning that, “You can’t talk much against dead people because if you knock them down they come back.” Certain typical dreams can be expected. They have been classified (40, 41) as:

- 1) “Frozen” dreams, to use a term many patients use themselves to describe tableaux without motion. One tableau may follow another as though the dreamer were watching the projection of a slide series. One patient used the analogy of watching slices of bread fall out of a package. The patient’s associations to each tableau indicate a connection with his complicated mourning and his fixation in the grieving process as though the process had congealed in its course.
- 2) Dreams in which the dead person is seen alive but engaged in a struggle between life and death. He may be lying in a hospital bed or under the rubble of a collapsed building, or sitting in a burning vehicle. The dreamer tries to save him—or to finish him off. Interestingly, both

persons in the dream are usually undisguised. The situation's outcome remains indeterminate because the patient invariably awakens before it is resolved.

- 3) Dreams of the dead body in which something indicates that death is only an illusion. The body seen in its casket may be sweating, or one long buried may show no sign of decay. Such dreams are not unusual among normal mourners during the months immediately after the death, but these dreams either cease or the appearance of the body begins to change. However, the mourner in pathological grief will dream of the undecayed body many years after death.

Several investigators (28, 41) have spoken of the reporting of dream *series* appropriately parallel to phases of uncomplicated grief in persons either completing their grief work without incident or beginning to re-grieve in normal fashion as the therapy for pathological grief starts taking effect. For example, what is first reported is a view of grass-covered earth in which, in the following dream, there is a grave-like excavation. The next dream will include the half-alive body of the lost one lying nearby; the dreamer may next see himself pushing it into the grave. In the final dream of the series, the manifest content of which has been the dreamer's progress toward resolution of his grief, a grave, smoothed over and covered with grass, appears. The established pathological mourner is usually ready enough to disclose to the therapist, when asked about his dream life, the appearance of the kinds of dreams we cite as characteristic of this pathological state. These dreams are usually repeating dreams, and information about them is diagnostically helpful.

The person with established pathological grief can keep in touch with the image of the dead, over which he maintains absolute control. He is able to establish contact with the dead by forming a presence (introject) of the dead person within himself that is perceived, by the patient, as having definite boundaries separating it from the mourner. Most patients, when questioned about it, can give good descriptions of this phenomenon. Volkan (41, 42) and Volkan, Cillufo and Sarvay (46) tell of patients who, during the time of their

treatment, would ask the inner presence to get out of their bodies and leave them alone. It is also not unusual for the person with established pathological grief to hold “inner conversations” with the image of the deceased that dwells within him. One patient would hold conversations with his dead brother while driving in his car, and ask business advice from him, feeling that the brother was somehow living within his own breast.

Another sort of contact with the dead, again one under the mourner’s absolute control, is maintained by the use of some object contaminated with certain elements, some of which came from the dead while others come from the mourner himself. These have been named “linking objects” (43, 44, 45). They differ from the ordinary keepsake since the mourner invests them with magic capable of linking him with the one he has lost. Typically, he keeps his linking object locked away or located in some place where he can be in touch with it in a way that is consciously or unconsciously ritualized. One patient, still mourning the death of a son from an automobile accident many years earlier, kept his son’s shoes, polished except where they were blood-stained, in his own clothes closet. There he could see them daily as he removed and put away his own garments, while all the time never touching them. When he went into full-blown pathological grief after the passage of many years, and was sent by his family physician for consultation, he wore the shoes to the first interview. He was greatly surprised and anxious when the therapist asked if he had kept any special object or objects that had belonged to his dead son, and only then realized what shoes he was wearing.

A great variety of objects may become linking objects. The mourner chooses such an object from among a) something once used routinely by the dead, perhaps something worn on the person, like a watch; b) something the dead person had employed to extend his senses, like a camera (an extension of seeing); c) a symbolic or realistic representation of the dead person, the simplest example of which is, of course, a photograph; or d) something at hand when the mourner first learned of the death or when he viewed the body. We have also

known patients to cling to something less tangible, such as an elaborate fantasy. For example, the mourner might entertain a certain thought during the burial ceremony and regularly reactivate it to keep controlled contact with the image of the dead.

### The Psychodynamics of Established Pathological Grief

Three major intrapsychic processes underlie the clinical picture described here: splitting, internalization, and externalization. One must identify and understand the defensive use of these mechanisms in order to make definitive diagnosis.

#### Splitting

The adult patient with established pathological grief uses the mechanism of *splitting* extensively. The term *splitting* refers here not to the “primitive splitting” currently used widely in relation to borderline personality organization—that persistent separation of “all good” self- and object-representations from those seen as “all bad.” Here we see splitting on a higher, neurotic level, as a splitting of the ego functions to protect the individual from any global break with reality. Thus the ego’s denial of the death can coexist with the ego’s knowledge that the death has, in fact, occurred. The pathological mourner’s splitting of ego function is selective and concerned only with the issues of the death in question. Freud (13, 14) spoke of this type of splitting in connection with both grief and fetishism. The fetishist does not experience a global break with reality either; he understands that women do not have penises but behaves as though they did. Similarly, the established pathological mourner acknowledges the death but behaves as though it had not occurred. One particular function of his ego has become inconsistent with the rest. He is usually able to identify the point at which splitting began, as when he recalls gazing at the corpse in full knowledge that it was a dead body, and convincing himself that he saw perspiration appearing on its brow as an evidence that life continued in it. Such a notion is not

outside the experience of the normal mourner, but he soon sets it aside, whereas it remains a powerful question in the mind of the pathological mourner, militating against the separation/castration anxiety triggered by the death. Two other cogent psychological processes inherent in this condition—internalization and externalization—foster the illusion of continuing contact with the dead and thus support the mechanism of splitting in its defense against anxiety. All three of these mechanisms contribute to the patient's continuing existence in a limbo of uncertainty.

### **Internalization**

Such processes—including introjection and identification—which are involved in both grief and reactive depression, have been known since the original publication of the works of Abraham (1) and Freud (12). When his search for the lost one forces the mourner to test the reality of his disappearance, he uses hundreds of memories to bind him to the one he mourns, and becomes so preoccupied with doing so that he loses interest in the world around him. This painful longing must be worked through piecemeal. Tensions are discharged through weeping, for example. He regresses and resorts to "taking in" the deceased by introjection. Thus, the dead person's representation within the mourner's self becomes hypertrophied and is seen as an introject. As noted earlier, the introject may be perceived by the patient as an inner presence. Although the patient may describe this psychological phenomenon in such a realistic way as to call it "a foreign body in my bosom," it should be remembered that, in actuality, introjects are only code symbols of complicated affective-dynamic psychological processes. Fenichel (11) states that "introjections [introjects] act as a buffer by helping to preserve the relationship with the object while the gradual process of relinquishing it is going on." Our work with established pathological mourners indicates that the gradual process of relinquishing an introject fails to take place. Thus the introject's continued presence does not lead either to disruptive identification, as in reactive

depression, or rewarding identification (19) for the enrichment of the patient's psychic system. He is obliged to retain it and, like the introjects of early life representations in psychotic patients, it never evolves further but remains chronically cathected and is continually a party in the yearning/dreading transactions of the patient.

### **Externalization**

The child's transitional object (49), perhaps a teddy bear or a "security blanket," is vitally important to him. Its main function, one universally present, is to cause the infant to develop in response to the ministrations of the "good enough" mother. In it he has created his first "not-me" possession, which falls short nevertheless of being totally "not-me" since it links not-me with mother-me (15). The transitional object provides a bridge over the psychological chasm that opens when the mother and child are apart; the child may need it if he is to sleep, for example. Some children who experience defective child/mother interaction may have such extreme anxiety when separated from the mother that they concentrate unduly on this object and use it in bizarre ways. At this level such objects are called childhood fetishes (37), psychotic fetishes (21), or instant mothers (36). Since the main function of these inanimate objects is to deal with separation anxiety, it is not surprising that the adult suffering a separation, to which he has responded with established pathological grief, may reactivate in his regression this archaic way of dealing with this stress. This would create in a linking object a locus for the meeting of part of his self-representation with the representation of the dead. Thus an externalization—a projection of self- and object-images—is crystallized (43, 45).

Jaffe's (16) emphasis on the dual role played by projection in object relations, and the ambivalence it facilitates, can be applied here. He wrote: "On the one hand of the continuum, the annihilation of the object is predominant, while on the other, the identification with and preservation of the object is paramount" (pp. 674-675).

The linking object is completely under the patient's control; he has the unconscious illusion that it makes it possible for him to kill the dead person or bring him back to life. It is contaminated with intense emotion, i.e., the urge to kill, and is nothing that can simply be put to use in the manner of a keepsake. It must be hidden away and perhaps even locked away, or have a ritual for relating to it. For example, one patient had a picture of his father as linking object and developed a ritual concerning it that persisted for many years until he had treatment. He could manage to remain in a room alone with it until, when lost in contemplating the picture, it seemed to him that his father began to move toward him out of the frame. Then he would be so overwhelmed by anxiety that he would rush from the room. He had a strong desire to know at all times where his linking object was. Many mourners are satisfied to keep theirs in a distant place, provided that it is safe and accessible. Another patient used the clothing of his dead brother as a linking object; he kept the garments locked away, but worried constantly that he would grow to "fit" them.

One young woman's psychotherapist committed suicide while she was in the middle of a transference neurosis. When she learned that he had been cremated and his ashes had been placed in an urn, she bought an urn-like vase which she established on the mantel in her living room, depositing her last appointment slip in it as a linking object. Although knowledge of its presence in the vase was necessary to her, she would neither look at it nor throw it away.

No patient we studied reactivated a transitional object in the form of the transitional object or childhood fetish used in his childhood, but patients did employ the same dynamic processes that foster in the infant his illusion of power over the environment. Put into the external world, the linking object also helps the patient externalize the work of mourning and helps him put the work aside for future attention which he keeps on postponing because of the pain it would cause.

### Differential Diagnosis



There is no dearth of observation in psychiatric literature that recognizable mental illness, such as the different neuroses, psychoses, antisocial behavior patterns, psychosomatic conditions, etc., is precipitated by a loss by death (6, 10, 18, 20, 22, 24, 26, 27, 33, 38). In such conditions, while death and loss are precipitating events, these are distinctly different from established pathological grief, the latter state being, as we have stressed, unique in a number of ways. It should be differentiated with care from depression, fetishism, and psychosis.

### **Depression**

Internalization processes are common to both depression and established pathological grief, but in the latter, the introject of the dead does not bring about identification. Thus, the introject does not blend into the patient's self-representation, but it is something he reacts to as an internal presence that has its own discrete boundaries. The mourner's tie to the introject does not loosen. In a reactive depression, however, introjection of the lost object leads to identification so that the mourner is the battleground on which the conflicts, formerly so lively between the patient and the one now dead, continue to be played out. Thus, we see the pathological guilt, and the self-reproachful and self-degrading features of the depression. We agree with Pollock (28) and Smith (35) that in depression, identification tends to be nearly total, with little difference being made between characteristics of the mourner and aspects of the dead he takes in. As Freud (12) indicated: "...if the love for the object—a love which cannot be given up— takes refuge in narcissistic identification, then the hate comes into operation on this substitute object, abusing it, debasing it, making it suffer and deriving sadistic satisfaction from its suffering" (p. 251). To be sure, there are grey areas between pathological grief and a depression that follows a death. One suffering from depression (total identification with the representation of the dead) after a death may, in fact, go into typical established pathological grief with an ambivalently related introject before he is able to respond appropriately to his loss. We have seen situations in which it was hard to

determine whether the patient had an introject or identified totally with the dead; since the mourner's behavior resembled on the surface that known to have been characteristic of the deceased, careful scrutiny was required. In any case, the patient who can easily fluctuate psychodynamically between reactive depression and established pathological grief may be a suitable candidate for re-grief therapy. The *fusion* with the image of the deceased that is exhibited by the person in established pathological grief, and which comes and goes, contains manifestations of identification. However, the identification of the reactive depressive is usually different inasmuch as it follows the establishment of an introject before turning into something more clearly identification *per se*.

The pathological mourner may experience feelings of guilt, but with him such feelings are transient, since he maintains the unconscious illusion that he can bring the dead to life again (as well as kill him) if he chooses. Intense guilt is the earmark of depression, which is characterized also by the dominant ego feeling of helplessness (3). In established pathological grief there is *chronic* hope—and dread (40, 42).

### **Fetishism**

High-level splitting occurs in both fetishism and established pathological grief, as does the use of certain objects in magical ways. The differences that distinguish the fetish, the linking object, and the transitional object are described elsewhere in some detail (43, 45). The linking object provides a means for external maintenance of object relationships with the dead. The ambivalence of the wish to annihilate the deceased and to keep him alive is condensed in it so that the painful work of mourning has an external reference and is thus not resolved. The linking object thus deals with separation anxiety, but the classical fetish used by adults serves primarily to deal with castration anxiety and only secondarily with separation anxiety. The literature (2) reports the development of fetishistic behavior in a classical sense after a loss by death, and in this circumstance a grey area between fetish and linking object is evident. If the

therapist takes his patient's history with great care and is watchful for any historical loss that might have initiated the appearance of the clinical picture, he is usually able to find clues to the nature of the magical object being used by his patient. One of our patients discovered a pair of women's shoes in the desk of his father after his death, and kept them—primarily fetishistic objects for his father—for his own linking objects.

### **Psychosis**

As noted, a break with reality does in one sense occur in established pathological grief through the use of high-level splitting, but it falls far short of being global, as it would be in a full-blown psychosis. For example, we would not over-diagnose as psychotic a widow who tells of hearing her dead husband's footsteps. If she is suffering from established pathological mourning her experience indicates no more than what might be called "mini-psychosis," since it is focused and reversible by the patient's own capacity for reality-testing.

### **The Suitability of Patients for Re-grief Therapy**

There are a number of reasons why an adult may be caught up in established pathological grief. He may not have been prepared for a sudden death, for example, and fall victim to something like traumatic neurosis when a sudden death does occur. His situation may in this case be seen as one of established pathological grief that is a variation of traumatic neurosis, the most suitable variety of pathological grief for re-grief therapy. Or the mourner may have unfinished business with the one who died, and be unconsciously trying to keep him alive for this reason, while at the same time feeling anger toward the dead person that makes him want to "kill" him. Such unfinished business would include uncompleted intrapsychic processes. An example is provided by a young man whose father had died suddenly while the son was courting the girl who was to become his wife. During the boy's puberty his father, a physician, had had some reason to be concerned about his son's genital development and shared

these misgivings about what a failure to develop properly might mean to the boy's manhood. So the son, who had a need to prove his virility to his father, accordingly impregnated his fiancée soon after the father died. He had to keep his father's image alive to convey this triumph to him (41).

It is significant whether the death being mourned came about from natural causes or involved violence, as in suicide, accident, or homicide. Violence, unconsciously connected with the mourner's aggressive feelings, fosters guilt that can preclude the expression of natural anger and aggressive reactions. This situation may involve the patient's fixation in established pathological mourning, so that he can avoid feeling aggression and guilt. Such fixation may in some cases be accomplished in the service of so-called secondary gain. When a death brings about such changes in the real world as the blow of losing the family home or having to face a sudden loss of income because of the wage-earner's death, the mourner is more apt to keep the dead one alive and struggle with the wish to "kill" him in order to complete the natural process of grieving.

Any loss, including the death itself, deals a narcissistic blow to the psyche of the one left behind. If the mourner has narcissistic character pathology, brief psychotherapy is unlikely to change this, however closely the clinical picture following the death may resemble that of established pathological grief. He may seem to go through re-grief therapy readily enough but still become symptomatic very easily whenever his narcissistic character organization is threatened. Such patients, while seemingly trying to deal with the lost object, are actually trying to deal, whether in hidden or open ways, with the narcissistic blow itself. For such people to become able to grieve genuinely usually requires more than re-grief therapy by itself can provide. We do not advise taking into re-grief therapy the patient with narcissistic personality organization.

The therapist should ascertain if the individual with the clinical picture indicative of established pathological grief has severe problems that stem from separation/individuation, and has extensively used such primitive defenses as

internalization and externalization prior to the death he mourns. If he has low-level psychic organization—that is, if he has moderate-to-severe pathology in his internalized object relations—it is doubtful that he will benefit from “re-griefing.” The most suitable patients are those with intact ego functions in all respects other than higher-level splitting, and who are psychologically-minded, motivated, and thus capable of forming a therapeutic alliance. Since “re-griefing” is a process leading to an inner structural change, it is not surprising that candidates suitable for it are those who would be suitable for classical psychoanalysis proper.

It has been demonstrated (46) that the Minnesota Multiphasic Personality Inventory is not only an effective self-rating measurement of change occurring during re-grief therapy, but a promising instrument for the selection of patients for this kind of treatment. It pointed to an underlying personality trait of hysteria and dependence in those patients who received great benefit from re-grief therapy with us. A pilot study suggested that established pathological mourners tended to have an elevation of scales 1, 2, 3, 7 and 8, and, to a lesser extent, of scales 4 and 6 also. Peaks came generally in scales 2 and 7. The data of the pilot study suggest that elevation of scales 2 and 7 to a point in excess of the showing on scale 8 is predictive of maximum benefit from “re-griefing.”

### **A Description of Re-grief Therapy**

Once the patient has been seen in a diagnostic interview and found suitable for re-grief therapy, he is told that his psychological condition is due to llls inability to complete the grieving process, which a brief course of therapy will help him to complete. One of the therapist’s first tasks will be to develop a formulation as to the cause of his patient’s being “frozen” in the course of his grieving. This requirement makes it necessary for him to have had adequate experience in psychodynamically oriented therapies, and to have developed a high degree of competence in formulating unconscious mental processes. If the patient is capable of really “hearing” at the outset what his reasons are for failing to complete the normal process of mourning, they can be shared with him;

otherwise, the therapist may keep his formulation to himself for later use in interpretations when the patient is ready to hear them.

Since the established pathological mourner is in a state of chronic hope that the dead will return—and simultaneously wants to “kill” him in order to complete grieving—he is preoccupied with psychological contact with the introject. During the initial phase of re-grief therapy, after carefully taking a history, we help the patient to distinguish between what is his and what belongs to the representation of the one he has lost, using what have been called (47) demarcation exercises. Demarcating the introject, so to speak, will enable the therapist to help his patient see what he has taken in and thus what he feels about the introject, and which of its aspects he wants to retain in non-disruptive identification and which he wants to reject. It is important here to note again that although the patient employs the kind of physical terms we use in referring to his introject, it is, in actuality, an affective-dynamic *process*. The therapist of such patients should have sufficient experience to keep from engaging in intellectual gymnastics instead of bona fide therapy when he attempts the analytic formulations involved here. The manifest content of the patient’s dreams may demonstrate to him how his grieving has been “frozen.”

In the initial phase of demarcation, which lasts for several weeks, the therapist does not encourage an outpouring of intense emotions, but helps his patient into a state of *preparedness* for such an outpouring. If the patient senses emotion building up in himself and feels frustrated at being unable to allow himself yet to feel its full impact, the therapist may say, “What is your hurry? We are still trying to learn all about the circumstances of the death and the reasons why you cannot grieve. When the time comes you may allow yourself to grieve.”

Following the demarcation exercises and exploration of the reasons why the patient was fixated and unable to work out his grief, the therapist will focus on the linking object. When the linking object is being dealt with, the therapist will make a formulation about its choice from among many possibilities.

Meanings condensed in a linking object are discussed elsewhere (43, 45). Because it has physical existence with properties that reach the senses, it has greater impact as “magical” than the introject has. Once the patient grasps how he has been using it to maintain absolutely controlled contact with the image of the dead, as well as to postpone grieving and keep it frozen, he will use it to begin his “re-grieving,” and this move will increase his dread. He is asked to bring the linking object to a therapy session, where it is at first avoided. With the patient’s permission the therapist may lock it away somewhere in the therapy room, saying that its magical properties exist only in the patient’s perception of it. Finally, introduced into therapy, it is placed between patient and therapist long enough for the patient to feel its spell. He is then asked to touch it and explain anything that comes to him from it. We are constantly surprised at what intense emotion is congealed in it, and caution others about this; such emotion serves to unlock the psychological processes contained until now in the linking object itself. Emotional storms so generated may continue for weeks; at first diffuse, they become differentiated, and the therapist, with his patient, can then identify anger, guilt, sadness, and so on. The linking object will then at last lose its power, whether the patient chooses to discard it altogether or not.

A graft of secondary process thought is needed to help heal the wound that this experience has torn open. During the weeks that follow, patient and therapist go over in piecemeal fashion memories of how news of the death came; recognition of when splitting began; the funeral; the attempts to keep the dead alive, etc. Although this review may make the patient highly emotional at some point, he can now observe what is happening to him, and disorganization no longer frightens him. Many patients spontaneously plan some kind of memorial ritual. For example, one went, without advice from us, to the synagogue from which his father had been buried and to the grave in which he lay making a photographic record of it all. Many patients consult their priests, ministers, or rabbis for religious consolation as they begin to accept the death toward the conclusion of re-grieving. With suitable patients, we were successful in using,

toward the end of their therapy, the manifest content of their serial dreams to indicate where they were in their re-grieving (41). Patients then have a sense of the introject's leaving them in peace, and they are often able to visit the grave to say "goodbye." They feel free, even excited with the lifting of their burden, and begin to look for new objects of their love. Re-grieving is over. Our experience has been that it can be completed in about four months, with sessions occurring at least three times a week.

### **Transference: Therapeutic Efficacy**

In re-grief therapy the transference relationship becomes the vehicle whereby insight into ambivalence and the conflict between longing and dread may be gained, and resolution effected. A truly supportive approach is required, as in all other therapies whether psychoanalytic or not. The therapist must convey his non-exploitative desire to heal, and encourage his patient to express himself directly without any fear of hostile, punitive, engulfing, or abandoning responses. The therapist should actively, directly, and instructively oppose any initial shame or excessive control with which the patient may conceal the complications of his grief, and encourage his head-on exploration of feelings and fantasies about the person he has lost and the internal and external relationship he has with him. Through his activity the therapist offers himself as a new object for the patient's consideration, aiming, as in psychoanalytic therapy, to develop a therapeutic alliance without encouraging an *infantile* transference neurosis. Transference—but not transference neurosis—is inevitable, and may be therapeutic by providing close and intimate contact within the therapeutic setting as conflicts are understood. At times the patient may relate to his therapist as he had related to the one he mourns, and thus make it possible to work through in a focal way the conflicts he had had with him. The fresh grief caused by separation as therapy terminates can be put to appropriate use.

Although re-grief therapy is brief, lasting for some months rather than for years, it is intense, intimate, and certainly not superficial. It can be likened to a



“mini-focal analysis” since it leads to the activating of certain areas of intrapsychic process, however focalized, and effects intrapsychic change in areas under treatment by means of “working-through.” Thus, it is not recommended for therapists inexperienced in listening to the flow of unconscious process. It requires adherence to a therapeutic position and expert handling of transference and countertransference.

### A Case Report

A 30-year-old, well-respected, and highly competent female lawyer sought treatment from one of us (Josephthal) for the trouble she was having in resolving her grief reaction to her husband’s death in an airplane accident six months earlier. Although she showed some manifestations of what could be understood as prolonged “normal grief,” her case history revealed a basic picture of established pathological grief with typical psychodynamics underlying it. She continued unable to control the tears and weeping that came whenever she thought of him, and she was ashamed over so losing her self-control and dismayed that the situation seemed not to improve as time went on. Her tears were accompanied by sad and poignant longing for her husband and for her own death to come in order that they might be together again. She reported being especially upset on the tenth and twelfth of each month; she had had to identify the body on the tenth day of the month in which he died, and to make arrangements for the cremation two days after.

Her history indicated no significant psychological, developmental trauma, nor deprivation, overindulgence, or difficulties with object relations. She grew up in a farm family in which self-reliance was a virtue, and she rejected any sign of dependency within herself. Her social, educational, sexual, and vocational development progressed smoothly, and when she was 24 she married a dynamic, successful, and glamorous lawyer who was also a real-estate investor, and she spoke of having had a full and exciting life with him. The couple traveled extensively and had many friends. She felt that her relationship to her husband,

which was deep, rich, and intimate, had only one flaw—his engagement in several transient extramarital affairs while on business trips. Although she tried to condone this as unimportant in the contemporary climate of openness and enlightenment, and felt that he did not, in fact, have any real emotional involvement with the women in question, she was inwardly upset and felt that her husband had shown less than total commitment to their marriage. She tried to feel accepting and liberated, and not to be controlling, but, however she questioned her objections intellectually, emotionally she continued to resent his affairs. This was an unresolved issue at the time of his death, but otherwise she felt hers had been a very happy marriage. The couple had chosen to delay having children, but the patient was making plans for a child when her husband lost his life in the crash of a private plane while on a business trip abroad.

In the first few sessions she recounted her experiences immediately after being notified of her husband's death. She had felt shock and disbelief at first, and continued to hope against hope that the news was in error until she identified the body two days after the accident in the country where the plane had crashed. The identification had been very traumatic for her; she saw to her horror that his face had suffered severe mutilation. Part of his jaw was gone, and the tissue that remained was bloated and discolored. His mutilated face kept appearing in her mind's eye in what she called a "flash," but it was interesting to hear that as time went on it began to return to its normal appearance without volition on her part; the missing area was filling in, and the swelling was subsiding. Such gradual fading of horror was reminiscent of what happens in the recurring dreams of traumatic neurosis.

The patient kept her husband's ashes in her bedroom in a wooden box. Although she had made plans to dispose of them in several places meaningful in terms of their shared experiences, she found that she kept procrastinating. She had never been able to open the box and examine the ashes, but she could not dispose of them. When she happened to see the Tutankhamen exhibit which was touring the country, she had what she described as a "weird experience." In

reading the dates of the excavation of the Tutankhamen tomb and doing some mathematical calculations concerning her husband's birthdate, his age at death, his age at the excavation dates, etc., she had a sudden flash of insight that momentarily persuaded her that her husband had been the King's reincarnation. She quickly saw the absurdity of this and understood that it indicated a wish that her husband could return through reincarnation. This insight was replaced by a search for meaning. Being of a philosophical turn of mind and well-read in Eastern philosophy, she began trying to understand what lessons or meaning her husband's death would reveal to her.

She came weekly for therapy, except for one week during which the box of her husband's ashes was in the therapist's office, where she opened it in his presence; then she came on four consecutive days. She began treatment with a well-developed capacity for the alliance and unusual insight and psychological-mindedness, and she seemed at each session to bring in fresh and absorbing material, showing deep and appropriate affect. She had shared her grief response with no one and seemed eager to unburden herself and to work on some of her difficulties. She very quickly began to work through her problems while the therapist encouraged her and acted as an auxiliary superego to help her overcome her initial resistance based on shame and fear over being what she thought of as weak, dependent, and vulnerable. After the first few visits she had fewer episodes of crying; now they seemed to occur chiefly during her sessions in therapy. Shortly after beginning treatment she took a previously arranged trip which included a plane flight. This was preceded by a dream:

Five pterodactyls fly over my property. I hide. One of them seems to have a man's body. He swoops down and carries me off. It felt pleasant.

Her immediate associations were that there had been five people in the plane crash, that the pterodactyl was her husband, and that this was a dream of reunion. The therapist offered that her husband has mastered what killed him by being able to fly, and she immediately added "and thus be immortal." She then reported a recurring thought, a quotation from T. S. Eliot's *Quartos*: "After all our

searchings we return to the same place and see it for the first time.”

She then suggested—as the therapist had been about to do—that it might be therapeutic to open the box of ashes in the therapist’s office. Her wish for reunion, seen in the dream, along with the attendant dread, was experienced and worked through in the following way. She brought the box to her therapist’s office and left it there in his safekeeping while together they explored all her fantasies about it. These included what she called her “terrible imaginings”; she had not opened the box because she was afraid she would be impelled to smear the ashes over her face and hug herself if she did so. Although clearly pointing to images of merger, the opening of the box also meant the final separation from her fantasied reunion, and thus an act of “killing” her husband.

On the day she opened the box she was dressed completely in black without realizing the meaning of this, and wore a necklace of seashells. When she opened the box, trembling and with great trepidation, she gasped at unexpectedly seeing chips of bone. She likened these to seashells—she and her husband had enjoyed sailing and spent considerable time at the seashore. She sifted through the ashes in an almost caressing manner, then unconsciously patted the side of her jaw. When this gesture was called to her attention, she immediately realized that she was trying to “fix him.” She then relaxed and examined the ashes with a more detached interest. After that session she took the ashes home with her and went on to dispose of most of them, keeping some in the box. She would occasionally pat it as she walked out of the room, and engage in fond reminiscence as she did so. The box of ashes continued to be a linking object, but further exploration disclosed that it no longer evoked anxiety and dread, but held a new meaning. At first she said, “I’d rather keep it and not think about it.” She explained that if she thought about it she was afraid that she “would think angry thoughts and lose the fond memories.” She also thought, “I’m keeping him in the box,” and this came to mean that she was holding him as she had been unable to do completely when he was alive. She was somewhat ashamed to realize that she was acting this fantasy out, but her shame gave way to greater interest in her motivation. She began to

work with more integration on the ambivalence she felt, trying to sort out and reconcile the anger she had been denying and the affectionate feelings that had contained an over-idealization of her husband. At this point, “further unfinished business” came up when she described in greater detail her experience of mourning the death of her father when she had been in her early twenties. He had died of metastatic cancer and until the end so used denial that she had been unable to discuss his impending death with him. Any approach to the subject disturbed him and with tears in her eyes she would begin talking of something more hopeful. She felt that she had never had “the chance to say goodbye,” and she realized that this had been true also with her husband.

After six months, reference was made to terminating her treatment. She was reluctant to terminate, recognizing spontaneously that this would involve yet another separation and experience of grief that she would have to resolve. She recognized also that the positive feelings and the closeness and intimacy that she had invested in her treatment had served at some level as a replacement for the loss of closeness and sharing with her husband. She reported what she called a termination dream. In this she was a schoolgirl painting with great care and in considerable detail the portrait of a girl. She was unable to finish the portrait in the time allotted because when she applied the brush to one eye and one side of the mouth no color resulted although the rest of the face had been colored without difficulty. She thought, “Oh well, I can always come back and finish it later; besides, what I’ve done is beautiful.” She saw the incomplete eye as evidence that there was more to see about herself, and the incomplete mouth as testimony that there was more to say.

The therapist offered the interpretation that the lack of color around the eye represented her tears, and wondered about the incomplete mouth as representing her husband’s jaw. This made her tearful and she said, “I thought I had gotten over identifying with him.” She went on to describe her feeling that a piece of her had died with him. Delineating a small square space with her hands, she spoke of “this space in me where he resides.” However, there was now a

boundary around her and the dream, and the dream face, although a fusion of herself with her husband, was also separate from her, the dreamer. The suggestion in the dream that she could “finish the portrait later” represented her thinking that she might like to be analyzed at some future time since some characterological issues—some obsessional and superego features, and her concerns about dependency—had come into discussion. Agreement had been reached that analysis might await fuller resolution of her grief. The feeling that the rest of the painting was beautiful had to do, she surmised, with her feeling of being otherwise fairly hopeful and optimistic about herself and her life. Thus a termination date was planned for a short time after the first anniversary of her husband’s death.

During the termination period she presented what she called a “healing dream.” It was introduced in association with her mention of a man she had been seeing toward whom she now felt it possible that she might come to respond deeply; she had until then been judging men as, first, not her husband, and then, not like him.

I was running in a marathon, a peculiar kind with a lot of obstacles, over a gorge. It was 26.2 miles. My husband was there encouraging me. In the first part of the dream it was as if I were running in a slow motion. I thought I’d never do it. It got dark. I didn’t want to stop but I was afraid I’d trip in the dark. My husband went into a store, bought me a flashlight, and gave it to me. I was able to run easily. The next morning I had finished the race. Getting the light was a great relief. At the finish, where I placed or what my time was didn’t matter—it was a notable finish.

She immediately connected this dream with her experience in therapy and the past year of dealing with her husband’s death—how hard it had been, how slow and painful. In association to getting the light she felt that her husband’s death had made her aware of troubles previously warded off, and that the therapist had given her the light of the therapeutic process to guide her way. She began that session with a radiant smile which reflected her relief and well-being—her delight at finishing the race after dreaming heretofore of incompleteness. She had not finished grieving, but the obstacles and complications of her grief were gone. The obstacle of the gorge or chasm with an unfathomable black bottom

represented her wish for union with her husband in death. She had gotten over that obstacle, hand over hand, in therapy. The finish of the race, which came in the morning in the dream, transformed *mourning* into *morning*; she associated to this by saying that she had once again begun to enjoy the morning sunrise on her way to work. She wept as she said that although she had been eager to tell her therapist this dream, it also made her very sad because it was so evident that she was ready to leave him. He had appeared as her husband in the dream as she lived again through the loss of her husband with him. She felt that if she could set a date for terminating therapy she could prepare herself for losing the therapist, and feel some control over the loss as she had been unable to do when she lost her husband so unexpectedly. She was wearing a black dress, but a white blouse and grey jacket with it, and she commented that she realized after dressing so that she had finally become able to blend white and black.

## REFERENCES

1. Abraham, K. (1924). A short study of the development of the libido, viewed in the light of mental disorders. In: *Selected Papers in Psycho-Analysis*. London: Hogarth Press, 1927, pp. 418-501.
2. Bak, R. C. Fetishism. *J. Amer. Psychoanal. Assoc.*, 1953, 1:285-298.
3. Bibring, E. The mechanism of depression. In: P. Greenacre (Ed.), *Affective Disorders*. New York: International Universities Press, 1953.
4. Bowlby, J. Process of mourning. *Int. J. Psycho-Anal.*, 1961, 42:317-340.
5. Bowlby, J. and Parkes, C. M. Separation and loss within the family. In: E. J. Anthony and Cyrille Koupernik (Eds.), *The Child in His Family*, vol. I. New York: Wiley Interscience, 1970.
6. Brown, F. and Epps, P. Childhood bereavement and subsequent crime. *Brit. J. Psychiat.*, 1966, 112:1043-1048.
7. Deutsch, H. Absence of grief. *Psychoanal. Quart.*, 1937, 6:12-23.
8. Engel, G. L. Is grief a disease? A challenge for medical research. *Psychosom. Med.*, 1961, 23:18-22.
9. Engel, G. L. *Psychological Development in Health and Disease*. Philadelphia: W. B. Saunders, 1962.
10. Evans, P. and Liggett, J. Loss and bereavement as factors in agoraphobia: Implications for therapy. *Brit. J. Med. Psychol.*, 1971, 44:149-154.

11. Fenichel, O. *The Psychoanalytic Theory of Neurosis*. New York: Norton, 1945.
12. Freud, S. (1917). *Mourning and Melancholia*. In: J. Strachey (Ed.), *The Complete Psychological Works of Sigmund Freud, Standard Edition*. London: Hogarth Press, 1957, 14:237-258.
13. Freud, S. (1927) *Fetishism*. In: J. Strachey (Ed.), *The Complete Psychological Works of Sigmund Freud, Standard Edition*. London: Hogarth Press, 1961, 21: 149-157.
14. Freud, S. (1940). *Splitting of the Ego in the Process of Defense*. In: J. Strachey (Ed.), *The Complete Psychological Works of Sigmund Freud*. London: Hogarth Press, 1964, 23:271-278.
15. Greenacre, P. The fetish and the transitional object. *Psychoanal. Study Child*, 1969, 24:144-164.
16. Jaffe, D. S. The mechanism of projection: Its dual role in object relations. *Int. J. Psycho-Anal.*, 1968, 49:662-677.
17. Kübler-Ross, E. *On Death and Dying*. New York: The Macmillan Company, 1969.
18. Lehrman, S. R. Reactions to untimely death. *Psychiat. Quart.*, 1956, 30:565-579.
19. Loewald, H. Internalization, separation, mourning and the superego. *Psychoanal. Quart.*, 1962, 31:483-504.
20. Lidz, T. Emotional factors in the etiology of hyperthyroidism. *Psychosom. Med.*, 1949, 11:2-9.
21. Mahler, M. S. *On Human Symbolism and the Vicissitudes of Individuation*. New York: International Universities Press, 1968.
22. McDermott, N. T. and Cobb, S. A psychiatric survey of fifty cases of bronchial asthma. *Psychosom. Med.*, 1939, 1:203-245.
23. Nagera, H. Children's reactions to the death of important objects, a developmental approach. *Psychoanal. Study Child*, 1970, 25:360-400.
24. Parkes, C. M. Recent bereavement as a cause of mental illness. *Brit. J. Psychiat.*, 1964, 110:198-205.
25. Parkes, C. M. *Bereavement, Studies of Grief in Adult Life*. New York: International Universities Press, 1972.
26. Parkes, C. M. and Brown, R. J. Health after bereavement: A controlled study of young Boston widows and widowers. *Psychosom. Med.*, 1972, 34:449-461.
27. Peck, M. W. Notes on identification in a case of depressive reaction to the death of a love object. *Psychoanal. Quart.*, 1939, 8:1-18.
28. Pollock, G. Mourning and adaptation. *Int. J. Psycho-Anal.*, 1961, 42:341-361.
29. Pollock, G. Anniversary reactions, trauma and mourning. *Psychoanal. Quart.*, 1970, 39:347-371.
30. Pollock, G. Temporal anniversary manifestations: hour, day, holiday. *Psychoanal. Quart.*, 1971,



40:123-131.

31. Pollock, G. On mourning, immortality, and Utopia. *J. Amer. Psychoanal. Assoc.* 1975, 23:334-362.
32. Pollock, G. The mourning process and creative organization. *J. Amer. Psychoanal. Assoc.*, 1977, 25:3-34.
33. Schmale, A. H. Relationship of separation and depression to disease. I. A report on a hospitalized medical population. *Psychosom. Med.*, 1958, 20:259-275.
34. Schuster, D. B. A note on grief. *Bulletin of the Philadelphia Association for Psychoanalysis*, 1969, 19:87-90.
35. Smith, J. H. Identificatory styles in depression and grief. *Int. J. Psycho-Anal.*, 1971, 52:259-266.
36. Speers, R. W. and Lansing, C. *Group Therapy in Childhood Psychosis*. Chapel Hill, North Carolina: University of North Carolina Press, 1965.
37. Sperling, M. Fetishism in children. *Psychoanal. Quart.*, 1963, 32:374-392.
38. Volkan, V. D. The observation of the "little man" phenomenon in a case of anorexia nervosa. *Brit. J. Med. Psychol.*, 1965, 38:299-311.
39. Volkan, V. D. Normal and pathological grief reactions—A guide for the family physician. *Virginia Medical Monthly*, 1966, 93:651-656.
40. Volkan, V. D. Typical findings in pathological grief. *Psychiat. Quart.*, 1970, 44: 231-250.
41. Volkan, V. D. A study of a patient's re-grief work through dreams, psychological tests and psychoanalysis. *Psychiat. Quart.*, 1971, 45:255-273.
42. Volkan, V. D. The recognition and prevention of pathological grief. *Virginia Medical Monthly*, 1972a, 99:535-540.
43. Volkan, V. D. The linking objects of pathological mourners. *Arch. Gen. Psychiat.*, 1972b, 27:215-221.
44. Volkan, V. D. Death, divorce and the physician. In: D. W. Abse, E. M. Nash, and L. M. R. Loudon (Eds.), *Marital and Sexual Counseling in Medical Practice* Harper & Row, 1974, pp. 446-462.
45. Volkan, V. D. *Primitive Internalized Object Relations*. New York: International Universities Press, 1976.
46. Volkan, V. D., Cillufo, A. F., and Sarvay, T. L. Re-grief therapy and the function of the linking object as a key to stimulate emotionality. In: P. T. Olson (Ed.), *Emotional Flooding*. New York: Human Sciences Press, 1975, pp. 179-224.
47. Volkan, V. D. and Showalter, C. R. Known object loss, disturbances in reality testing, and "re-grief" work as a method of brief psychotherapy. *Psychiat. Quart.*, 1968, 42:358-374.

48. Wahl, C. W. The differential diagnosis of normal and neurotic grief following bereavement. *Psychosomatics*, 1970, 11:104-106.
49. Winnicott, D. W. Transitional objects and transitional phenomena. *Int. J. Psycho-Anal.*, 1953, 34:89-97.
50. Wolfenstein, M. How is mourning possible? *Psychoanal. Study Child.*, 93-123, 1966.