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The dynamics of grief and melancholia

ESSAY

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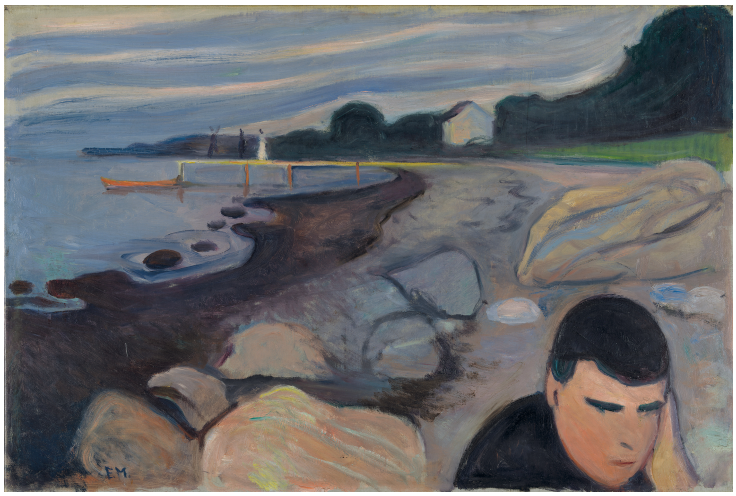
Grief is not a disease, but some people nevertheless become ill from grief. Freud was one of the first to attempt to understand why.



'Melancholia by Edvard Munch, painted 1892. Photo: Børre Høstland / Nasjonalmuseet

In 1917, Sigmund Freud (1856–1939) published one of his most important clinical works. *Mourning and Melancholia* was written over several years and was based on discussions with colleagues at a time when Freud himself was burdened with grief and worries (1). Is there any reason for doctors and other health workers to read and immerse themselves in something that was written so long ago? In my opinion, yes. Freud was the first to present a unified set of ideas about the dynamics of normal and pathological grief and depression, and his article is still highly relevant today.

A personal work

Freud wrote the first draft of *Mourning and Melancholia* already in 1915. In parallel, he was working on two other articles related to the same topic: thoughts about war and death (2) and transience (3).

This was in the midst of the First World War. Freud lived in Vienna, and the Habsburg Empire was engaged in a full-blown war with Russia, Britain and France.

Freud discussed the manuscript about mourning and melancholia with two of his psychiatrist colleagues, Sándor Ferenczi (1873–1933) in Budapest and Karl Abraham (1877–1925) in Berlin. The latter had already in 1913 published his psychoanalytic studies of manic-depressive disorder, while Freud borrowed the concept of 'introjection' from Ferenczi. It was not uncommon for Freud to use his colleagues' ideas and concepts and transform them to elaborate on his own theoretical contributions (4).

During the war years of 1914–18, large parts of the population of Vienna was struck by famine and disease. The winters were harsh, and fuel was scarce. Few patients came to see Freud. Previously, his patients had included a number of rich Russians but they no longer came, and he struggled to make ends meet.

Two of Freud's sons and a son-in-law fought in the war. At first, Freud was proud of his sons who wanted to fight for the emperor, but he soon came to another understanding as the horrors of modern warfare dawned on him. He was deeply distressed by the 'tens of thousands of dead' and also by how rational, modern man could descend into primitive bestiality and the urge to destroy, putting the entire European civilisation and culture at risk (2, 5, p. 338). The project closest to his heart, psychoanalysis, was facing an uncertain future. In 1913, he and Carl G. Jung (1875–1961) had broken off their collaboration. Furthermore, one of Europe's most prominent psychiatrists, Swiss Eugen Bleuler (1857–1939), broke with psychoanalysis (6, p. 289). There was enough to worry about and mourn over. *Mourning and Melancholia* is therefore a personal work. Freud was already well acquainted with mournful and depressive thoughts. In the 1880s he treated himself with cocaine for conditions of a psychosomatic and depressive nature (5, p. 194). *The Interpretation of Dreams* – the book that established psychoanalysis as a separate discipline – was written as a creative response to the grief over his father, who died in 1895 (7). Many of the dreams that he discusses and analyses here stem from his most intensive periods of mourning.

The Interpretation of Dreams was written as a creative response to the grief over his father

In 1923–24, Freud suffered another bout of depression. It started when his daughter Sophie Freud Halberstadt (1893–1920) died from the Spanish flu. Freud subsequently developed maxillary cancer in 1923 and underwent surgery. He was afraid of dying and unable to work with patients or participate in the work of the psychoanalytical organisations he had founded. In the summer of 1923, his grandson Heinerle (Sophie's son) died of tuberculosis at the age of four years and six months. Freud was greatly attached to his grandson and mourned over him for a long time (5, p. 346; 8, p. 91; 9, p. 161).

Freud's own death was an assisted suicide. Max Schur (1897–1969), who had been his doctor for many years, administered an overdose of morphine in accordance with an agreement they had entered into many years previously, when Freud was first diagnosed with cancer. The agreement was that when Freud had become too ill and no longer able to work and see any meaning in life, he should be helped to die. Some believe this to be is sign of how Freud had a clear relationship to death (5, p. 344). In my opinion, this is rather an effect of the idealisation of Freud. Freud's doctor has provided a vivid, detailed and unsentimental account of his patient's final days, including the circumstances around the death itself (10, p. 504).

Mourning

Grief is a condition that all humans experience when they lose a loved one. Freud pointed out that this can also apply to the loss of fatherland, freedom or an ideal. He claimed that it is wrong to regard grief as pathological and something requiring treatment. Grief passes after some time, and upsetting this process unnecessarily may be harmful. By this, Freud meant that we should trust the human ability to endure stresses and strains and overcome

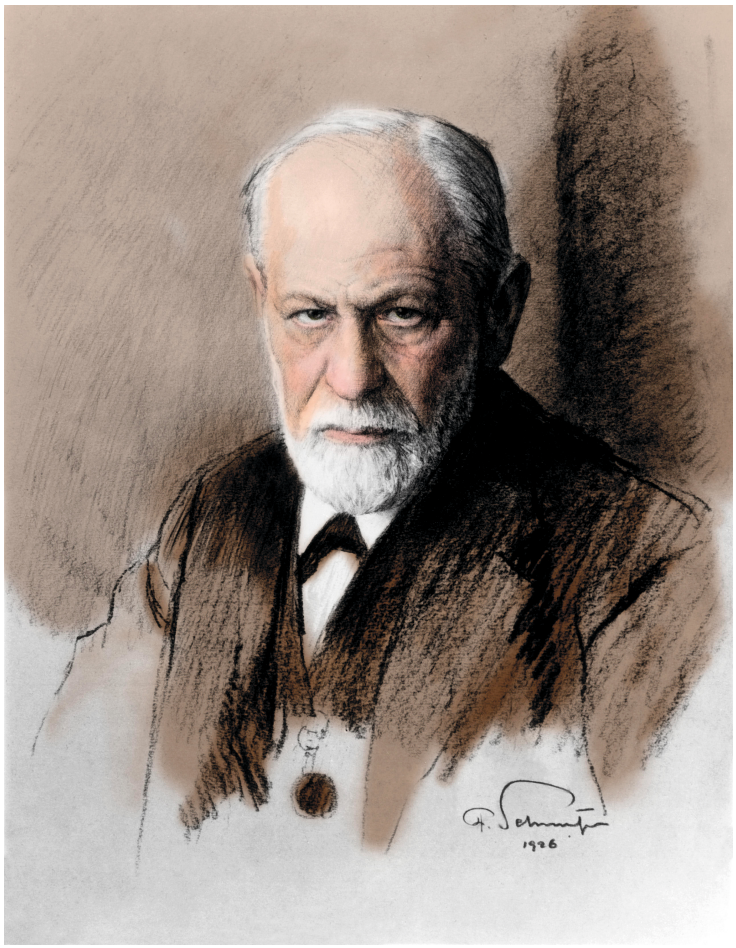
hardship through personal effort.

Freud underscored that the mourning process can assume a pathological form if the relationship with the deceased was overly characterised by ambivalent feelings and/or if the mourner has a proclivity to 'narcissistic object-choice', i.e. having too many immature features. A person can perceive an 'object loss' (such as bereavement) as an injury to his or her ego. Freud believed further that the precondition for this skewed personality development is frustration at the earliest stage of life. It is implicit in Freud's text that mourning is a conscious as well as an unconscious process, and that grief always encompasses multiple narratives.

Freud's distinction between complicated mourning and depression appears unclear, however. The psychoanalyst Vamik D. Volkan (b. 1932) outlines a psychodynamic perspective that highlights this distinction (11). In complicated mourning, the internal representations of the deceased (the introjects) do not merge with the mourner's self-representation, as in ordinary mourning (identification); they seem to continue having an independent existence. It appears as though the deceased person remains alive in the mourner's mind. On the other hand, there are few signs of the more comprehensive splitting of the ego and the self-critical accusations that characterise a depressive condition.

Freud claimed that it is wrong to regard grief as pathological and something requiring treatment

Kristensen and colleagues also discuss this distinction in association with the introduction of 'prolonged grief disorder' as a new diagnosis in ICD-11 (12). In prolonged or complicated grief, the common grief reactions will last for a longer time with undiminished or even increasing strength, frequently combined with self-reproach associated with the deceased person. It may also include a sense of having lost part of oneself. In depression, the awareness of loss is not so prominent, whereas in prolonged grief we can observe an intense and persistent longing for the deceased person. Symptoms of depression are more general and global, combined with brooding, dejection and feelings of hopelessness.



Portrait of Sigmund Freud, drawn by Ferdinand Schmutzer in 1926. Photo: Science History Images / Alamy Stock Photo

According to Freud, we learn gradually by reality orientation that the loved one is gone forever. The association with the memories of this person must be dissolved and brought to a close, one by one. This is a painful process, and most people resist it for a while. When Freud lost his grandchild, he felt that it destroyed something within him and made it difficult to establish emotional ties with others (9, p. 121). Later, Freud later stated that although it can be said that the acute mourning phase will pass, the sense of loss will remain, perhaps forever (13).

Melancholia

Freud also elucidates the processes that form the basis of melancholia (depression). It may well be triggered by an external loss, but *the recognition of the loss and its implications* is often unconscious.

Pain is a shared feature of both grief and depression. Freud says that in grief, the world appears poor, because the loved one is no longer there, while in melancholia (depression), the ego has become impoverished. The melancholy patient belittles themselves, speaks of themselves in terms of contempt, feels morally reprehensible and unworthy of someone else's love. The condition is accompanied by eating disorder, sleeplessness and loss of the will to live. Freud explains this feature of depression as an expression of a splitting of the personality, i.e. that one part operates separately from another. One part can criticise and humiliate the other, causing the patient to feel lonely, worthless, unhappy and guilty of all sorts of misery (14, p. 168).

Recent psychoanalytical reflections

Freud has been widely read, studied and also criticised for his views on mourning and depression. George Hagman underscores how Freud's views accorded with prevailing opinions in the Western world at the time (13). His choice of words and ideas bear the imprint of this, for example that other people are regarded as objects by a subject who is governed by unconscious urges. Modern psychoanalysis emphasises the relational aspect, including when it comes to the experience and processing of grief. Hagman claims that when assessing the mourning process, we need to consider individual, familial, situationally dependent, cultural and religious variables. The mourner must find new roles and a new content in life. Most of them will also experience changes to daily life, for example in terms of their finances.

A mourning therapist can be a good therapist

Léon Wurmser comments on Freud's use of the terms 'object' and 'object loss' and states that a person (to whom one is close) cannot be an object, unless he or she is dehumanised (15, p. 115). We are not mourning the loss of an *object*, but of a *fellow* human. Gurmeet S. Kanwal expresses similar ideas in an account of his interpersonal approach to the understanding of grief (16, p. 169). Instead of the concept of 'object loss', Kanwal claims that this is rather a matter of destabilisation of a self-system that consists of integrated interpersonal experiences. Finding 'new objects' is the same as integrating new interpersonal experiences to re-stabilise this self-system. Kanwal, who grew up in India, also emphasises how the mourning process is linked to both the cultural context around the mourner and the circumstances that surrounded the bereavement in question.

The psychoanalysts Léon Wurmser and Otto F. Kernberg provide personal accounts of mourning over their spouses, with whom they had shared most of their lives (15, p. 96; 17). They believe that Freud devoted too little attention to the opportunities for personal development that a completed mourning process entails, including at an advanced age.

A reminder of the importance of rituals in mourning processes. «Peasant burial» by Erik Werenskiold, 1885. Photo: Børre Høstland / Nasjonalmuseet

The mourning psychotherapist

Wurmser believes that a mourning therapist can be a good therapist, but the therapies will be more coloured by the actual relationship in the therapy room (15, p. 115). In the transference, new conflicts may arise, especially associated with the reawakening of previous traumas. For the mourner (i.e. the therapist), working and thinking of other matters may have a positive effect. However, he will also find himself to be more emotionally volatile, perhaps with an increased urge to cry.

Another key issue concerns whether or not the therapist should reveal aspects of his own situation. After the loss of his wife, Wurmser felt that his patients cared about him. It might be a unique opportunity for patients to be allowed to experience and develop these qualities in themselves in a therapeutic setting. However, too much compassion may easily take the form of resistance.

Based on his ideas of complicated grief, Volkan developed 're-grief therapy', a short-term psychoanalysis focusing on restarting the mourning process, based on transference work (11). Complications in the mourning process may lead to depression or persistent pathological grief, Volkan underscores. According to him, this is implicit in Freud's article.

Kristensen and colleagues also believe that psychotherapy appears to be effective in cases of prolonged grief, but when depression is accompanied by comorbidity, it may often be useful to combine this with antidepressants (12). However, they do not discuss the dynamic understanding of the association between these two conditions.

In a psychoanalysis, knowledge of pathological grief may aid in understanding the scope of transference between the patient and the therapist, which may occur especially at the final stage of therapy.

Conclusion

Sigmund Freud's writings bear the imprint of contemporary currents in various sciences, such as medicine and psychology. On the other hand, his work points far beyond these, and stands out as relevant to us today. *Mourning and Melancholia* will endure as an example of how a person, through crisis, can mobilise self-healing and creative forces.

The description and understanding of the dynamics behind pathological grief are highly relevant in modern medicine and psychiatry, and the condition has finally been recognised as a separate diagnostic unit. It is important for doctors and other health personnel to be knowledgeable about the condition, its dynamics and close relationship to other affective disorders.

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