

March edition

Article of the Month

‘The mourning process and its importance in mental illness..’

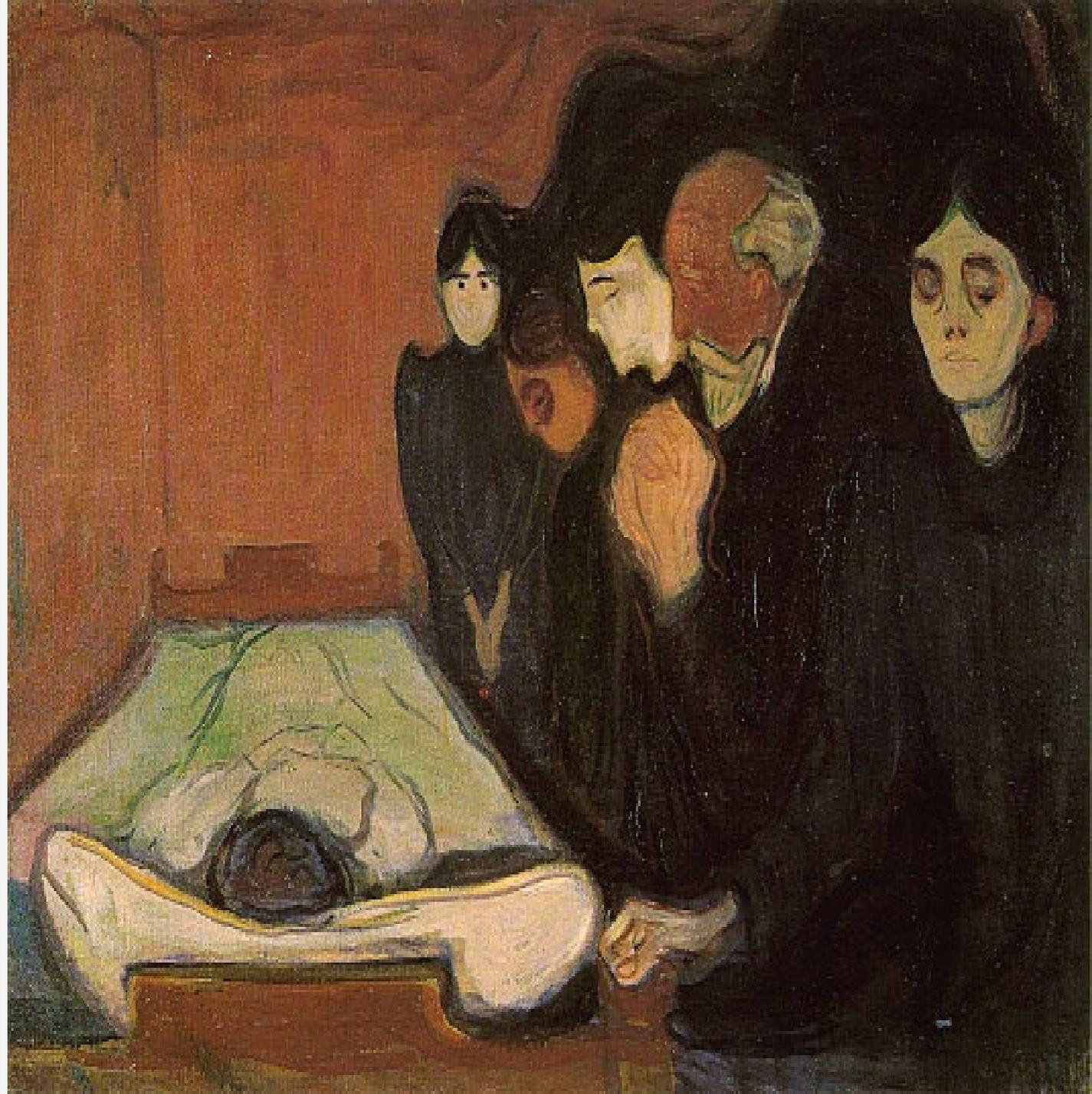
By Dr Rachel Gibbons

#BJPAdvances



**The mourning process
and its importance in
mental illness: a
*psychoanalytic
understanding of
psychiatric diagnosis
and classification***

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'What it is to be human. It seems to me that the common agent that binds us all together is loss, and so the point in life must be measured in relation to that loss. Our individual losses can be small or large. They can be accumulations of losses barely registered on a singular level, or full-scale cataclysms. Loss is absorbed into our bodies from the moment we are cast from the womb until we end our days, subsumed by it to become the essence of loss itself.'



Nick Cave





Aims

Brings together psychiatric and psychoanalytic understanding of mental disorder

Symptoms and psychodynamics.

The importance of loss and mourning in clinical practice

Underpins all mental illness

Deepen the understanding of mental disorder

Why this person has this particular illness at this point in their lives

Summary

All psychiatric illness can be understood to result from 'pathological mourning' due to arrests, or retreats, in the passage through the mourning process.

The characteristic symptoms of different psychiatric illnesses used to classify disorders can be conceptualised as resulting from the overuse of different constellations of psychic defences used at specific and different stages in the mourning process.

Differently classified illnesses have different symptoms depending on the particular point in mourning where the arrest occurs.





Factors that lead to arrest in mourning

1. *Genetics*
2. *Organic brain injury/disease*
3. *Lack of developmental containment*
4. *A loss of such magnitude that a retreat from reality is essential for psychic and/or physical survival*
5. *Collusion of the social system around the bereaved to perpetuate the disturbance*

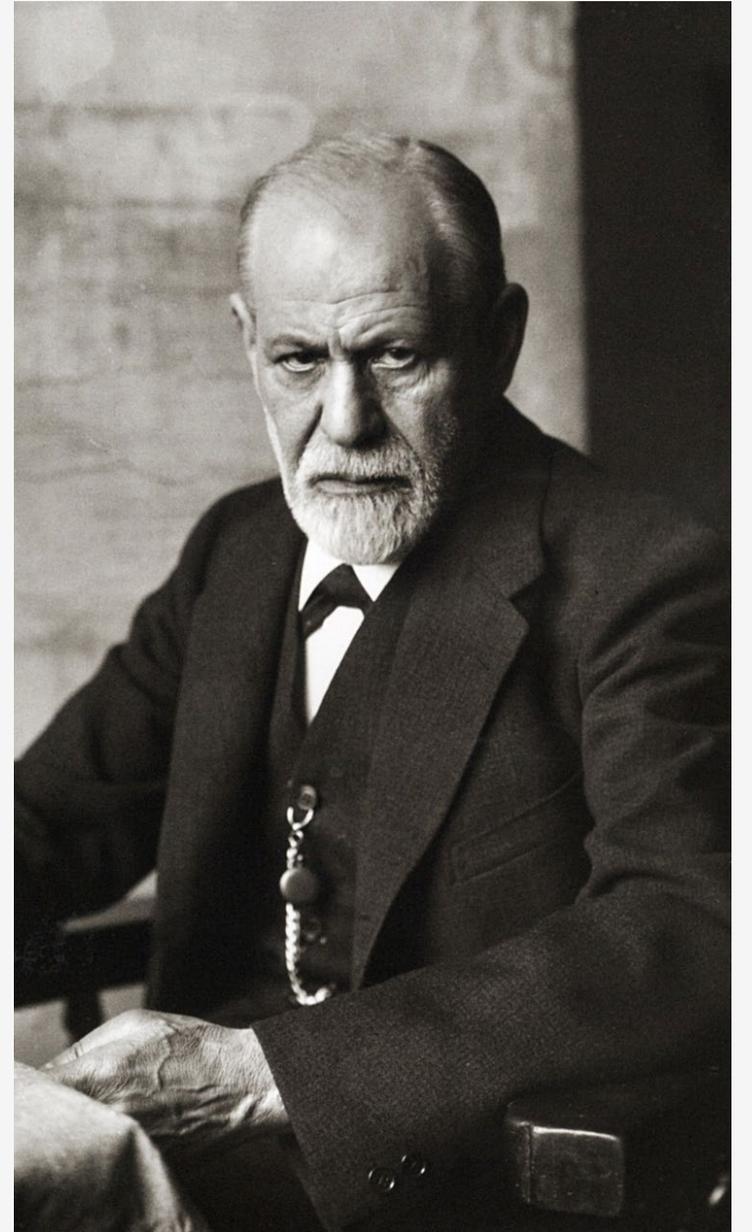


Psychic Defences

Name of Defence

Mature	Altruism, Anticipation, humour, sublimation
Neurotic	Anger turned inwards, isolation of affects, intellectualisation, reaction formation, undoing, dissociation
Immature/Primitive	splitting, projection, denial, acting out, idealisation

'[The normal mourning process] carried out bit by bit, at great expense of time and cathectic energy [...] Each single one of the memories and expectations in which the libido is bound to the object is brought up and hyper-cathected, and detachment of the libido is accomplished in respect of it.' (Freud, [1917](#)).



Normal Mourning Process

Life's great challenge fundamental to separation and individuation

Excruciatingly painful and laborious 'work'

When successful, is rewarded by ego growth

Template developed in early years



The Kübler-Ross Grief Cycle



State 1: Denial

'[M]an's usual response is "No, it cannot be me." Since in our unconscious mind we are all immortal, it is almost inconceivable for us to acknowledge that we too have to face death.' (Kubler-Ross, [1969](#): p. 55)

- *Stage 1 starts in the period directly after the loss.*
- *The ego is overwhelmed with anxiety and the capacity to mentalize and therefore symbolise is lost*
- *Primitive psychotic defences, including denial, splitting and projection, that can be mobilised rapidly and require little psychic capacity, are utilised to buffer and titrate the awareness of reality.*
- *This results in a dissociation from the experience of loss and the initial characteristic picture of numbness and unreality. The loss itself and the hatred of reality generated by it are totally denied.*



Stage 2: Hatred, Anger, Persecutory Guilt, Blame

'Since none of us likes to admit anger at a deceased person, these emotions are often disguised or repressed and prolong the period of grief or show up in other ways' (Kubler-Ross [1969](#)).

- *Defences that utilise some symbolic functioning are activated.*
- *The hatred and later, the more nuanced anger, are not initially directed at who or what is lost*
- *A perceived less valuable external 'bad object' is identified - Can be psychiatrists and psychiatric services*
- *the ability to grieve and the nature of the relationship to the lost object are of utmost importance- internalization of 'good objects' that can be utilised*
- *A very dangerous stage of mourning*



Stage 3: Transition and Bargaining

'You were giving him, my father, another chance, even with your nose still crooked from his countless backhands.' (On earth we are briefly gorgeous, Ocean Vuong, [2014](#))

- *During the transitional stage there is a gradual growing awareness of the reality of the loss, although it continues to have an unreal quality*
- *There is some hope, through the defence of 'magical thinking', of reversal.*
- *It is a time of 'hope and hopelessness'*
- *With the recovering of symbolic functioning there is the development of a 'transitional' space, where the loss can be played with in phantasy.*
- *This transitional phase continues until there is finally a taking in, or submission to, the full reality of loss.*



Stage 4: Sadness and Neurotic Guilt

'His numbness or stoicism, his anger and rage will soon be replaced with a sense of great loss.' (Kubler-Ross)

- *During this stage the loss is actively mourned, and painful sadness predominates.*
- *This grief takes a considerable amount of psychic energy, libido, which is directed into the internal world and therefore cannot be externally discerned.*
- *Instead, the individual suffering tends to appear listless, withdrawn and lacking in motivation.*
- *Gradually, through the 'work' of stage 4, a genuine compassionate resilient mental representation of the 'lost object' is internalised.*
- *This is the time of realistic neurotic guilt, and gradual reparative feelings and behaviours.*



Stage 5: Acceptance

'I hold it true, whate'er befall; / I feel it when I sorrow most; / 'Tis better to have loved and lost / than never to have loved at all.'

Arthur Hallum

- *In this final stage the pain eases and there is the possibility of learning to live with the loss.*
- *Gradually the memories bring pain, joy and gratitude for having loved and for life itself.*
- *These stages are negotiated repeatedly, often with some degree of cyclicity.*



Pathological Mourning and Psychiatric Illness

'[...] disease proceeded from an attitude of hate [...] paralysing the patient's capacity to love.' (Abraham, [1911](#))



- *Psychiatric illness results from defensive processes 'interfering with' or 'fixating' the progress of mourning in stages 1 and 2*
- *The arrest/fixation provides a 'refuge', a defence against reality - 'psychic retreat'*
- *When entrenched the retreat leads to developmental arrest and psychiatric illness.*

Illness Determined by the Place in Mourning where Arrest occurred

- Psychosis/mania in denial- stage 1

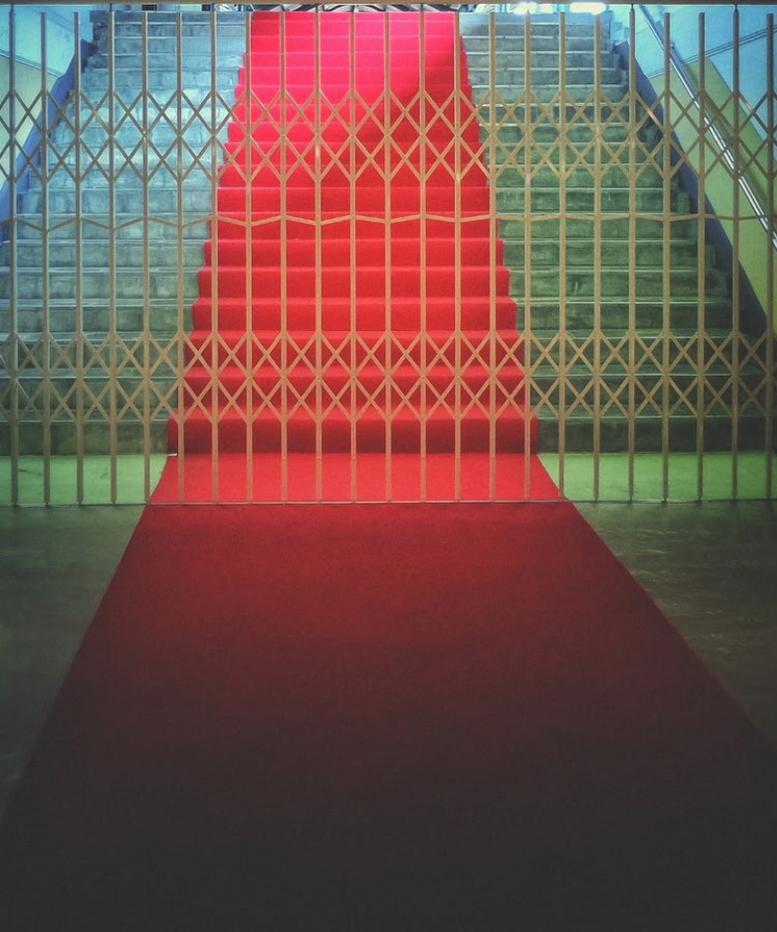
Defences: Psychotic- splitting, denial, projection

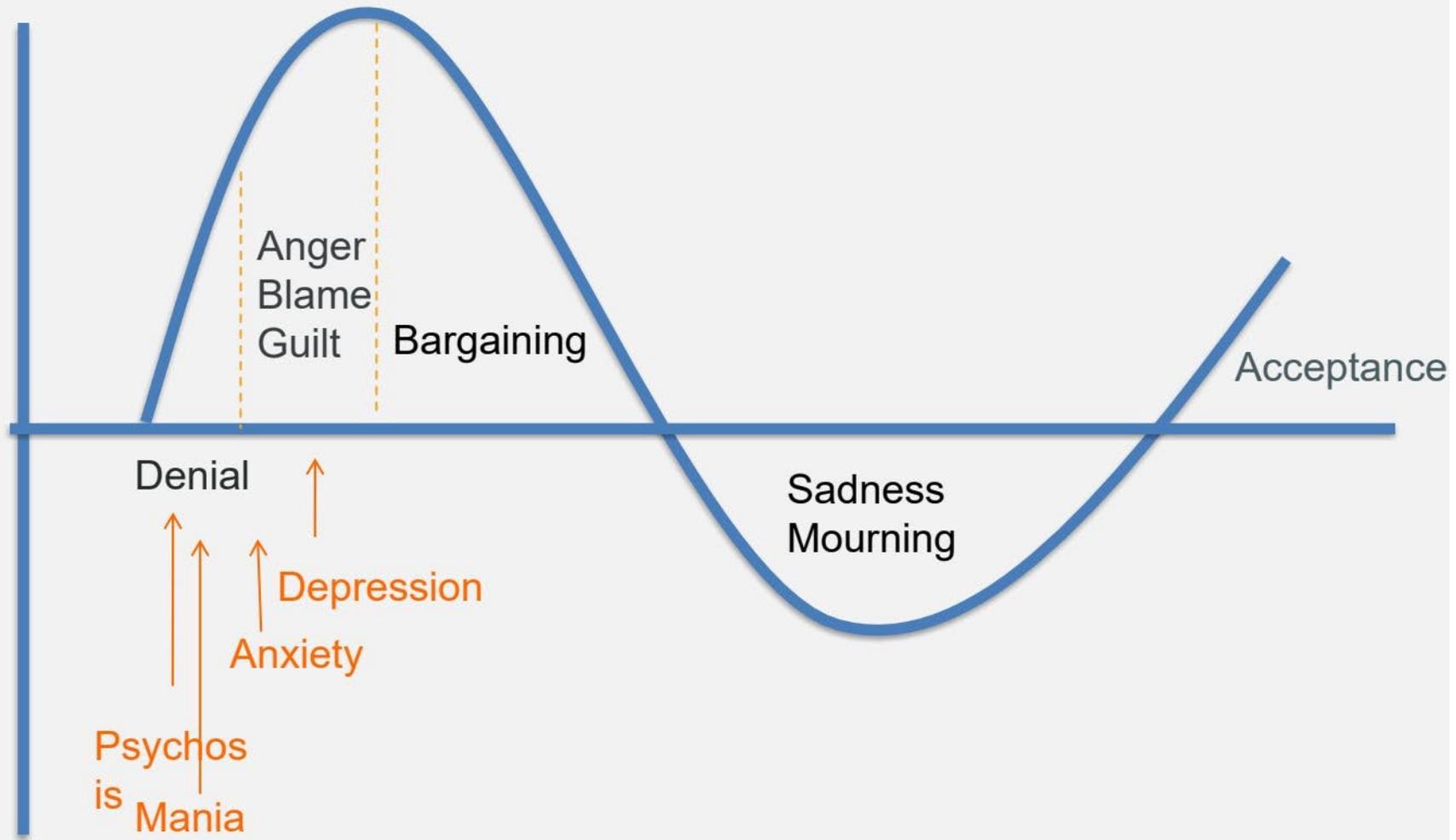
- Anxiety in between denial and anger/blame- stage 1,2

Defences: Psychotic and neurotic- magical thinking, isolation of affect, regression, reaction formation

- Depression stage 2

Defences: Neurotic- anger turned inwards





Case vignette 1: Schizophrenia (ICD-11 6A20, DSM-5 F20.9)



Mr R was a university student who had achieved well in all his exams. He had family history of mental illness. His first year at university seemed to be going as expected; When he came home at the first Christmas break, he did not seem himself. He was withdrawn and stayed in his room smoking cannabis and playing computer games. Soon after his return to university his parents began hearing concerning reports. He had started to behave oddly. He had lost a lot of weight and was not caring for himself. He told his housemates that he believed that a secret organisation was following him and had been tracing his work on the internet because, he said, they found out that he understood the networks of all governments.

Mr R was admitted to hospital voluntarily. He willingly agreed to a brain scan so he could show his family that a chip had been implanted in his brain by this secret organisation. This scan showed enlarged brain ventricles and a loss of brain volume. He was subsequently diagnosed with schizophrenia. He left hospital 6 months later. He was stable on antipsychotic medication, but he did not recover his symbolic capacities and cognitively he was severely disabled. He moved from the ward to accommodation with 24 h support.

Mr R

- *A significant genetic component to his illness (A1).*
- *Neurodegeneration had robbed him of significant symbolic functioning (A2). His mental capacities decreased, and the only defences available to him were primarily primitive in nature.*
- *The development of a psychotic illness enormous loss (A4)*
- *At no time did Mr R express anger or sadness. He remained in denial about his illness.*



Case vignette 2: Delusional disorder (ICD-11 6A24, DSM-5 F22)



Miss L was a 60-year-old woman presenting for the first time to psychiatric services. She had developed a psychotic illness following her mother's death. She came from a wealthy background and had never left home, continuing to live with her mother and never finding a partner, studying or working. She believed that her mother had not died but was being experimented on at the local hospital. She lived the rest of her life with a high level of support from psychiatric services and maintained this delusion.

Miss L

- *Difficulties in developmental containment*
- *Had never managed to develop a mature capacity for mourning.*
- *Separation from her mother had not been possible (A3).*
- *The death of her mother was therefore too large a loss for her to cope with (A4).*
- *She remained stuck in stage 1 of mourning, with a persistent delusion.*



Case vignette 3: Psychotic disorder unspecified (ICD-11 6A25, DSM-5 F298.9)



Mr P was detained in prison. He was a man in his 30s who had no history of psychiatric illness and no previous criminal record. He had been working successfully in retail before his arrest. He was charged with the murder of his pregnant girlfriend. He made no attempt to cover up the crime. When seen by the prison psychiatric team, his behaviour was bizarre. He was clearly perplexed and disordered in thought and speech. He believed his girlfriend was still alive and he denied all knowledge of the crime. He was diagnosed with a psychotic illness. He remained unwell and was transferred to a forensic hospital, where he remained for the next 10 years.

Mr P

- *The loss itself and the role he had played in it was too great for him to acknowledge (A4).*
- *He had to remain in a state of total denial to retain his unawareness.*
- *This therefore was an arrest in stage 1 of mourning and the symptoms were of psychosis.*



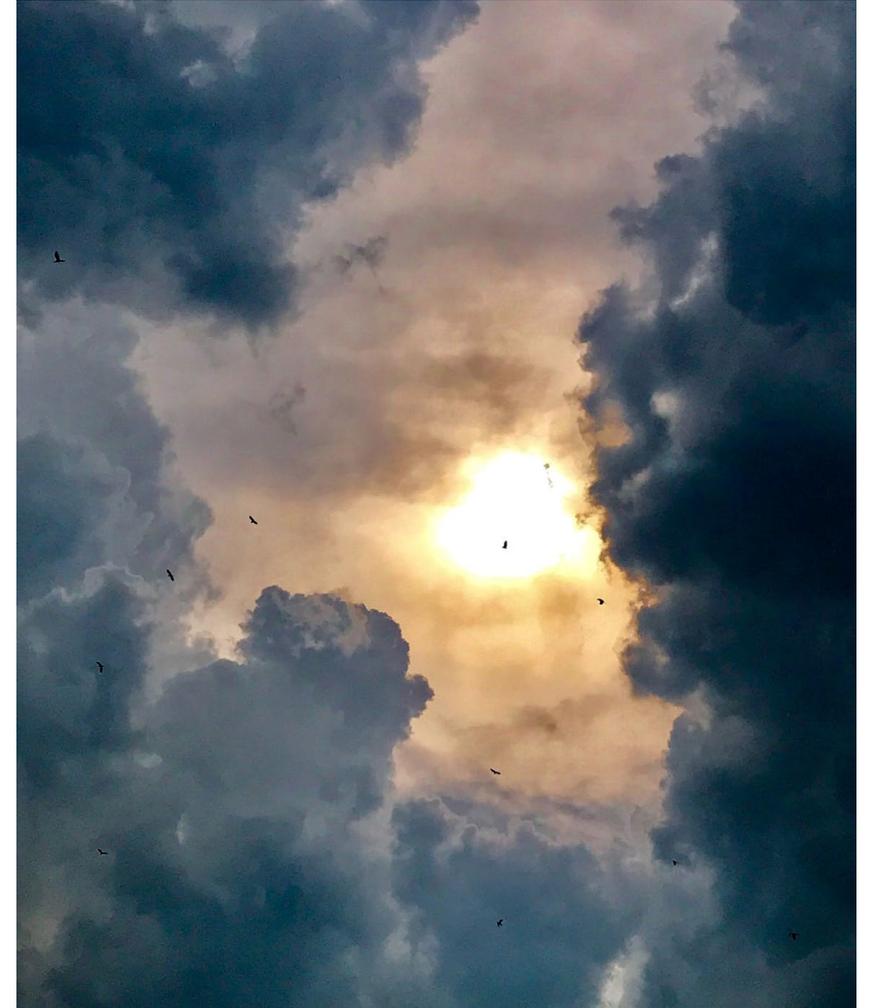
Case vignette 4: bipolar affective disorder, current episode manic (ICD-11 6A60.1, DSM F31.2)



Mr M was a 31-year-old high-functioning lawyer who was admitted to a psychiatric ward with florid manic symptoms. He had a family history of significant mental illness. He had a difficult early life. His parents divorced when he was 9 and his father had no subsequent contact with the children or their mother. Mr M said that this had little effect on him and that it was only his mother who was important. His father died around 18 months before his admission. It was after this loss that he gradually became ill with symptoms of a manic episode.

Mr M

- *A genetic vulnerability (A1)*
- *A lack of containment in early childhood with the loss of his father from the family (A2).*
- *This loss was not acknowledged and mourned.*
- *Later, the death of his father was the primary factor in Mr M's illness.*
- *There was a build-up of denied grief and Mr M arrested in stage 1 of mourning, developing symptoms of a manic episode.*
- *He subsequently recovered with mood-stabilising medication and psychotherapy. He suffered a subsequent episode 10 years later when he stopped taking his medication.*



Anxiety disorder (ICD-11 6B, DSM F40–F41)



Dr J was born in the UK just after both his parents fled from Germany in 1933. When he was 3 years old his mother became terminally ill. Throughout the years of her illness, the young boy was told that he could not see her because she was 'poorly'. After her death, Dr J became an anxious child and during much of the rest of his childhood was preoccupied with anxieties about his health. He would repeatedly ask his father 'Am I poorly, will I die like my mother?' This drove his father to distraction because no matter what he said and how much he reassured his son, the boy repeatedly asked him the same question. His father lost his temper and told Dr J when he was 10 that if he continued like this he would be sent to boarding school.

Throughout his adult life, Dr J worked as a doctor and hid his hypochondriasis. He often quietly thought that he was dying of various diseases. When Dr J's father died, he said he felt 'nothing'. With retirement, his anxiety became worse and he had various agitated depressive breakdowns which became delusional at times, when he thought he was dead or dying.

Dr J

- *An early lack of containment following the loss of his mother (A3).*
- *In adulthood, Dr J found a way to manage his illness by working hard and projecting the ill part of himself into his patients.*
- *He had two losses in later life, with the loss of his father and his retirement, and he developed a more overt mental illness.*
- *He denied the feelings about the loss of his father and projected more profoundly into his body the anxieties about death that his patients had previously held for him.*
- *With age he also had some cognitive decline and developed additional psychotic symptoms (A2).*



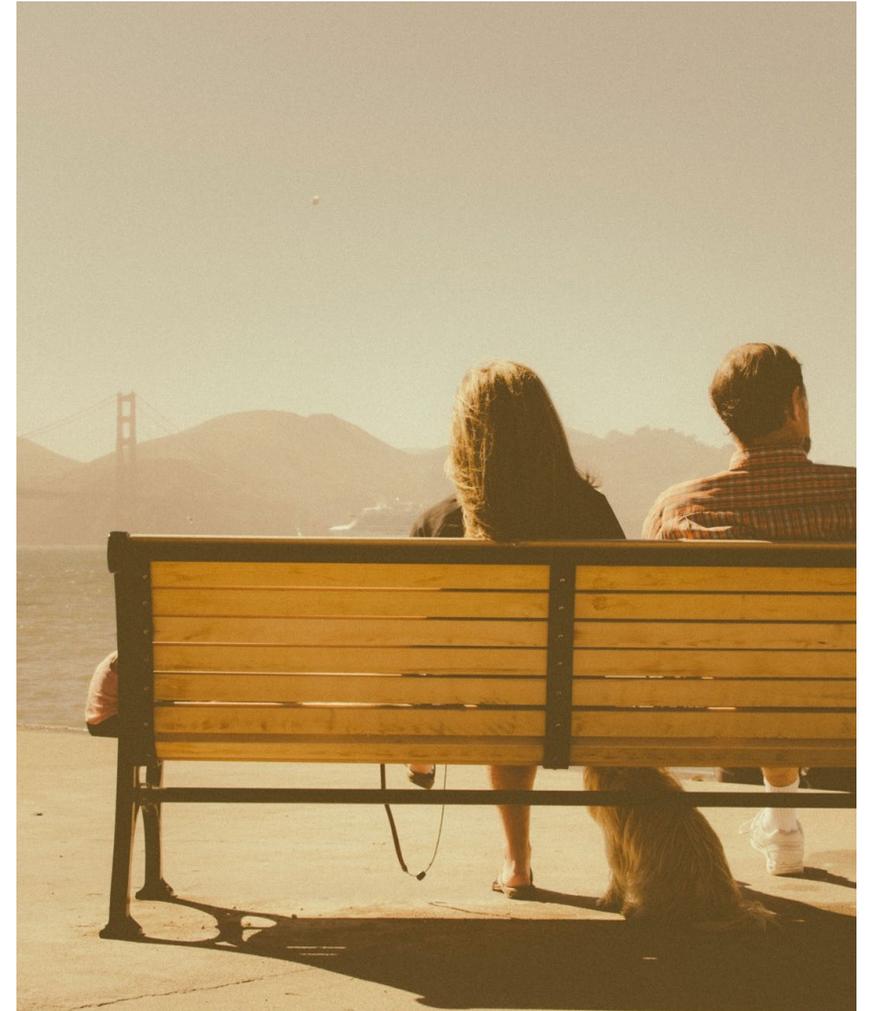
Case vignette 5: Major depressive disorder, current episode moderate (ICD-11 6A70.1, DSM-V F32.1)



Mr H was sent to boarding school when he was 7. He was initially very distressed but learned to survive by joining in with the sadomasochistic games and bullying of his classmates. He achieved well academically and worked in the financial markets. He married a woman whom he met at university, and they had children. When the children left home, his wife told him that she wanted a divorce. This brought about a depressive breakdown for Mr H. He attacked himself, blaming himself for the marital breakdown and disappointing his wife. He expressed suicidality and hopelessness. His wife felt she could not leave because he might harm himself.

Mr H

- *A lack of developmental containment as a result of premature separation (A3).*
- *He lacked the capacity to mourn the breakdown in his marriage and he retreated from reality (A4).*
- *The anger directed at his wife, which resonated with the anger he had felt earlier towards his mother for being sent to boarding school, was turned against himself.*
- *His suicidality served to control his wife, stopping her from leaving, and maintained his illness (A5).*



Conclusion and Summary

1. *This model allows for clarity of formulation and renders diagnosis understandable at a deeper level.*
2. *The symptoms of illness can be understood as resulting from the overuse of different constellations of psychic defences activated in different stages of the mourning process.*
3. *Looking for the loss event that underpins the disorder helps determine therapeutic treatment options.*
4. *To increases the chance of authentic therapeutic engagement and recovery.*
5. *To make some sense of clinical pictures that can at times seem incomprehensible*
6. *To bring to the fore the importance of loss and mourning in clinical practice.*

