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An exploration of pathological grief through Freud's paper Mourning and Melancholia

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Abstract

This study aims to explore how grief can become pathological. Specifically, focusing on Freud's 1917 paper, 'Mourning and Melancholia'. The paper distinguishes between Freud's account of the normal path of mourning and pathological grief. Melancholia, pathological grief is the result of the mechanism of identification. Freud's theory of narcissistic identification becomes the central theme and Freud's answer as to why loss can become pathological. Contemporary theory is considered which highlights the relevance of Freud's paper today.

Introduction

Experiencing the loss of a loved one is a sad reality of life. The majority of individuals who navigate their way through the long and painful grieving process adapt over time to life without their loved one. This process of mourning is called 'normal grief' (Enez 2018, pg.442). This study aims to focus on the minority of individuals who do not follow the normal path of grief. Between ten and twenty percent of grieved people are affected by complicated grief irrespective of age, nature of death and relationship with the deceased (Miller as cited by Enez 2018, p.271).

As part of the literature review for this paper, varying definitions of complicated grief are noted. Rando et al. note fluctuating terminology to define this type of grief which include 'absent, abnormal, complicated, distorted, morbid, maladaptive, atypical, intensified and prolonged, unresolved, neurotic, dysfunctional, chronic, delayed, and inhibited' (Rando et. Al, 2012, pg. 252). The most fitting description is noted by Stroebe which describes complicated grief as a 'derailing of the normal, usually painful process of adapting to the loss of a significant person' (Stroebe, 2013, pg.3). For this research paper, the term pathological grief is used to describe this derailment from the normal path of grief.

In order to explore mourning and how this grief becomes pathological, Freud's seminal 1917 paper, 'Mourning and Melancholia' is examined. Contemporary theory is also assessed in order to determine how Freud's concept of pathological grief sits therein. Lastly, the question of why individuals experience grief so differently, taking childhood development and attachments into consideration, is explored.

Chapter one is an examination of Freud's paper 'Mourning and Melancholia' described as a 'landmark in the understanding of the normal and psychopathological aspects of the mourning and

depressive processes in human beings' (Bokanowski, 2018, pg. xix). To understand what Freud considered to be pathological grief, it is important to understand what Freud deemed the normal path of mourning. For Freud, mourning is considered a lengthy painful process involving 'grave departures from the normal attitude to life' (Freud, 1917/2001, pg. 243). This withdrawal from a normal attitude to life is considered completely natural and part of the mourning process (Freud, 1917/2001, pg. 243). According to Freud, this behaviour is a 'regular reaction to loss' which should not be 'regarded as a pathological condition' (Freud, 1917/2001, pg. 243).

Freud's paper then addresses melancholia. Melancholia is the unconscious reaction to a loss which is unknown (Freud, 1917/2001, pg. 245). Freud explains the loss is of an ideal kind, a loved object (Freud, 1917/2001, pg. 245). Freud remarks on the 'contradiction to mourning, in which there is nothing about the loss that is unconscious (Freud, 1917/2001, pg. 245). Freud describes the mechanism at work behind melancholia as narcissistic identification. When an individual is unreasonably critical of themselves, this indicates the ego has identified with the lost object. The ego has been taken over by the lost loved object, and the hate side of this ambivalent relationship begins to relish in its sadistic suffering of the ego. Theoretically linking mourning to melancholia gave Freud the opportunity to showcase his theory of identification in the formation of the ego which he had described in his 1914 paper, 'On Narcissism'.

Chapter two considers contemporary aspects of pathological grief. The inclusion of grief disorders in the DSM V (Diagnostic and Statistical Manual) and the ICD 11 (International Classification of Diseases) highlight the relevance of Freud's thinking. The DSM V is the reference manual used by healthcare professionals in the United States. The ICD 11 is a diagnostic classification tool produced by the World Health Organisation (WHO). Both manuals are considered the authoritative guides to aid in the diagnosis of mental disorders (APA, 2020). This

chapter takes a close look at the diagnostic criteria for both manuals and considers an overlap in the symptomology of Freud's melancholia and the diagnostic criteria.

Furthermore, the paper identifies contemporary theorists who focus on situational factors that can hinder the mourning process and result in pathological grief. Firstly, ambiguous loss theory is examined. Pauline Boss (2007) created the theory of ambiguous loss where the loss remains unclear. It prevents the person from grieving due to unknown factors around the loss. The study then considers disenfranchised grief developed by Doka (1989). Disenfranchised grief relates to loss that is not publicly acknowledged leaving the individual with grief unrecognised and unresolved (Doka, 1989). The paper then focuses on Stroebe and Schut's 1999 study of the Dual Process Model (DPM). The model indicates how well a person is coping with bereavement. It has two categories of loss and avoidant determinants and a healthy adaption to loss shows an 'oscillation' between both categories (Stroebe and Schut, 2010). Interestingly, in terms of this study, the DPM also indicates a pathological grief reaction where there is no 'oscillation' but a fixation on either category of loss or avoidance (Stroebe and Schut, 2010).

Chapter three considers the question of why people deal with loss differently. The first real loss which for Freud happens during the phallic stage of your psychosexual development when a person has overcome their Oedipus complex is considered. The resolution of the Oedipus complex brings a loss and represents the first loss we must overcome (Kahn, 2002, pg. 57). How the scars of your first loss unconsciously affect subsequent losses is also considered.

Bowlby's theory of attachment is also explored. Bowlby's theory suggests an insecure attachment style can affect bereavement outcomes (Stroebe, 2002, pg.132). Evidence suggests that the attachments made with an early caregiver are a factor not alone in the making of affectional bonds but also in the relinquishing of bonds (Stroebe, 2002, pg.132).

Chapter 1: Exploring Freud's Mourning and Melancholia

In 1915, Freud wrote the paper, 'Trauer und Melancholie'. Published in 1917, the paper's title translates as 'Mourning and Melancholia'. Mourning is defined by the editor in a footnote as 'the effect of grief and its outward manifestation' (Freud, 1917/2001, pg. 243, n.2). Freud did not present a working definition for melancholia instead he highlighted how its description 'fluctuates even in descriptive psychiatry' (Freud, 1917/2001, pg. 243). Freud paints a picture of melancholia as a pathological state and describes the psychological processes at work behind the condition (Freud, 1917/2001, pg. 243). He casually writes 'we will now try to throw some light on the nature of melancholia by comparing it with the normal affect of mourning' (Freud, 1917/2001, pg. 243). Freud recognised a correlation between mourning and melancholia in both the conditions and causes (Freud, 1917/2001, pg. 243). By linking mourning to melancholia, Freud was one of the first theorists to consider the pathological side of grief. Moreover, similar to Freud's reluctance to define melancholia due to its 'fluctuating definition' in 1915, fluctuations in the definition of pathological grief today may be noted. Worden (2009 pg. 136) explains this is due to the definition's requirement to be measured as set out in the Diagnostic and Statistical Manual (DSM). Pathological grief has fallen under various name changes from complicated grief to traumatic grief and most recently, prolonged grief (Worden, 2009, pg. 136). Before pathological grief was included in the DSM, (Simons and Pardes as cited by Gort 1984) defined pathological grief as when 'the individual has been unable to come to terms with the loss, either to acknowledge it consciously or give up yearning for the person' (Gort, 1984, pg. 195).

Mourning

Freud's interpretation of mourning is a loss not solely related to the death of a loved one. Freud states mourning can be of the ideal kind, the 'abstraction which has taken the place of one, such

as one's country, liberty, an ideal and so on' (Freud, 1917/2001, pg. 243). Freud describes mourning as 'a profoundly painful dejection, cessation of interest in the outside world, loss of capacity to love, inhibition of all activity' (Freud, 1917/2001, pg. 244). Freud states, although 'mourning involves grave departures from the normal attitude to life,' it is a condition which would not be considered as pathological but one which is 'overcome with a certain lapse of time, and we look upon any interference with it as useless or even harmful' (Freud, 1917/2001, pg. 244).

Freud continues to explain the gradual painful process of mourning. This process involves a turning away from reality, mourning involves 'grave departures from the normal attitude to life' (Freud, 1917/2001, pg. 243). Freud captures the gravity of mourning, slowly through the work of mourning, the person can face the reality their loved one is gone. This coming to terms with the loss is carried out by what Freud calls 'reality testing' (Freud, 1917/2001, pg. 244). The next step in Freud's mourning process is the withdrawal of the libido from the lost object. The libido represents the psychic energy that has been invested in the relationship with the deceased such as the memories and associations with the person (Kahn, 2002, pg. 171). Freud comments that this process is met with obvious opposition, 'people never willingly give up their love object' (Freud, 1917/2001, pg. 244). The resistance to this process may be so extreme that the individual may turn from reality and form a hallucinatory association with the lost object (Freud, 1917/2001, pg. 244). The final stages of the process which 'are carried out bit by bit, at great expense of time and cathectic energy' is the slow detachment of the invested psychic energy (Freud, 1917/2001, pg. 245). Each memory is resurrected and over time our libidinal ties are withdrawn. Mourning is complete when the 'ego becomes free and uninhibited again' (Freud, 1917/2001, pg. 245).

Melancholia

Melancholia is the term Freud uses for pathological grief which takes place within the unconscious (Freud, 1917/2001, pg. 244). Quinodoz (2004, p.149) in citing Bonaparte et al 1956, writes a contemporary description of melancholia in a therapeutic setting would be 'depression', however he elaborates that it would represent 'the most severe, psychotic form of depression'. Freud highlights the same factors that cause mourning in one individual may manifest into melancholia in another (Freud, 1917/2001, pg. 243). This is the central question of this study, why does grief go wrong for some people?

Freud states there are 'three preconditions of melancholia- loss of the object, ambivalence, and regression of libido into the ego' (Freud, 1917/2001, pg. 258).

Firstly, loss according to Freud is unconscious, what the melancholic person has lost is unknown. 'The loss is of a more ideal kind' (Freud, 1917/2001, pg. 245). The loss is unconscious and the melancholic is not consciously aware of what is lost (Freud, 1917/2001, pg. 245). Freud cites the example of the breakdown of a relationship. The person is consciously aware of the loss of the relationship 'but only in a sense that he knows whom he has lost but not what he has lost in him' (Freud, 1917/2001, pg. 245). Ogden highlights the 'ambiguity' in the object loss, the melancholic is unaware of the importance the object loss has had on them (2018, p.126).

The second precondition according to Freud to produce melancholia is the ambivalence in the relationship. Freud points out that in the case of melancholia, the loss does not have to relate to death rather the occasions which effect the illness are 'those situations of being slighted, neglected or disappointed' which bring about conflicting feelings of love and hate (Freud, 1917/2001, pg.

251). The ambivalence in the relationship with the lost object is a necessary condition for melancholia. Freud explains:

> '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 substitutive object, abusing it, debasing it, making it suffer and deriving sadistic satisfaction from its suffering'
>
> (Freud, 1917/2001, pg. 251).

Freud's third precondition for melancholia is 'regression of libido into the ego' which is found in the concept of narcissistic identification. Narcissistic identification occurs when an individual is unable to give up their libidinal ties to the lost object. Narcissistic identification theory was developed in Freud's 1914 paper 'On Narcissism'. It is often referred to as the sister paper to 'Mourning and Melancholia' (Bradbury, 2001, pg. 215). The paper details the 'relations between the ego and external objects' (Freud, 1917/2001, pg. 70). Freud proposed that as children we start out in a psychological state of 'primary narcissism' (Freud, 1917/2001, pg. 75). Over time the libido can extend itself to external objects (Freud, 1917/2001, pg. 75). Freud explains the work of the libido's energy 'object cathexes' can be 'sent out and drawn back in again' namely between the 'ego libido and object libido (Freud, 1917/2001, pg. 76). The primary form of identification found in melancholia is called narcissistic identification which Freud describes in children. The ego libido is loaned to the object libido, as an 'extension of one's self' (Ogden, 2018, p.133). Ogden explains that in infancy the melancholic never moved to a 'mature object love involving a person who is experienced as separate from himself' (Ogden, 2018, p.134). It is for this reason, when faced with loss, the melancholic can't face the reality of the object loss instead the ego withdraws the libido to avoid the pain of loss (Ogden, 2018, p.134). Quinodoz (2018) explains the path to narcissistic identification where the libido 'is not withdrawn from the lost object. The ego

"devours" the object in fantasy, in order not to separate from it' (Quinodoz, 2018, p.183). It is in the devouring of the lost object, in which Freud highlights a primary oral phase of the libidinal development which represents a regression to narcissism (Freud, 1917/2001, pg. 249).

Freud highlights a symptom of self-reproaches in melancholia. The individual will 'be brutally critical of himself, finding he doesn't measure up in any dimension' (Lear, 2005, pg. 168). Freud writes the melancholic individual will show an 'extraordinary diminution in his self-regard, an impoverishment of his ego on a grand scale' (Freud, 1917/2001, pg. 246). The diminished self-regard is witnessed through self-reproaches and vilifying the ego (Freud, 1917/2001, pg. 246). 'In mourning it is the world that has become poor and empty, in melancholia it is the ego itself; (Freud, 1917/2001, pg. 246). It is through the self-reproaches, Freud started to see the self-accusations were not against the individual but the love object that has been introjected.

For Freud the resolution of melancholia is unclear, the condition seems to leave the individual unscathed (Freud, 1917/2001, pg. 252). Melancholia passes after a certain lapse of time 'without leaving traces of any gross changes' (Freud, 1917/2001, pg. 252). It would appear time is the necessary requirement for both conditions of mourning and melancholia to come to an end (Freud, 1917/2001, pg. 252).

Thus, it may be understood mourning becomes a pathological condition for Freud, when there has been an unconscious loss, that loss was marked with feelings of ambivalence of both love and hate. Instead of coping with the loss, the ego regresses to a primary form of identification – narcissistic identification. The ego can't face letting the lost object go, what happens instead the ego withdraws the libido to avoid the loss. This will become evident in the therapeutic setting when the individual is extraordinarily critical of themselves, to a point it may be recognised, the criticism is not directed at them but the love object that has formed an identification with the ego.

This chapter explored Freud's 1917 'Mourning and Melancholia' paper. Mourning is the conscious reaction to loss, which one must work through to detach the libido from the lost object. Melancholia is the unconscious response to a lost loved object. In melancholia, the ego has been altered by the object loss. The unconscious does not deal with the loss and results in a state of depression. In the following chapter, the discussion will turn to contemporary issues of pathological grief.

Chapter 2: Contemporary view of pathological grief

The relevance of Freud's seminal paper is reflected in the inclusion of a grief disorder, Persistent Complex Bereavement Disorder, in the DSM V and the inclusion of Prolonged Grief Disorder in the ICD 11 due to be published in 2022. There has been contention over the inclusion of grief disorders in the DSM V due to concerns of manipulation of the grieving process. The influence of the pharmaceutical industry on the prescribing habits of clinicians has been cited as a concern in its inclusion in the DSM V (Doka, 2017).

Where pathological grief has been recognised, the inclusion has brought much debate to determine the correct terminology to encompass the various grief disorders (Kaplow 2018, Doka 2017). Rando et al (2012, p.253) stresses the point that 'complicated grief is complicated' and welcomes the addition of PCBD to the DSM V as a stand-alone disorder but highlights further research is required in relation to the many additional grief related syndromes.

Prolonged Grief Disorder symptoms are characterised by a longing and 'persistent preoccupation with the deceased' with the inclusion of 'intense emotional pain' and ambivalent feelings of guilt and denial. There is a turning away from society with 'difficulty engaging in social activities' (WHO, 2019).

Persistent Complex Grief Disorder is characterised by a severe and persistent grief and mourning reactions (American Psychiatric Association (APA), 2013 p.289). The main difference between both disorders the ICD 11 diagnoses may be made following six months of persistent symptoms where the DSM V requires twelve months of persistent symptoms.

While Freud's symptomology does not follow the same formal structured presentation of the current diagnostic manuals, he has managed to give a detailed picture of a person suffering with

melancholia. There is a 'profoundly painful dejection, cessation of interest in the outside world' (Freud, 1917/2001, pg. 244). There is a certain hostility in the ego loss who 'vilifies himself' which results in sleeplessness and refusal to eat (Freud, 1917/2001, pg. 246).

Prolonged Grief Disorder, Persistent Complex Grief Disorder and Freud's representation of melancholia appear comparable to each other. Each disorder demonstrates an ego that has been overcome with grief. Each is characterised by a distinct turning away from the daily rituals of life. All indicate a grief reaction that for some reason is preventing the individual to come to terms with their mourning process. Kahn (2002, pg. 179) highlights this point writing, 'From Freud onward, those who have studied grief say that to liberate themselves, most bereaved must mourn fully'.

Simon et al. (2020, p.11) point out the overlapping clinical characteristics complex grief shares with Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder (MDD), though stress the stand alone features and boundaries of complex grief. O'Connor and Sussman 2014 as cited by Simon et al. (2020) highlight the absence of yearning in PTSD and MDD. Fields et al (2018, p. 638) highlight, those suffering with a complex grief are presenting with 'death focused guilt' and 'suicidal thoughts' although the suicidal thoughts come from a desire to be reunited with the deceased. These findings highlight the need for the inclusion of complex grief and prolonged grief disorders as stand-alone conditions in the DSM V and ICD 11. The inclusion will hopefully encourage further studies in grief disorders.

Ambiguous loss theory

It is apparent that contemporary psychological theory continues to grapple with the same issues as Freud. For Freud, resolution of mourning came with the withdrawal of the libido from the lost object so the ego can become free and uninhibited (Freud, 1917/2001, pg. 243). Though in

circumstances when the loss is uncertain this leaves a person without resolution and may prevent the withdrawal of the libido from the lost object.

Pauline Boss, who developed ambiguous loss theory, focuses on the difficulty of uncertainty around loss. Ambiguous loss is a 'loss that remains unclear' (Boss, 2007, p. 105). Trauma arises from all the unanswered questions in relation to their loved one. Are they dead or alive? The grief process is frozen and the unknown truth 'prevents cognition, thus blocking coping and decision making processes. 'Closure is impossible' (Boss, 2007, p. 105). Ambiguous loss relates to the physical loss of a person but also includes the loss of a loved one's psychological presence. Boss 2007 characterised the two types of loss as 'Leaving without good-bye' and the second type as 'Good-bye without leaving' (Boss, 2007, p. 105).

Disenfranchised grief

Disenfranchised Grief as developed by Doka in 1989 focuses on loss which are not acknowledged publicly. The loss is silent which may be a result of society grieving norms. A person with disenfranchised grief falls out of the circle of society's grieving rules and are left without a voice, where their grief is unrecognised and unresolved (Doka, 2017, p.373). In line with Freud's thinking disenfranchised grief recognises that loss is not solely related to the death of a loved one. Disenfranchised grief is viewed in the literature to include the loss of an adolescent relationship (Kaczmarek and Backlund, 1991), infertility (James and Singh, 2018), unrecognised relationships, abortion and pet loss (Doka, 2017,).

Grief is halted as the person is unable to mourn, disenfranchised grief highlights the importance of societies recognition of the many reasons an individual grieves. The individual needs to take

the silence out of their grief to start their healing process. The inability to mourn intensifies grief reactions and complicates grief (Doka, 2017, p.373).

Dual Process Model

In 1999 Stroebe and Schut designed the Dual Process Model of coping with bereavement. The purpose of this model was to 'predict good versus poor adaption to this stressful life event' (Stroebe & Schut, 2010, pg. 274). This model provides a greater understanding of how individuals cope with bereavement (Stroebe & Schut, 2010, pg. 274). The model is particularly useful when looking at why individuals do not come to terms with their loss, resulting in a pathological grief reaction. The model has identified two categories of stressors called 'loss orientated' and 'restoration orientated' (Stroebe & Schut, 2010, pg.274). A healthy adaption to the loss is noted when the person 'oscillates' between loss and restoration categories. The 'oscillation' represents a confrontation of the loss and an avoidance of the loss (Stroebe & Schut, 2010, pg. 274). The individual who engages in both loss and avoidance categories are making an adaption to their loss. It shows the person is going back and working through the loss whilst at the same time adjusting to their new world by taking on new challenges (Gross, 2018, pg. 86). Stroebe & Schut express 'An important postulation of the model is that oscillation between the two types of stressors is necessary for adaptive coping' (Stroebe & Schut, 2010, pg. 274). In contrast, where the individual does not 'oscillate', there is a focus on one orientation which indicates a pathological form of grief reaction. A focus on 'loss orientation' indicates a chronic grief reaction whereas a focus on restoration/avoidance orientated loss indicates an avoidant or absent grief reaction (Gross, 2018, pg. 86). Stroebe and Schut indicate an extreme grief reaction when there is extensive focus on one category and highlight 'complications in grieving and poor adaptation likely to occur' (Stroebe & Schut, 2010, pg. 282).

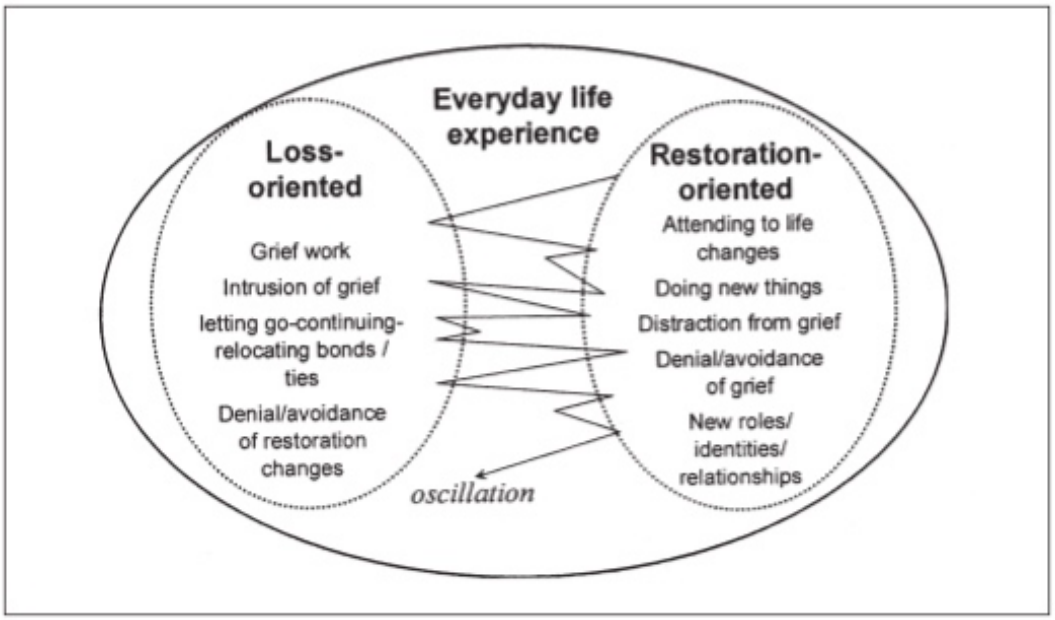

Figure 1. The Dual Process Model of Coping with Bereavement (Stroebe & Schut, 1999).

This chapter considered contemporary theory where grief can become pathological and the DPM which indicates how a person is coping with their grief. There was a common theme in both ambiguous loss theory and disenfranchised grief, whereby the mourner was prevented from grieving fully. These barriers to grief could potentially result in a pathological grief reaction. The following chapter will explore potential reasons as to why we deal with grief differently.

Chapter 3: Why we deal with loss differently?

Freud's The Oedipus Complex

How an individual manages loss in the early development of the psyche may be a contributing factor to how individuals manage all subsequent losses. For Freud, the first real loss is overcome in the Oedipus complex. The Oedipus complex coincides with the phallic stage of psychosexual development. Quinodoz (2005, pg. 63) highlights the importance of the Oedipus complex in the child's development as it 'constitutes the central organizer of mental life, around which the individual's sexual identity is structured'. Through analysis and listening to his patients, Freud believed that boys wished to kill their fathers in order to be their mother's lover. The resolution of the Oedipus complex brings a loss and represents the first loss we must overcome (Kahn, 2002, pg. 57). In rivalry with the father, the child develops a fear of castration, a fear the father will castrate his penis due to the sexual feelings the child has for his mother. According to Freud, it is due to this intense anxiety from the castration complex that encourages a child to give up their love for the mother (Quinodoz, 2005, pg.64). The giving up of a child's sexual desires to the opposite sex parent is the resolution of the castration complex. The impact of the loss will be unique as everyone navigates their psychosexual development differently. Freud notes development is not always linear 'that some overlapping may easily occur, because each stage leaves permanent marks even when the individual has moved on to the following one' (Quinodoz, 2005, pg. 61). These marks or scars that are left in the unconscious may be a factor when dealing with their next big loss. There is a parallel of relinquishing the object in both cases of the Oedipus complex and mourning and melancholia.

Bowlby's Attachment Theory

In contrast to Freud, who focused on anxieties connected to separation and loss, psychoanalyst John Bowlby focused his attention on anxiety in relation to attachments. Bowlby's theory proposes that attachment comes from a need for security and safety developed in early infancy with an immediate caregiver, usually the mother (Worden, 2009, pg.14). The attachment formed in early childhood 'determines the child's capacity to make affectional bonds later in life (Worden, 2009, pg. 14). Mary Ainsworth (1978) developed Bowlby's theory of attachment and created three types of attachment styles: secure attachment; avoidant attachment; and anxious/ambivalent attachment. Bowlby's theory suggests attachment styles affect bereavement outcomes (Stroebe, 2002, pg. 132). Bowlby suggests that those who have insecure attachments in childhood will be impacted in forming, maintaining and relinquishing relationships in later life (Stroebe, 2002, pg. 132). Stroebe et al (1991) as cited in Stroebe (2002, pg.134) measured grief outcomes in relation to attachment style. Their study was completed using Stroebe and Schut's Dual Process Model. Findings highlighted a securely attached individual will oscillate easily between the two stressors and do not suffer complications in grief. Insecure attachment types show a more disturbed, fractured manner of oscillating between these orientations. The study highlights the long-term effects early childhood attachments may have throughout life in terms of forming, maintaining and ending relationships (Stroebe, 2002, pg.134). Difficulty in ending relationships is highlighted as a factor that may complicate the grieving process for the individual (Stroebe, 2002, pg.134). According to Bowlby, healthy mourning occurs when an individual accepts ''both that a change has occurred in his external world and that he is required to make corresponding changes in his internal, representational world and to reorganize, and perhaps reorient, his attachment behavior accordingly'' (Bowlby, 1980) as cited by (Field, 2006, pg. 740).

This chapter considered both unconscious and environmental factors which may cause individuals to manage grief differently. It is important to consider the unconscious processes at work in how we deal with grief. The navigation of the Oedipus complex inevitably leaves a scar and it must be considered a factor in how we deal with subsequent losses. Bowlby's attachment theory indicates a person with an insecure attachment style will have a greater difficulty in coping with loss than those with a secure attachment style. Bowlby's theory highlights the long term impact an insecure attachment may have on an individual in terms of both forming and ending relationships.

Conclusion

This paper set out to understand how grief becomes pathological. Freud's seminal paper, 'Mourning and Melancholia' underpins this analysis. For Freud, mourning represented a taxing process on the individual whom over time revisits memories as the libido is slowly withdrawn. The work of mourning is complete when the 'ego becomes free and uninhibited again' (Freud, 1917/2001, pg. 245). Freud believed people do overcome mourning with an emphasis on time as the 'work of mourning' is performed (Freud, 1917/2001, pg. 244).

According to Freud, pathological grief occurs unconsciously through the mechanism of narcissistic identification when three preconditions are met, namely 'loss of the object, ambivalence, and regression of libido into the ego' (Freud, 1917/2001, pg. 258). Thus, it may be deduced that pathological grief, arises from an unconscious inability to let the object go. This refusal to let go has devastating effects on the ego. The ego withdraws the libido where it takes a hold, happily playing the role of vilifying the ego.

The literature explored in this paper shows a recurring theme of the need for the mourning process to be completed or worked through. Freud talks of the 'work which mourning performs' which gives the author a sense of a definitive process (Freud, 1917/2001, pg. 244). Contemporary theory discussed in the paper of disenfranchised grief and ambiguous loss indicate grief can become pathological when the grief process was halted. It is for this reason grief may become pathological when the mourner prevents himself or herself or is prevented from the grieving process due to other factors.

At the time of writing this paper Ireland is amid the COVID-19 pandemic. Typical grieving rituals are required to comply with government imposed measures on mass gatherings of individuals.

Restrictions demand a funeral is limited to family only and/ or no more than ten people (Department of Health, [DOH], 2020). This situation may potentially minimise an individual's grief reaction and presents a worrying indicator for the completion of the grieving process. Future research will be required to assess the long-term impact of these restrictions on the grieving process as a result of the COVID-19 pandemic.

This study explores grief based on Freud's paper, 'Mourning & Melancholia' and in particular seeks to understand why grief becomes pathological for a minority of individuals. Pathological grief affects a minority when unconsciously the resistance is too great to give up the loved object. Instead, a primary narcissistic identification is made so the object is not given up. The ego withdraws the libido where it takes a hold, like a shadow over the ego.

Analysis of a selection of contemporary theorists highlights the continuing relevance of Freud's work. It is evident that revisiting his work is worthwhile in order to apply his findings to contemporary grief experiences. Grief remains a complex personal journey and yet, Freud's analysis of his patients' experiences continues to inform professional psychotherapy today.

References

Ainsworth, M. D. S.., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Lawrence Erlbaum.

American Psychiatric Association (APA) (2013). *Personality Disorders*. Retrieved December 19, 2019, from www.psychiatry.org › DSM › APA_DSM-5-Personality-Disorder

American Psychiatric Association (APA) (2020). *DSM V – Frequently Asked Questions*. Retrieved April 19, 2020, from https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions

Bokanowski, T. (2018). *On Freud's Mourning and melancholia*. Routledge.

Boss, P. (2007). *Ambiguous loss theory: Challenges for scholars and practitioners*. Family relations, *56*(2), 105-111. doi/abs/10.1111/j.1741-3729.2007.00444.x

Bradbury, M. (2001). Freud's mourning and melancholia. Mortality, 6(2), 212-219. Doi/10.1080/13576270125109

Comtesse, Hannah, Anna Vogel, Anette Kersting, Winfried Rief, Regina Steil, and Rita Rosner (2020). "When does grief become pathological? Evaluation of the ICD-11 diagnostic proposal for prolonged grief in a treatment-seeking sample." *European Journal of Psychotraumatology* 11, no. 1 (2020): 1694348. doi/10.1080/20008198.2019.1694348

Doka, J. K., (2017). Complicated grief is complicated, Grief in the DSM V. Retrieved December 19, 2019 from psychology today website.https://www.psychologytoday.com/ie/blog/good-mourning/201701/complicated-grief-is-complicated

Department of health [DOH] (2020). Covid-19 (Coronavirus): A guide to the bereaved. Retrieved April 29, 2020, from https://www.gov.ie/en/publication/f43301-covid-19-coronavirus-a-guide-for-the-bereaved/

Doka, K. J. (2017). *Grief is a journey: Finding your path through loss*. Simon and Schuster.

Enez, Ö. (2018). Complicated Grief: Epidemiology, Clinical Features, Assessment, and Diagnosis. *Psikiyatride Güncel Yaklaşımlar*, *10*(3), 269-279.

Field, N. P. (2006). *Unresolved grief and continuing bonds: An attachment perspective*. Death studies, *30*(8), 739-756. doi/10.1080/07481180600850518

Fields, S. A., Johnson, W. M., & Mears, J. (2018). *How to treat complicated grief*. Journal of Family Practice, *67*(10), 637-640.

Freud, S. (2001). Mourning and Melancholia J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 14, pp. 243-259). London: Vintage. (Original work published 1923)

Gort, G. (1984). *Pathological Grief: Causes, Recognition and Treatment*. Canadian Family Physician, 30, 914.

Gross, R. (2018). *The psychology of grief*. Routledge.

James, S. S., & Singh, A. K. (2018). *Grief and Bereavement in Infertility and Involuntary Childlessness*. Journal of Psychosocial Research, *13*(2).

Kahn, M. (2002). *Basic Freud*. New York: Basic Books

Kaczmarek, M. G., & Backlund, B. A. (1991). *Disenfranchised grief: The loss of an adolescent romantic relationship*. Adolescence, *26*(102), 253.

Lear, J. (2005). *Freud*. Routledge.

Ogden, T. H (2018). A new reading of the origins of object relations theory. Bokanowski, T. *On Freud's Mourning and melancholia*. Routledge.

Quinodoz, J. M. (2005). *Reading Freud: A chronological exploration of Freud's writings*. Routledge

Quinodoz, J. M. (2018). Teaching Freud's 'Mourning and Melancholia. Bokanowski, T. *On Freud's Mourning and melancholia*. Routledge.

Rando, T. A., Doka, K. J., Fleming, S., Franco, M. H., Lobb, E. A., Parkes, C. M., & Steele, R. (2012). *A call to the field: Complicated grief in the DSM-5*. *OMEGA*-Journal of Death and Dying, *65*(4), 251-255. doi /10.2190/OM.65.4.a

Simon, N. M., Shear, M. K., Reynolds, C. F., Cozza, S. J., Mauro, C., Zisook, S., ... & Lebowitz, B. (2020). *Commentary on evidence in support of a grief-related condition as a DSM diagnosis*. Depression and anxiety, *37*(1), 9-16. doi 10.1002/da.22985

Stroebe, M. S. (2002). *Paving the way: From early attachment theory to contemporary bereavement research*. Mortality, *7*(2), 127-138. doi /10.1080/13576270220136267

Stroebe, M., & Schut, H. (2010). The dual process model of coping with bereavement: A decade on. *OMEGA-Journal of Death and Dying*, *61*(4), 273-289. doi /10.2190/OM.61.4.b

Stroebe, M., Schut, H., & Van den Bout, J. (Eds.). (2013). *Complicated grief: Scientific foundations for health care professionals*. Routledge.

Worden, W.J. (2009). *Grief counselling and grief therapy. A handbook for the mental practitioner 4th edition*. Routledge

World Health Organisation (WHO, 2019). *ICD-10 Version:2019*. Retrieved March 29th 2020, from World Health Organisation website. https://icd.who.int/browse10/2019/en#/F43.2