The construction of memory, the construction of sub-types of pathological mourning: implications for treatment

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Summary
The author describes diverse conditions that generate pathological mourning, examining different modes of interaction between past and present and the ways the lost object is constructed through them. On this basis, he distinguishes sub-types of pathological mourning and discusses the approach to psychoanalytic intervention that each type may require.

Abstract
The author examines the conditions that generate and maintain pathological mourning based on the different kinds of interaction between past and present: the past shaping the way the present is experienced; the present resignifying an unsymbolized past (Freud: Nachträglichkeit, deferred action, après coup); the needs of the present distorting the past to the extent of creating a mythical past. He distinguishes sub-types of pathological mourning and discusses the approach to psychoanalytic intervention that each type may require.

Primary fixation to the object, extant before the loss, is differentiated from secondary fixation, which occurs when suffering in the present, whatever its cause, leads to idealization of an object that is only then felt to be actually lost.

In some cases, difficulty for overcoming pathological mourning hinges on the narcissistic injury produced by object loss; in other cases, it stems from guilt feelings or paranoid anxieties that keep the bereaved person away from possible substitute objects; it may also be supported by aggressiveness, with consequent deterioration of the object representation and/or negative
responses from people in the subject’s milieu, leading to a repetition in the form of renewed object loss. Clinical vignettes illustrate some of these conditions.

The author stresses that the essential component in pathological mourning is the feelings of helplessness and hopelessness to recover the lost object. This object provided multiple functions for the subject that may have been: a) satisfying needs and wishes of self-preservation; b) psychobiological regulation; c) narcissistic needs; d) maintaining a feeling of identity; e) maintaining vitality; etc. Pathological mourning takes different forms corresponding to these functions: it may variously manifest a predominant feeling of being in danger, lowered self-esteem, disorientation, lack of vitality, or disorganized emotionality. In other cases of pathological mourning, a major component may be anxiety or generalized phobia or hypochondriac preoccupations, symptoms absent before the loss, which occur because what was initially a feeling of helplessness to recover the object finally permeates the subject’s entire representation, including the feeling of ability to face reality and the danger that might imaginarily arise. The subject’s representation as being helpless, incapable, inferior and weak creates the conditions for everything to be threatening.

Although one determinant may predominate in generating and sustaining pathological mourning, in other cases we find that various factors are involved, one or another coming to the fore at different moments in the treatment.

The author discusses a possible psychoanalytic nosology of sub-types of pathological mourning, suggesting that its usefulness lies in its potential for orienting the analyst toward the factors that need to be modified in each particular case.

Conference

Since the outset of psychoanalysis, the subject of memory, of how the past and the present interact, has provided a constant focus of interest. Freud’s discovery of transference phenomena, the importance of infantile life in determining how the present is seen through the eyes of the past, revealed one of the variants of the relation between present and past. However, Freud soon found that this relation was more complex, in that it was bidirectional. This led him to describe the condition of Nachträglichkeit, translated as deferred action or après coup (Eickhoff, 2006; Faimberg, 2005; Thomä & Cheshire, 1991), in which an event in the past, at a time when the capacity for symbolization could not give it meaning, acquires meaning through another later event. He also examined how memory is modified by the present, distorted and adapted to current needs (Freud, 1899).
In this paper, I discuss the role of the present in pathological mourning for the re-construction of the memory of the lost object, differentiating the diverse conditions that originate and maintain pathological mourning, thereby generating different sub-types. I also examine the implications of this categorization of sub-types of pathological mourning for psychoanalytic treatment.

Just as the fantasy of a lost paradise arises from suffering in the present life, the development of pathological mourning involves constant re-construction of the memory of the object, attributing to it certain features that it was not formerly felt to have. The present unhappiness, whatever its cause, creates longing for a time and for an object that is progressively idealized. This issue leads us to differentiate primary fixation to the object -previous to the loss- from secondary fixation or fixation to an object of fantasy, constructed in the present and considered the cause of an assumed past of happiness or absence of suffering.

I will now present a clinical example and then propose a more general model of pathological mourning.

Mrs. Y, around 50 years old, started analysis because of depression following her husband’s death. At our first meeting, the sad look on a face lined with suffering and her listless movements were clear indicators that the loss of her husband had become a devastating event for her. I learned that while her husband was alive, his outstanding status in society had allowed her to enjoy special deference and a life full of narcissistic satisfactions. Following his death, at first, people continued to call her often, but when the contacts waned she experienced this with resentment and growing hostility towards others. She was overcome by a feeling of helplessness and hopelessness with respect to recovering her former position. She fought off the malaise caused by these feelings of helplessness and hopelessness, which as we shall see are an essential feature of pathological mourning, by taking refuge in an idealized identity: she represented herself as the widow of a great man too easily forgotten by the world, something she would not do. She dressed totally in black, and researched and compiled her husband’s writings and speeches, which had never interested her formerly. Her husband’s figure was the object of growing idealization and began to occupy a prominent place in her thoughts that it had not held while he was alive, which led to secondary fixation to the idealized object. But this attempt at narcissistic compensation was untenable because her hostile attitude toward the people near her made the rejection she encountered make her feel more and more helpless to generate the desired responses that were indispensable for her. Her relationships dwindled to only a few members of
her family and the relationship with me in the treatment, to which she came to convey her bitterness, expecting me to share her hostile view of people. I had to be very tactful. On the one hand, I sometimes felt that I should accept her transference demand and let her know in a non-explicit way that I appreciated her human virtues, intelligence and interests. However, on the other hand, I knew that I could not limit myself to this since I would have thus confirmed her vindictive and narcissistic views, which I considered important causes of her suffering. As the treatment progressed, I was able to help her to recognize her narcissistic needs, rooted in a family with high expectations, where she had to forge a place for herself among her brothers, who received preferential treatment from their father, while she participated in her mother’s emotional atmosphere: a self-sacrificing woman with silenced but very marked paranoid elements, who used Mrs. Y as the shoulder to cry on in her bitterness.

But Mrs. Y’s isolation was not only narcissistic withdrawal aimed to preserve her feeling of superiority in solitude. From a very early age, she had been a frightened person who considered the outside dangerous. Her husband’s disappearance reactivated these old fears. Together with the narcissistic nucleus -the area of self-value- Mrs. Y suffered from a paranoid component of her personality that made her feel she was surrounded by figures that might harm her. This vision was the product of triple determination: her identification with the maternal discourse and attitude of feeling constantly threatened, her father’s violence and the projection of her own hostility.

During the treatment, whenever I touched on the paranoid component, I had to keep one eye on this and the other on her narcissistic needs that made her feel “contemptible for being weak and easily frightened”, as she said referring to a female co-worker. It was an important moment in the therapy when she could understand the circularity between the idealization of her husband and the distrust of the external world: her hostility toward external figures made her regress to the relationship with the husband, whom she needed to idealize, but the idealization of the relationship with the husband kept her from feeling that she might find another gratifying relationship in external reality.

It would have been useless for me to try to question this idealization of her husband, or to attempt to make her see the ambivalence and hostility toward him. This would have meant turning a blind eye to the imaginary relationship with her dead husband, constructed in the present, in her present suffering, and based on serious disturbances of her narcissistic equilibrium.
and feeling of basic security. This brings us to the issue that, in working through mourning, it is not a question of focusing only on the relationship with the lost object but, also, on helping the grieving person to overcome the anxieties and limitations that are now leading the person to reconstruct an object that never existed in external reality, nor in psychic reality - the way it was seen in the past.

Summarizing the case of Mrs. Y, the loss of her husband created a situation that basically destabilized her narcissism, generating feelings of helplessness, to which she reacted with aggressiveness, grandiose isolation and growing idealization of her husband, secondary to the loss. These defenses, in turn, had their consequences: the more aggressive she was, the more rejection she received from the outside, with narcissistic re-traumatization as well as increased distrust of people because of the projection of her aggressiveness. This situation was a trap: her difficulty for forming connections with the external world where she could have found substitute objects, and the return, because of this very difficulty, to an increased idealization of the lost object - secondary fixation - which reinforces the difficulty for connecting in reality with other persons whom she routinely considered inferior to the deceased. As a consequence, she relapsed into feelings of helplessness and hopelessness for recovering a valued self-image that the lost object had contributed to maintaining.

In Mrs. Y’s case we can speak in terms of secondary fixation because when the husband was alive the relationship was not felt to be a close one and the husband was not an attachment figure. When the husband went away on trips, even for as long as a month, she often told me that she felt relieved that she didn’t have to do anything for him and that she didn’t miss him. She hadn’t married him because she was in love, but rather because at her age it was what her circle and she herself expected to happen, and the fact that the man who was going to be her husband was in a good position contributed to her decision.

The depression Mrs. Y suffered when her husband died must be differentiated from other cases that present painful longing for the person lost, the absence of emotional and physical contact as the source of the suffering, the object having been an important attachment figure that was esteemed over all others, with a primary fixation to it.

It must also be differentiated from cases with predominant feelings of guilt or pity for the fate the lost person has suffered, as in the case of a patient whose baby died in his crib, having choked on
his own vomit while he and his wife were watching television in another room.

It is different when the object has essentially provided a feeling of security, so that its disappearance throws the person into a constant state of fear, paralysis and inhibition that make the person feel helpless and hopeless regarding any type of project or achievement. This sequence is characterized by: loss of the object, fear, inhibition and frustration of the many wishes that require action in reality for their gratification, with the consequent depression that is secondary to the phobic avoidance.

In Mrs. Y’s case and the others I have just mentioned, feelings of helplessness and hopelessness to achieve what is desired -the return of the object- are the common denominator that places them in the generic category of mourning, but the different causes of this helplessness and hopelessness offer the possibility of a psychoanalytic nosology of sub-types. I will return later to feelings of helplessness and hopelessness as basic elements of pathological mourning.

As for the object, it can be categorized into sub-types according to its function for the subject, in the sense of the needs it satisfies for the different motivational systems organizing wishes, anxieties and means of self-protection from them (Bleichmar, 2004). Just as there is an object of the sexual drive, some objects may enable psychobiological regulation, or a decrease in anxiety, or provide mental organization, or the feeling of vitality, or the feeling of identity, or narcissistic balance.
Objects may be categorized according to their functions in satisfying the subject’s needs, such as:

- Providing feelings of security, as in counter-phobic symbiosis
- Psychobiological regulation, reduction of anxiety, mental organization, sense of identity, vitality, enthusiasm, etc.
- Sexual pleasure
- Narcissistic needs (the object sustains self-esteem)

When the object is lost, its functions for the subject are disturbed and, consequently, the subject’s psychological balance as well. In Inhibitions, Symptoms and Anxiety, Freud asked the important question: “When does separation from an object produce anxiety, when does it produce mourning, and when does it produce, it may be, only pain?” (1926, p. 169). We can use the functions provided by the lost object for the initial description of some of the conditions involved in the different symptoms we observe after object loss. When these conditions are joined to feelings of helplessness and hopelessness they lead to the particular manifestations of pathological mourning.
Whether or not the clinical depression of pathological mourning occurs depends mainly on the tendency to feel helpless and hopeless, feelings that for some persons are part of their basic way of reacting to wish frustration or adversity, whose origin is experiences of helplessness and hopelessness they have suffered and/or identification with significant figures that suffer from them. The tendency to feel helpless in situations of wish frustration, of which helplessness to recover the lost object is a variant, is thus an essential dimension to be analyzed and modified in cases of pathological mourning.

It depends on the psychic tendencies with which it combines. Thus, if projective mechanisms are an important dimension of the personality, then object loss may lead to paranoid mourning with criticism of the environment and of what others did or do. However, if aggressiveness is combined with the tendency to experience guilt feelings, then we have a sub-type of mourning in which moments of aggressiveness are followed by others with guilt in the foreground, as we shall see in the clinical vignette below.

The loss of a significant figure that sets off the mourning process has certain repercussions if suffered by an anaclitic personality and others if by an introjective type of personality. The work of Sydney Blatt (2004) concerning these two dimensions, based on investigations characterized by consistent results, provide psychoanalytic clinical work with a valuable guide for
understanding the reaction to different types of loss, for the types of symptoms that predominate in clinical depression, as well as for a degree of predictability of the possible effects, in one case or another, of interventions centered on support or on insight.

What we have just said aims to support the idea that the sub-types of pathological mourning are best understood in a dimensional model of the psyche, that is, the functioning of the psyche determined by particular combinations of dimensions that are articulated in complex structures, which has always been the psychoanalytic approach to nosology in contrast to approaches using isolated categories, such as the successive versions of the DSM.

**Working through mourning: the treatment**

Pathological mourning characteristically involves a basic state in which the subject feels helpless and hopeless (Bibring, 1953; Haynal, 1977; Bleichmar, 1996) to recover an object and the relationship with it, a relationship that is experienced as able to provide a state of well-being (Joffe & Sandler, 1965). We use the term “basic state” to indicate that during pathological mourning a person goes through different moments: sadness predominates in some, while in others, psychic suffering triggers diverse defensive processes that are attempts to escape from it (Brenner, 1982; Grinberg, 1963; Haynal, 1977; Hoffman, 1992; Jacobson, 1971; Klein, 1940; Kohut, 1971; Pollock, 1989; Stone, 1986). There are also efforts at restitution in an attempt to restore what has happened by means of the fantasy that modifies events experienced, making them take a different course, now under the sway of the subject’s desire (Renik, 1990). In other cases, there is an appeal to weeping as a cry for help to the people around them, or else defensive self-reproaches predominate, these being self-punishment to relieve guilt feelings and to recover the love of the superego (Rado, 1951).

At some moments, the depressive affect is relegated to the background and replaced by anxiety resulting from the feeling of being in danger of something that could happen to the subject as a consequence of the loss of an object felt until then to be the subject’s protector. In this case, anxiety may be a central component in some pathological mourning, or it may present a generalized phobia with fear of everything, or hypochondriac preoccupations, symptoms absent before the loss, because what began as a feeling of helplessness to gratify the wish to recover the object finally permeates the subject’s whole representation, including the feeling of ability to
face reality and any dangers that may come imaginarily from the body.

The subject’s representation as being helpless, incapable, inferior or weak creates the conditions for everything to be threatening. Fear of an external or internal threat results from comparison with the resources the subject thinks he/she has. It is always a result of comparison between the subject representation and the object representation. Once the subject perceives himself as a self in danger, the way the danger becomes concrete depends on areas of vulnerability determined by the subject’s particular biography. Thus, hypochondriac preoccupations that were only unrealized potentials may come to the foreground, or paranoid fantasies of being attacked or limited phobias may make an appearance. Old identifications with hypochondriac or paranoid parents, which never became manifest pathology, find appropriate conditions in which to develop and expand.

The scheme above may explain what we frequently observe in the course of a treatment: symptoms that are resolved even though they have not been treated specifically. This may be due to a modification of the subject’s global representation: improving the basic feeling of security and capability eliminates the condition the symptom depends on. Basic feelings of insecurity/helplessness act as a switch leading to symptoms that are manifested as the forms in which they acquire particular qualities.
The working through of pathological mourning needs work on multiple factors, different in each case, hindering separation from the lost object -primary fixation- or hampering the subject from establishing relationships with substitute objects, which determines returning to memory with longing for the lost object, which undergoes a process of idealization and the consequent secondary fixation.

### Primary fixation

- Sense of security
- Psychobiological regulation (soothing)
- Sense of identity, mental coherence, organization of behavior
- Sexual pleasure
- Narcissistic balance

When the object is lost, the longing is not only for the object but for the state of well-being it provided

### Secondary fixation

Suffering in the present leads to return to the object, progressively idealized because of

- Persecutory anxieties with current objects
- Guilt feelings
- Harsh external conditions
- Lack of ego resources for dealing with current situation

Then, the object is progressively constructed as a desired object and felt as a lost object

In the treatment of pathological mourning, as long as narcissistic balance, paranoid anxieties or the original or defensive guilt feelings remain unmodified, and if emotional and instrumental resources are not developed to take advantage of the possibilities offered by reality, the conditions by reason of which the loss of the object is so devastating will remain active.

The conditions we have just mentioned are dimensions that guide our interventions in each particular case, bearing in mind that in the course of the treatment we will always be subject to the tension between two poles: on the one hand, a certain focalization and selection of the most pertinent interventions in view of the therapeutic objective. But on the other hand, an opening to permit the emergence of what we analysts cannot foresee. This means that maintenance of the type of evenly suspended attention, that is one of the distinguishing features of analytic therapy, enables the course of the treatment to follow the vicissitudes signaled by the patient’s psyche, rather than a rigid plan formed a priori.
An important factor at work is having remained fixated to feelings of helplessness/hopelessness in former stages of life (Bibring, 1953). M. Klein (1940) pointed out the relevance of confidence in the capacity to repair. The real experience of having lost something important and having been able to go on is inscribed in the psyche as a belief that losses are reparable, that the light at the end of the tunnel will appear. But this confidence in the capacity to repair depends not only on what happened to the person, or the real reparation the person may have been able to make in response to adverse events in their life, but also on the beliefs that their significant others have been able to convey to them that reparation can actually be made, and on what the persons accompanying the mourning person in the present do (Hagman, 1996, Shane & Shane, 1990).

The power of the discourse and attitude of a significant other has decisive implications for understanding what the analyst’s position can mean in the treatment, in regard to confidence that the patient can overcome pathological mourning. In effect, while the capacity to set in motion a process toward reparation depends in part on a fantasy or belief that this is possible, it is the analyst’s confidence in the patient’s capacity to overcome these difficulties, conveyed in a thousand ways, especially unconsciously since this is the level that matters, that helps the patient to keep hope in a different future alive. Analytic treatment is a wager that something can be modified, but for this to happen we as analysts need to have this confidence. The limit in the transformation of someone in therapy is set not only by his pathology or resources. These variables are doubtless important, but not the only ones; the other variable depends on the analyst, on what he or she believes, on the confidence in the transforming power of analysis.

**The deficits of the subject and secondary fixation to the lost object**

The working through of mourning requires three-fold work: a) on the object representation; b) on the subject representation and c) on the subject’s operative functional capacity or real ego resources. It is quite one matter when fixation to the object and dependence result from the subject’s disbelief in his resources in spite of having them, representing them instead as properties of the object; it is quite another when the subject has real deficits and, in order to complete his psychic structure, participates in a symbiosis with the object to get what he is lacking. In the former case, we mainly work on the subject’s fantasies, the imaginary representation, on the reasons why he cannot take charge of what he does possess and the anxieties impeding it. In the latter case, analytic work requires the subject to acquire resources he never had, regardless of the causes of this deficit, which force him into symbiosis with someone.
to complete his psychic structure.

The secondary idealization of the object enables us to understand why some people do not succumb to depression at the moment when the object is lost. It is not only that the present loss reactivates the pain for losses of the past or a simple accumulation of traumas, but because in the present the entire past is reconstructed, turning something inexistent into a memory, something that was not experienced before as being missing. Mourning for what was lost emerges and develops only when difficulties appear in the present for satisfying the different needs and wishes of the self-preservational, narcissistic or sexual type, etc. This warns us against applying globally the thesis, valid for many cases, that working through an actual loss requires previous working through of past losses. It is often exactly the other way around: by working through the internal and external conditions now predominating in the person which are causing feelings of helplessness to reach the individual’s legitimate aspirations and by thus overcoming these limitations, then the past losses acquire a different meaning- an action of the present on the past.

As we said above, if the encounter with new objects produces persecutory anxiety, if the subject has a hostile or distrusting relationship with the people in the environment, if the subject is insecure about being able to elicit a positive response from others, if because of a paranoid or narcissistic personality structure the individual fears attack, criticism or rejection, then they will isolate themselves and construct a phobic-avoidance barrier that will impede encounters, even when they are desired. Aggressiveness and ambivalence are essential factors in the origins and maintenance of certain cases of pathological mourning, which Freud described in *Mourning and Melancholia* and has been thoroughly confirmed in psychoanalytic clinical work by M. Klein (1940), Edith Jacobson (1971, Otto Kernberg (1990) and others.

Also, if the person has poor ego resources, for example, the emotional ability to elicit interest and attraction from others, or if the lost object is a job, when the person has no instrumental skills, knowledge or practice, then attempts to approach a new object to replace the lost one will fail. For this reason, the lost object will be remembered in a process of secondary fixation to it.

Guilt feelings after the death of a loved one determine the return, once and again, to the memory of that person, to how the subject failed to provide adequate care and the damage presumably inflicted on that object, in which case any discontinuation of thinking about the object or attempt to replace it is experienced as disloyalty or insensitivity. Faithfulness to the dead person operates
as a mandate of the superego, which obliges the subject to stay in touch with it, never stop missing it and grieve over its absence. In these cases of pathological mourning, suffering is the subject’s way of showing himself that the lost person was and is still loved, and becomes a defense against feelings of being guilty and bad. For this reason, the patient resists, both consciously and unconsciously, any therapeutic effort to allay the guilt, pain and sadness, which he feels are proof of his love and goodness (Mitchell, 2000). Also, the guilt feelings prevent the subject from being resigned to the loss, with endeavors to re-write the history of what happened, and the fantasy of “if this or that had been done…; if I…”, thus maintaining the fixation to the object.

When the loss is experienced as a narcissistic injury, hatred of the lost object may be activated, with the defensive aim of trying to remove it from its position as supreme judge of the subject’s value, a position it continues to be given. Thus, it is impossible for this person to get the object out of the mind. Life can eventually be organized around the relationship of hate with the object: it is attacked in order to depreciate it but, like obsessive ideas, it then holds the center of interest. In personalities with paranoid-narcissistic features, though the whole world may be there for them to love, the hate keeps them from releasing the lost object. However, since the hate is insufficient to free them of the object, the consequent feeling of helplessness throws the subject into depression.

If the person simultaneously suffers from feelings of guilt and narcissistic pain, the defensive hate to overcome the latter tends to reactivate the guilt feelings, so that the subject needs in turn to increase the hate in order to overcome them. This is the case of a female patient, married for several years, whose husband told her that he was no longer in love with her, that he appreciated her and would like to go on being friends but has decided to separate from her. The patient reacts with frustration and narcissistic pain but especially helplessness to make reality conform to her wishes. This suffering activates a sequence that we have seen in different situations: wish frustration, general aggressiveness and, in this patient with a good level of logical reasoning, aggressiveness that finds reasons to justify it: she recriminates the other for deceiving her, and tries to prove that he is a bad person, undeserving of her love. After these explosions of aggressiveness, she feels guilty and dissatisfied with her behavior, which motivates her to justify the hate on the basis of her ex-husband’s behavior, again falling into a search for his defects. The hate defending her from narcissistic pain reverberates with the guilt feelings that tie her to the memory of each moment she experienced with the person who left her.
Further, the attacks on her ex-husband generated not only guilt but also the fear of losing what little remained of the relationship, a fear that she tried to mitigate with expiatory behavior in order to regain the love of the lost object, by giving him presents, asking his forgiveness for her aggressiveness and promising to change. This behavior, an attempt at closeness, made her feel humiliated again, when she saw herself as being excessively in need of the other, a need she realized was not reciprocal. In turn, when she was unable to recover her ex-husband by accusing him in her explosions of coercive rage (Rado, 1951) or with acts of contrition and expiation, she felt helpless, and this feeling reinforced her narcissistic depression.

Together with the internal factors involved in the origin and maintenance of pathological mourning, the role of the external figures around the person who has just suffered a loss is most important. All clinical experience and empirical investigation (Brown & Harris, 1989) confirm that having or not having supportive figures to accompany the mourning process, who are not themselves suffering from pathological mourning, can be the decisive factor that tips the course of the process in one direction or another.

Finally, to recapitulate, I would like to return to the issue of a possible psychoanalytic nosology of sub-types of pathological mourning based on its conditions of genesis and maintenance: cases with predominant primary fixation to the lost object, or those in which conditions of suffering in the present for internal or external causes lead them to return to the lost object, or those whose guilt feelings or narcissistic injury maintain the fixation to the object, or in which the present loss more directly evokes a past loss because the conditions in which they occurred are similar, or in which aggressiveness and hate block reconciliation with the lost object and acceptance of new objects. Thinking in these terms is useful for the treatment because it may orient us toward the factor that needs to be modified in each particular case while bearing in mind that, although the condition originating and sustaining the pathological mourning may predominate, we can also find a combination of factors, and that one or another may come to the fore at different moments in the treatment.

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