Mourning and Grief as Healing Processes in Psychotherapy*

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The argument developed in this paper can be outlined as follows: relationships are vital for growth, for adults and especially for children; to ensure that we work to maintain relationships, evolution provided for pain on separation, which stimulates behaviours designed to restore the relationship.

If the separation is permanent, it is necessary to form other relationships. This requires modifying the attachment to the lost object, a process which involves unlearning of emotional bonds and then learning new bonds to new objects. The process of mourning and the affective state of grief, I believe, assist in this unlearning and new learning.

The stages of mourning involve cognitive learning of the reality of the loss; behaviours associated with mourning, such as searching, embody unlearning by extinction; finally, physiological concomitants of grief may influence unlearning by direct effects on neurotransmitters or neurohormones, such as cortisol, ACTH, or norepinephrine.

Besides losses occasioned by bereavement, life and normal development include many other kinds of losses. Mourning for these losses is as necessary as mourning after a death. Failure to adequately mourn can result in psychopathology or psychosomatic illness. In comparison, appropriate mourning is adaptive, and parallels can be drawn between it and healing in psychotherapy.

The psychoanalytic and psychotherapeutic literature supports the notion that mourning and grief in therapy act to heal. Given that there may be a biological basis for this healing through the effects of mourning on learning, psychotherapists might actively seek to encourage identification of losses and their adequate mourning in therapy. Various approaches are discussed.

Two case reports of mourning occurring in psychotherapy are given, followed by suggestions for research.

Infants need caretakers simply to survive. Older children and adults benefit from relationships for psychological growth. John Bowlby (1) wrote that attachment behaviour, while at its most obvious in early childhood, can be observed throughout the life cycle. It is regarded as an integral part of human nature.

Parkes (2) emphasized the necessity for secure attachments, without which a person's ability to modify his assumptive world in the face of change is impaired. People who have few "available attachments" are at special risk of developing neurotic symptoms under adversity.

Relationships are believed to play a critical role in regulating the behaviour, maturation, and development of mind, brain, and body (3,4).

Given the importance of relationships, what has evolution provided to ensure that organisms remain attached? For example, what causes mothers to stay with infants and look after them?

One factor is surely the pain that individuals experience in separation. Just as strong affects serve to communicate (5,6), pain communicates both internally (7-9) and to others (10) to act in ways to reduce it. Thus we search for the lost person, and others reach out to us to help. One of the signals of pain is crying (11), which elicits autonomic system arousal in others. Bell and Ainsworth (10) concluded: "Crying is the most conspicuous of early attachment behaviours. ... It ... promotes proximity more effectively than other early signalling behaviour."

What happens if pain and crying fail to restore the relationship? Our need for relationships for survival and growth dictates that we overcome the exclusive ties to the lost person, so that we can put our energies into new attachments. Breaking these ties, or emotional investments, to the lost object, may involve disconnecting memory traces and associations (4), in a process of "unlearning." Similarly, recathexis to a new object requires that new associations, particularly affective ones, be laid down as memory traces in a learning process.

Since a permanent loss usually results in a mourning process which may include strong affects such as grief or sadness, it may be that mourning and grief are directly involved in this unlearning and new learning, through physiological mechanisms.

Mourning, Learning, and Memory

Before dealing with the evidence relating mourning to learning and memory, some caveats are necessary. First, it is important to distinguish a normal mourning process from depression. They differ in a number of ways; for example, psychomotor retardation and suicidal ideas are usually absent in mourning (12), and the dexamethasone suppression test

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is usually normal (13-16). Effects on immune system functioning differ (17).

Another caveat has to do with the belief of a number of writers that infants and children are constitutionally incapable of undergoing a normal mourning process (18-20). Others feel, however, that children can mourn, but in a different way from adults (21,22).

If infants and children cannot mourn, this might apply also to infant monkeys and rats. Thus research on mother-infant separation paradigms in animals, referred to below, may relate to normal mourning and grief only in an indirect way.

With these caveats in mind, we can look at the several ways in which mourning and grief may influence unlearning and learning. These ways include conditioning, cognitive learning, and possibly through physiological effects, for example, on neurotransmitters or neurohormones.

Affects include an impulse or inclination to act (7). The affect of grief almost always stimulates searching behaviour (23). In the absence of the reinforcement which would be afforded by either finding the lost object or by maintaining real links with it, searching behaviour would decrease in intensity and frequency because of extinction.

In regard to cognitive aspects, the stages of mourning as described by Zisook and DeVaul (25) contribute to the individual's reality testing: "The first stage, shock, includes elements of disbelief and denial. It lasts for hours to weeks. Funeral rites and mourning rituals facilitate passage through this stage, by helping the bereaved to acknowledge the reality of the loss."

The second stage, acute mourning, includes an "intense feeling" phase, which they described as: "Painful awareness of the loss occurs in periodic waves of intense emotional and often somatic discomfort. These waves bring on uncontrollable sighing and sobbing and are often attended by a feeling of tightness in the throat, a shortness of breath, an empty feeling in the abdomen, fatigue, restlessness, purposeless activity, and a subjective sense of stress experienced as exhaustion, weakness, and sadness."

Objects, places, people, music, sights, smells, sounds, and memories which include associations to what has been lost, bring on these waves of anguish. Each occurrence brings home the reality that these objects, places, etc. will no longer be able to invoke the lost object as a real, living person, but only as a memory.

The third stage, resolution (25), heralds the return of the feeling of wellbeing and the ability to get on with living, as the bereaved recognize what the loss has meant to them, and feel able to seek the companionship and love of others.

Although direct examples of the influence of affect on learning and memory can be found (26), most of the evidence is indirect.

Strong affects induce physiological changes. An obvious example is the "fight or flight" response turned on by fear or anger. Neurotransmitters such as norepinephrine are central to these changes. Examples related to grief include the depressed immune functioning found in bereaved people (27,28), and their tendency to "sigh" which seems to be caused by physiological changes in the breathing control mechanism (29).

Affects associated with object loss may also result in subtle and long-term effects on the central nervous system (4,30).

We can only speculate about the possible function of these various biological accompaniments to grief. With regard to physiological changes which might influence learning and memory, there are several candidates: changes in REM sleep patterns, changes in brain cortisol, and cortical norepinephrine levels.

Infant monkeys have less REM sleep (31,32) and a longer REM latency time (33), after being removed from their mothers. REM sleep and catecholamines interact (34); moreover, REM sleep seems to be involved in maintaining long-term memories (35,36). This suggests that after a loss, "forgetting" the lost object is aided by decreased REM sleep.

Cortisol becomes elevated in infant monkeys, and in their mothers, when separated from each other (37). Other experiments have shown that cortisol helps extinction and relearning processes (37).

Cortisol tends to facilitate extinction and relearning. In squirrel monkeys separated from their mothers, there was a significant increase in plasma cortisol levels which was sustained over two weeks. Although obviously distressed, these infants tended not to show depressive symptoms, but rather acquiescence and adaptation. Their mothers also showed cortisol elevations, although not as marked. This suggests that cortisol may play an adaptive role in unlearning after a loss.

"Active coping" responses to stress, including losing one's job (38), or anticipating the death of a spouse from terminal cancer (39), cause increased catecholamine output in the urine (40).

On the other hand, brain NE is thought to be low in endogenous depression (41). When separated monkeys receive drugs which increase NE levels, they experience less despair, while drugs which reduce NE levels result in increased despair (42).

NE seems to play a very central role in facilitating learning and improving memory (43-46), and lowered NE is associated with impairments in learning and memory (47-49). It is thought to be particularly important in the formation of associations and in neural plasticity (50). It may be that the elevated NE levels which appear to occur in bereavement (51), but not in depression, aid in the extinction of memory traces to the lost object.

A recent review (52) of the effects of stress, including bereavement, on the immune system suggests that noradrenergic autonomic signals from the brain influence immunocompetence. Learning and immune system competence also appear to be linked: immunosuppression can be conditioned in mice. Furthermore, antigenic challenge may decrease norepinephrine turnover in the brain.

Losses in normal development

Losses occur in ways other than by death or separation; for example, losses occasioned by giving up childhood

attachments can be considered part of normal growth (53). Changes during development can be experienced as losses, for which mourning is adaptive. According to Fleming and Altschul (54): "Partial and temporary separations from libidinal objects are experiences which from birth possess significance as activators of the adaptive mechanisms of the ego. To a large extent these separation experiences influence the rate and direction of growth, and play a part in organizing the developing ego structure. Thus the process of growth and maturation can be compared to mourning work in that every step towards maturation involves some adaptation to separation, and therefore some mourning work."

Losses themselves can be considered developmental phases. Brice (55) wrote: "The road of life is paved with occasional mournings. There is no gain in life without loss."

Mourning as a process of adaptation, involving an undoing of the previous adaptational equilibrium established with the lost object and the gradual re-establishment of new relationships, can be viewed (53) as phylogenetically evolved, as it appears to occur in certain mammals and birds, but not in reptiles, amphibians, or fish. Grief work facilitates a person's emancipation from his or her attachment to the deceased, readjustment to an environment without the deceased, and formation of new relationships (56). The capacity to form secure new object relationships which can be gained only through a process of normal mourning after an object loss, may be essential in permitting the person to adapt to change.

Freud, in his paper "Mourning and Melancholia" (57) conjectured that mourning might carry out the task of overcoming the object loss in the following way:
"Each single one of the memories and situations of expectancy which demonstrate the libido's attachment to the lost object is met by the verdict of reality that the object no longer exists: and the ego, confronted as it were with the question whether it shall share this fate, is persuaded by the sum of the narcissistic satisfactions it derives from being alive to sever its attachment to the object that has been abolished."

Bowlby (58) agreed that processes of healthy mourning effect a withdrawal from the lost object and commonly prepare for making a relationship with a new object.

Altschul (59) felt that failure to grieve leads to an arrest in ego development. Alice Miller, in her landmark book "Prisoners of Childhood," makes the point that "the achievement of freedom from.... narcissistic disturbance in analysis is hardly possible without deeply felt mourning" (60). She believes that real healing can occur only if the patient mourns for what he has missed at the crucial time in his childhood.

Anticipatory mourning can be adaptive. Sudden and unexpected death leads to more pronounced grief reactions in relatives than if the death is more expected (61).

A number of authors have remarked that failure of adequate mourning appears to be a precursor of psychopathology later on (62-66). It has also been suggested that inadequate mourning leads to psychosomatic illness (67-72).

Mourning and Psychotherapy

Mourning processes are an integral part of many psychotherapies, and have been remarked upon by a number of experienced therapists and analysts (53, 54, 59, 60, 63, 65, 73-76). There is also some research which bears on this question.

Parkes (77) reviewed eight studies of bereavement counselling. Five of the eight studies showed significant differences between helped and unhelped groups, favoring the group that had been supported in their bereavement. More recent studies also support this conclusion. Mawson et al (78) studied twelve patients split into two groups. The experimental group received guided mourning therapy (in the sessions, the patient was exposed to avoided or painful memories, ideas or situations, both in imagination and in real life, related to loss of the deceased. Events surrounding the loss or its consequences were discussed and the therapist then focussed on areas that the patient found difficult to describe, for example a situation associated with great sadness or guilt. The patient was encouraged to describe repeatedly these situations until the initial distress was diminished). In the control therapy, the patients were encouraged to avoid thinking about the deceased. Patients with guided mourning therapy improved significantly more than controls at two weeks of therapy, an improvement that was maintained at 10 and at 28 weeks.

In a study of time-limited dynamic psychotherapy with 52 bereaved patients (79), it was found that therapist emphasis on differentiating real from fantasized meanings of the stress event, that is, exploration and uncovering, led to better outcomes for well motivated patients with a stable self-concept.

Preventive intervention has been shown to be effective in lowering postbereavement morbidity. In 64 widows at risk for morbidity, a randomly allocated group of 31 who were given specific support for grief and encouragement of mourning during three months, there was significantly less morbidity at a 13 month followup, compared to the control group who received no intervention (80).

Brief psychotherapy with recently bereaved adults who were also felt to be psychologically vulnerable because of borderline or narcissistic disturbances, was useful in stemming a downhill course (81), and in some cases providing a bridge to an indicated longer-term psychotherapy.

Cabral et al (82) reported on a study of group psychotherapy, in which patient assessment of process variables was related to outcome. A consistent, although not statistically significant, relationship was found between improvement and the amount of abreaction, defined as the discharge of pent-up material relevant to the main complaint, occurring in the therapy. Of the process variables studied, only acceptance (as gauged by the warm and permissive atmosphere in which to express one's main complaint) was significantly correlated with improvement.

Gurman (83) reviewed 26 studies conducted between 1954 and 1974. Twenty of the 26 studies reported a positive association between patients' ratings of the therapist-offered relationship and outcome, which supports the hypothesis that

the therapist's warm and accepting attitude towards the patient's expression of affect is helpful.

In a study of brief cathartic psychotherapy (84) 43 university students were randomly assigned to emotive or nonemotive therapy with six experienced therapists. All sessions were tape-recorded and rated. It was found that emotive techniques were effective in generating catharsis, and that high catharsis patients changed significantly more on a measure of behavioural target complaints. The amount of emotional discharge was highly correlated with change on a rating form to gauge patients' personal satisfaction.

Given this connection between mourning and psychotherapy, what can the therapist do to enhance mourning and thereby aid in the process of healing? First, the therapist's warm and accepting attitude permits the patient to express feelings associated with an awareness of his loss (for example, anger and sadness). Strupp et al (85) in their questionnaire study of patients who had received outpatient therapy indicated that therapist warmth and acceptance were correlated with improvement.

Lindemann in his classic paper on bereavement (56) expressed his belief that morbid grief reactions could be transformed into normal ones and then resolved, by helping the patient to accept the pain of the bereavement and to express the sorrow and sense of loss which he has been trying to avoid. Bowlby (73) emphasized the similarities between psychotherapy and assisted mourning: "When helping a psychiatric patient the tasks to be undertaken and the techniques for achieving them are, I believe, no different in kind to counselling the bereaved." The techniques he describes include encouraging the client to recall in detail the loss and the circumstances leading up to it, so that feelings of regret, despair, anxiety, anger, and guilt can be sorted out.

Working with the patient to achieve an understanding of nonverbal communications, bodily and dream phenomena, is helpful in activating a grief process and "thawing" of psychological and muscular armoring leading to increased vitality (71).

Selma Fraiberg and her coworkers (74) believe that reexperiencing of early affects is important. What is repressed is not the early memories, but the associated affective experience, in parents who themselves were abused or deserted as children. Access to childhood pain, enabled in therapy, becomes a powerful deterrent against repetition in parenting.

According to Horney's theory (86), helping the patient to become aware of anger and sadness experienced in the transference, will assist the patient to recall early memories of sadness and anger, which may have been experienced in situations of actual or intrapsychic loss; such recall is necessary to mourn those early losses.

The therapist can assist the patient in becoming aware of what he or she has lost or has never had, by offering transference interpretations. For example, a patient who continually presses for gratification from the therapist, may learn of his lack of an internal gratifying or self-soothing object through the therapist's actions. In those patients who lost a parent as children, early denial of the meaningfulness of the loss (i.e. incomplete mourning) may manifest itself as resistance (59) to the formation of a usable, interpretable transference neurosis. Analysing this resistance leads to grief being experienced in the analysis.

Another way in which the therapist can help the patient to undergo a mourning process is by offering himself as a new, real object to which the patient can cathect even as he decathects from that which he has lost (65).

In all psychotherapies, the termination phase provides an opportunity for the therapist to assist the patient in experiencing a real loss and mourning it adequately, in this way allowing the patient to practise coping with other losses, both past and future. The importance of the ending phase is emphasized particularly in brief psychotherapies, in which the therapist may actively introduce the impending separation and loss at a relatively early point. Termination and the subsequent working through, which was likened to a process of mourning by Fenichel (75), allows the patient to continue to use the therapeutic endeavour to mourn future losses.

Harold Searles emphasizes that therapy with borderline patients, who are continually faced with the threat of loss, involves the therapist's deeper working through of his own losses (76). Loss of the therapist due to terminal illness can also be "therapeutically useful in relieving previous losses and abandonments and completing unfinished mourning" (87).

Clinical Examples

Ms. A., in her thirties when seen, had brought her son Johnny for an assessment by the child psychiatry team. The child had been behaving aggressively towards a younger sibling, and was also self-destructive.

Ms. A. has two other children, all of mixed race, and all from different fathers. Johnny is the only one who has no contact with his father.

Mother described a chaotic home situation. She shared a three-bedroom flat with another single mother with two children. The older one, an adolescent boy, terrorized the household, to the point where Ms. A. was afraid to enter the other side of the apartment. Both mothers were on welfare, but the other woman failed to pay her share of the bills. At one point, their electricity was cut off for three weeks for nonpayment.

Ms. A. came to get help with her son, who she feared was becoming just like her. She offered the child's self-destructiveness as evidence for this. Her reason for seeking help was to "break the cycle."

When Johnny felt unfairly blamed for something, he would bite himself and choke himself with a belt. Aggression towards the younger sister included setting her hair on fire. Mother maintained, however, that Johnny was unable to express anger, keeping it bottled up inside, like herself.

Mother herself had been treated for a suicidal depression when in her twenties.

She described a very deprived childhood. As a preschooler, her father had taken her out of the house and had her placed in a foster home. He wanted to protect her, he said, from continuing to be accidentally hurt by her own mother, who became very careless when drunk. Ms. A. was

in a dozen different foster homes. She did not hear from her father anymore; he died a number of years ago. Her mother visited perhaps monthly while Ms. A. was growing up, but abandoned her also when she turned eighteen. Ms. A. believes she was responsible for causing her mother to leave.

We contracted that Johnny would be seen in play therapy by one member of the team, and I would see Ms. A. in time-limited psychotherapy.

In the first session, while providing more historical details, Ms. A. broke into tears when talking about her father's death.

In the second session, she related a dream in which I appeared as a devil, with fangs.

The following session again brought sadness, anger, and bitter tears, as Ms. A. related her mother's indifference to her being taken out of the house by social workers.

In subsequent sessions, Ms. A. expressed fear of me, that I might take her children away from her; I connected this with her refusal to marry, and linked her distrust to her early experiences with her mother, who had alternated between withdrawn depressions and maudlin displays of affection when drunk. Tears and anger accompanied Ms. A.'s sad recounting of the events of her childhood.

Ms. A. did demonstrate significant improvement after termination, as she had predicted in the final session. She was able to move out of the shared flat into a large apartment in a complex with a swimming pool for her kids. She found a part-time job to supplement her welfare, and became an active member of a single parent association. Johnny's behaviour improved, as did his schoolwork, reflecting mother's increasing interest in her mothering role.

The second case is that of Mr. B., a married man with one child, in his thirties, who was seen once weekly for two years in therapy. He had been referred for medication follow-up and supportive therapy after a hospitalization for a psychotic episode.

An only child, he had been a good student, but had a strained relationship with his parents. His father, an alcoholic, depended on Mr. B. to look after him when he was drunk. In spite of Mr. B.'s attempts to placate his father, the latter was furious when Mr. B. got married, refusing to attend the wedding. Mother escaped from the home into her teaching job.

Mr. B.'s relationship with his father improved when the latter became ill with cancer of the large bowel, and Mr. B. resumed a nursemaid role towards him. When the father died, Mr. B. wondered why he shed no tears.

Subsequently, he developed abdominal pains, for which he was hospitalized a number of times. Gastroenterological and urological investigations, including multiple laparotomies, were essentially negative.

On the last of these hospitalizations, he became acutely delusional while recovering from surgery. He believed himself to be evil, and was terrified that the doctors and nurses were plotting to operate on him to "remove the evil." He was depressed and suicidal.

He recovered rapidly with medications, and was discharged. In outpatient therapy, a supportive approach initially focussed on improving the relationships with his wife and mother, in which he was rigidly locked into a martyr's role as caretaker. He started to explore his anger at his parents, and the resultant guilt. After one very emotional session, in which he was able to recall the repressed memory of having been placed for foster care for several months at three years of age, he again started to experience abdominal pain, and began missing sessions.

Interpreting this as a resistance led to his experiencing more anger at his parents, but he also began to become aware of his underlying sadness and sense of loss. His abdominal pain disappeared, and he became more assertive in his dealings with friends and spouse.

At this point, Mr. B.'s wife became pregnant. Mr. B. expressed a determination to shield the baby from what he felt would be an overwhelming and engulfing possessiveness from his own mother. In the therapy, he became aware of the connection between his earlier psychotic paranoia and his fear of his mother. This led to the expression of more anger and sadness, and an acceptance of his mother's limitations. After giving birth, he became able to set limits on his mother's possessive attitude towards the infant, and he was surprised to learn that his mother, too, was able to change. Their relationship lost its sense of strain, and Mr. B. was able to appreciate his mother's competence as a grandmother at the same time as he mourned his mother's unavailability during his own childhood.

Did Ms. A.'s predilection for becoming pregnant represent an unconscious desire to master a trauma by turning a passive experience (her rejection by her parents) into a life event she could control? As Klyman pointed out (88) pregnancy can function as that life event. Unfortunately, in Ms. A's case, even three pregnancies failed to give her a sense of mastery, instead increasing her feelings of being buffeted by forces outside of her control. It was only when she began, in therapy, to appreciate how she had transferred her fear and anger away from her own rejecting mother onto her son Johnny, and began to mourn her childhood deprivation, that she became able to organize her life and become a more effective parent.

Mr. B. may have been using his abdominal pain to try to erect a form of autonomy from his mother. Although it initially appeared that this independence would be obtained through a paranoid rejection of his own mother's overtures to the new baby, Mr. B.'s ability to mourn his own missed childhood allowed him to lose his fear of his mother's power over him. He was able to move from his psychotic paranoia to a "depressive position" in which he had the opportunity to make reparations by allowing his mother access to her grandchild.

Research Directions

The hypothesis that mourning and grief are significant healing processes in psychotherapy leads to a number of testable component hypotheses. These include:

1. Does the expression of sadness in psychotherapy (where the affect of sadness is differentiated from both the syndrome and symptom of depression) correlate with outcome? For example, for videotaped therapy

sessions, duration and intensity of grief and sadness could be rated by observers; patients and therapists could also quantify this variable.
2. Does the therapist's acceptance or tolerance of a patient's expression of grief or sadness correlate with outcome? This variable, again, could be rated by the therapist, by independent observers, or by patients.
3. Are therapeutic techniques which specifically encourage the expression of grief and sadness more effective in terms of outcome than techniques which encourage any expression of affect, such as emotive therapy?

The hypothesis that mourning and grief influence learning and unlearning is also subject to experimental verification. While the influence of states of affective arousal on subjects' performance in laboratory measures of learning and recalling has been studied, the effects of the specific affective states of grief or sadness on such measures needs clarification. Other aspects of the hypothesis which could be examined in the laboratory include:

1. Are there any biochemical or hormonal changes in the brain which correlate with the affect of sadness? This could be studied in higher animals (those capable of grief reactions) as well.
2. Are these putative biochemical changes related to the processes of learning or unlearning?

It would be important to distinguish grief as a component of a normal mourning process, from depression. To look at the issue of whether infants, including animal infants, are able to mourn adequately, older animals who have had a normal previous development can be compared to infants in primate studies of the separation paradigm.

Conclusions

There is little doubt that a normal mourning process is necessary after a bereavement to promote healing and enable psychological growth to continue. In psychotherapy of bereaved persons, the therapist's active promotion of mourning is associated with better outcome.

In this paper, I put forward the hypothesis that grief and mourning are important promoters of healing in psychotherapy in general. All patients have suffered losses of one kind or another, and have accommodated to these losses with varying degrees of success or failure. The therapist plays an important role in helping the patient mourn: he encourages the remembering of the loss, and the associated affects which have frequently been suppressed; he draws the patient's attention, by transference interpretations of affects experienced in the therapy, to losses experienced in prior object relationships; at termination, he helps the patient to anticipate appropriate grief for the new loss.

Although research on psychotherapy is plagued with many methodological difficulties, the hypothesis that mourning as a healing process may involve physiological alterations, for example in brain chemistry, which affect cognitive processes such as learning, leads to the possibility that we may one day be able to examine some aspects of psychotherapy in the laboratory.

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Résumé

L'argument dont il est question ici peut être décrit de la façon suivante : les adultes et plus particulièrement les enfants ont besoin de nouer des relations durant leur croissance; pour que l'homme maintienne des relations, l'évolution a créé la douleur au moment de la séparation, qui stimule le comportement social. Si la séparation est permanente, de nouveaux contacts sont essentiels. Ceci nécessite un changement vis-à-vis de l'objet de l'attachement maintenant perdu, un mécanisme qui exige le dénouement des liens émotionnels et la création de nouveaux liens avec d'autres objets. Le deuil et l'état affectif du chagrin, je crois, facilitent ce processus.

Le deuil comprend la conscientisation de la disparition de l'objet; les comportements connexes la quête, l'incarnation du "désapprentissage" par l'extinction; et finalement, les aspects physiologiques concomitants du chagrin, qui peuvent exercer une influence sur le désapprentissage en agissant directement sur les médiateurs chimiques ou les neurohormones comme le cortisol, l'ACTH ou la noradrénaline.

Outre les pertes occasionnées par le deuil, la vie et la croissance comprennent de nombreuses pertes d'un autre genre dans leur cours normal. Pleurer ces pertes est un mal aussi nécessaire que le chagrin après un décès. Ne pas pleurer de façon adéquate peut faire naître une psychopathologie ou une maladie psychosomatique. Comparativement, le chagrin est une mécanisme d'adaptatin et l'on peut tracer un parallèle entre ce mécanisme et la guérison en psychothérapie.

Les traités de psychoanalyse et de psychothérapie appuient le principe du deuil et du chagrin comme instruments de la guérison. Puisqu'il est possible que ce mécanisme ait un fondement biologique, par les effets du deuil sur l'apprentissage, les psychothérapeutes pourraient encourager activement l'identification des pertes et recourir aux manifestations de deuil adéquates durant le traitement. Pour cela, on examine diverses approches.

On presente également deux rapports sur le recours à cette approche en pyschothérapie et fournit des suggestions pour la recherhce,