PSYCHODYNAMIC THERAPY WITH THE BEREAVED:
LISTENING FOR CONFLICT, RELATIONSHIP
AND TRANSFERENCE

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ABSTRACT
Three main themes of classical and contemporary psychodynamic theories of
therapy are reviewed and their application to intervention with the bereaved
is considered: 1) The unconscious experience of bereaved individuals following
loss is a central aspect of psychodynamic therapy as it addresses drive,
defense and conflict. 2) The bereaved’s self- and other-focused relational
schema are considered under the object-relations paradigm. 3) The transference
relationship in therapy of the bereaved must make allowances for the
bereaved’s involvement with the deceased. The application of these aspects
of theory to the specifics of working with bereaved individuals is explored
in the therapy of a young man bereft of his father.

The bereaved’s ability to respond to the loss of a loved one and traverse the stages
of grief and mourning does not generally require psychotherapeutic assistance
in order to reach a satisfactory conclusion (Engel, 1961; Freud, 1917/1953; Rubin
& Schechter, 1997). Despite this basic truth, many bereaved are unsure as to
whether what they are undergoing is within the range of normal experience
(Malikson, Rubin, & Witzum, in press; Silverman & Klass, 1996). Somewhat
paradoxically, in today’s age of virtually boundless information, much of what
was “common-sense” knowledge of bereavement is now unfamiliar to many
first-time bereaved individuals (Stroebe, Gergen, Gergen, & Stroebe, 1992). The
plethora of information has resulted in a heightened selectivity about what we
attend to, and threatening topics that were once part of everyday experience (such
as experience of people dying at home rather than in the hospital) are now often
avoided. For many bereaved, receiving information on what to expect in response

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to loss, and what is involved during recovery, can be particularly helpful (Attig, 1996). Information containing a description of some of the more dysfunctional responses to loss, and guidance on when to seek assistance, are important to communicate to lay as well as professional audiences (Parkes, 1986; Rubin, Malkinson, & Wittzum, in press; Siggins, 1966).

The purpose of this article is to reconsider psychotherapy with bereaved individuals based on a number of primarily, but not exclusively, psychodynamic formulations. As may be expected in a discipline with over a century of development, it is not easy to specify or to reach agreement on what are the common elements of psychodynamic psychotherapy and what is important about them (Auld & Hyman, 1991; Pine, 1990; Wallerstein, 1995). The impact of Freudian thought on current Western civilization has resulted in both widespread acknowledgment of "the unconscious" and a certain blurring in the understanding of what is actually involved in the therapies that deal with it. Considering the enormity of the task, we shall try to make only modest headway toward the goal of specifying therapeutic axes that make clinical sense, and help people cope with the aftermath of loss and bereavement.

Avoiding too intense an involvement with loss at the expense of life tasks on the one hand, and too great an avoidance of loss on the other, are at the heart of adaptive coping with loss. Numerous difficulties may emerge following bereavement, manifest in behavioral, social, psychological, somatic, and interpersonal realms, that become resolved over the course of time. When they do not, or when their intensity is too great, therapy can often play a beneficial role (Bowlby, 1980; Rubin, 1993; Rubin & Schechter, 1997).

THE UNCONSCIOUS, MULTIPLE MOTIVES AND MEANINGS, AND CONFLICT OF DRIVE AND DEFENSE

Much has been learned since Breuer and Freud (1893/1953) published their initial paper on psychoanalysis charting the impact of psychological forces on functioning in individuals, and how to intervene when things went awry. That study clearly set forth the impact of catharsis of previously undisclosed material. Bringing into the client's awareness experiences, feelings, thoughts, and emotions rendered powerful by their very isolation from awareness, and whose power therefore cannot be dissipated, exerts a salutary effect. This approach remains a cornerstone of work with grieving individuals, as well it should. Catharsis by itself is a potent force for therapy and self-healing, but it is not a sufficient method of self-healing for most individuals who require and/or seek treatment. Underlying catharsis is the expectation that one can reopen and share difficult events in a setting that allows that sharing to connect threads of a story, to remember things that were not possible to remember earlier, to share emotion in the company of those who can tolerate it, and so on. Operating contrary to catharsis is the concern about what will happen if the events are reopened and the full story is told. The fear of being overwhelmed, of being traumatized (or retraumatized), of losing contact with loved ones, and/or of being confronted with unacceptable aspects of oneself lead away from catharsis and toward avoidance of engagement in what is often termed defense or resistance. This can take several forms, predominantly avoidance of discussing the loss, or a chronic but stereotypic focus on the loss (and the lost one). Where the traditional psychodynamic therapies have made a consistent contribution is in the understanding and use of the negative and anxiety-provoking aspects of change (Bateman & Holmes, 1995). These draw on images and sources within the psyche that may be distorted, illogical, irrational, unreal, or imagined, as well as long-forgotten, piecemeal, truncated, difficult to verbalize, and totally hidden from awareness. Understanding how to facilitate and respond therapeutically to these aspects of personhood is central to psychodynamic models of therapy (Auld & Hyman, 1991; Greenson, 1972; Havens, 1987; Langs, 1976).

Early explanations of psychodynamic forces emphasized the tension between the drives, in their derivative aspects of human cognition and emotion, and the defenses, namely the ways in which individuals' mental processes structure their lives so as to ward off threatening information from within and from without. Over time, psychoanalytic thinking intensified its focus upon the defenses and their relation to the full experience of threatening material at present out of the individual's conscious awareness, as an important part of the therapy (Gabbard, 1990). Through analysis of the material emerging in treatment, and its consistent interpretation, the clients are helped to expand their repertoire of narrative and awareness, so that less has to be defended against. Individuals are therefore able to increase their range of experience and functioning.

Duty and codes of practice in psychotherapy and health care are not easily reconcilable. Contracting with clients may be inhibited out of respect for the extent of conflicting information, motivations, and experiences that people are often unaware of within themselves in what may loosely be termed the unconscious (Peterfreund, 1983). In clinical practice, this means that people who present or are presented for psychotherapy following loss generally harbor a range of feelings and opinions about entering into treatment that cannot be adequately covered in a short time. For example, in the case of a woman referred for therapy because of "chronic mourning" for her deceased husband, the decision to enter treatment for "the problem" is most accurately described as the product of a struggle or conflict between reasons that support a continuation of the current attachment to her deceased husband in its present form and reasons that support change. If the therapist attends mainly to the parts that wish for change, he or she may soon confront those parts of the person which fear change, or desire it so much that they register anxiety some time after the idea is raised. Unless the anxieties and motivations that surround fear of change during the treatment are adequately dealt with, therapy can quickly reach an impasse, unravel, or remain trapped within limited effectiveness. Attending to the wishes
and fears of the individual, at manifest and covert levels of awareness, is the leitmotiv of much of psychodynamic therapy.

Understanding the response to bereavement is largely a matter of utilizing one’s own and others’ experiences in life and with clients to attend to the uniqueness of another person’s life. Some of the more successful therapeutic odysseys attest that what was known and understood at the start of treatment was a schematic and limited framework appropriate to the initial stage (Yalom, 1989). This is later complemented and fleshed out by the material and emotional changes that emerge during the course of treatment. The variations in motivation, memory, and affect are dynamic forces that run a developmental course in successful treatment. The shifting and evolving nature of the client’s “story” is reflected in the dynamics of treatment, when the myriad struggles to know and not to know, to experience and to avoid, progressively make themselves known.

THE SIGNIFICANCE OF SELF AND OBJECT RELATIONSHIP IN MAINTAINING PSYCHOLOGICAL EQUILIBRIUM

The significance of interpersonal relationships in psychodynamic theory and therapy has continued to grow and to recast almost the entire conceptual framework of the field. In contrast to the emphasis on drive and defense, along with insight and interpretation, the importance of the interactions with, and affective-cognitive representations of, relationships with significant figures in childhood and later has come to occupy a much greater part of the therapeutic frame (Buckley, 1986). While this trend has roots in Freud’s thinking (no less than classical psychosexual or instinct theory), this branch of dynamic theory and therapy owes much to other sources as well. The object relations school of British psychoanalysts, led by Melanie Klein (Klein, 1950; Segal, 1979), Donald Winnicott (Winnicott, 1965; Goldman, 1993), and to a lesser extent, John Bowlby (Bowlby, 1980), played a major role in this revolution on both sides of the Atlantic. In the United States, the self-psychology work of Kohut (1971, 1977) and his colleagues, and the infant-parent interactional work of Mahler (Mahler, Pine, & Bergman, 1975), Stern (1985), and others, placed the real and recollected relationships to self and other at the heart of psychodynamic understanding of human development and functioning. Newer understandings stressing the intersubjective experience of therapist and client are variations on the relational themes, albeit with a focus on the unique and conjoint subjective experiences of the therapy dyad (Bollas, 1987; Greenberg & Mitchell, 1983; Mitchell, 1988).

From the viewpoint of the practicing psychotherapist, this means that the relational patterns of the client, rather than the drive-related conflicts, are often the focus of therapeutic understanding and attention (Ogden, 1994; Sandler, 1987). As in the past, uncovering heretofore unrecognized or underaddressed experiences and their weave into the client’s life story is the essence of the therapeutic process. Yet in contrast to the more drive-related perspective, the therapy seeks to understand things from a relational point of view, that is, with a focus on the experience of the client in relationship to significant others.

In this perspective, the conflictual drive elements overwhelming the individual (e.g., “I love Mom and wish to kill Dad so as to marry Mom, and if Dad finds out he will kill me or emasculate me first”—as in the Oedipal metaphor) is not the main focus of treatment. This belongs to the interactional experiences with these individuals (e.g., “As a toddler I loved Mom who held me one way when we were alone, but held me another way when Dad was in the room, leaving me with two different sets of experiences of being with another and being loved”). The treatment may place greater focus on the here and now aspects of the experienced relationship. Attention to the therapeutic healing elements of the interaction, rather than of interpretation and insight per se, are understood as central to the healing and growth experience that psychodynamic therapy can be for most people.

The shift from drive-related sources of conceptualizing psychopathology and/or maladaptation to loss has clinical consequences that influence therapeutic interventions (Frankiel, 1994). A bereaved individual who experiences guilt following the loss of a close relative may be responding in a normative and understandable fashion (Rubin, 1984). The addition of a psychodynamic perspective, however, allows one to go beyond the normative and to explore more obscure and multi-determined features of loss. The more drive- and defense-oriented dynamic perspective might explore the individual’s guilt with an eye to uncovering unconscious sources of hidden anger and aggression about which the bereaved feels guilty. These may be rooted in feelings directed toward the deceased or to some other experience triggered by the loss, but the therapeutic value is in freeing up a more unencumbered expression of the aggression with insight as to its role in the development of guilt feelings. A more object-related approach might search in other directions as well. Does the presence of guilt reflect characteristic or significant features of an important figure in the bereaved’s life? If so, what is the meaning of that connection? How does the guilt reflect the nature of the bereaved’s concern with the deceased and the nature of that relationship to him or her? Not only is the expression of unconscious conflict and emotion in order to restore well-being addressed, but also the unique importance of the individual who was the deceased, and the relationship with him or her.

Although these distinctions between drive- and object-directed conceptualizations of bereavement may seem somewhat old-fashioned, it might be well to understand whether bereavement is best conceptualized as the severing of “libidinal (emotional) ties with the deceased via the withdrawal of emotional energy from the relationship, or as a recoupling of the relationship with the internal representations of the deceased other, as reflecting the orientation toward drive or toward object (significant other). Derivatives of this controversy have been reflected in the interpretation of Freud’s Mourning and Melancholia (1917/1953) as well as in the burgeoning interest in the maintenance
of continuing bonds with the deceased (Bowlby, 1980; Hagman, 1995a & b; Klass, Silverman, & Nickman, 1996; Moss & Moss, 1996; Rubin, 1996).

TRANSFERENCE AND COUNTERTRANSFERENCE IN BEREAVEMENT WORK

Much psychodynamic work revolves around and through the relationship that forms between the client and therapist (Gill, 1987; Havens, 1986). Those experiences that the client locates in the therapist and the therapeutic relationship, although they stem from his or her own intra- and interpersonal experiential world, are often at the heart of the therapeutic relationship and the change process. While the term “transference” has undergone variations in meaning over time, it is best understood in contrast to the “real relationship” that forms between therapist and client (Sandler, Dare, & Holder, 1992). Transference reactions are considered to be those located within the formative templates of the client’s interpersonal and intrapsychic history, and which in the therapeutic setting reassert themselves in a distorted perception of the therapist conforming to aspects of those earlier templates.

The parallel term, used to describe how the therapist relates to the client, often based on elements of the therapist’s own history and personality, is, of course, countertransference. Whereas countertransference was once historically seen as the expression of difficulties within the personality of the therapist, over time this view became largely replaced by a more inclusive and holistic view that encourages the therapist to utilize his or her reactions in empathic as well as diagnostic ways to further understand the client and the dyadic relationship that has formed in therapy.

The client’s experience of the therapist as benevolent, supportive, and helpful, or alternatively as malicious, non-supportive, and unhelpful, is rooted in both the real relationship with the therapist and in the formative template experiences of the client with early significant figures. At another level, however, the client’s experience of the therapist as positive or negative may stem from therapeutic activities associated with the threatening material of the client’s inner world. When the therapist is experienced as supportive, and the client is able to expand his or her internal experience, the significance of the therapist’s role is an important axis for analysis and interpretation.

As for treatment of complicated bereavement, and how the transference relationship may differ here from that encountered and conceptualized in traditional treatment, two types of bereaved-related problems may be distinguished. For example, the loss of a child, spouse, parent, friend, or lover may initially be identified as the precipitant for a course of psychotherapy. Typically, the loss will have occurred in the fairly recent past. The loss may have occurred under overtly or covertly traumatizing experiences, or under more “normal” circumstances; but having been identified at the start of therapy, it is often the presenting problem of the treatment and presumably a central theme. Under such circumstances, a dynamic psychotherapy will consider the meaning of the relationship with the deceased, as well as the emotions and thoughts stimulated by the loss as significant for the treatment.

At other times, the centrality of bereavement may emerge as a theme or subtheme in a therapy focusing on other issues. Often the loss of significant figures during childhood, or unrecognized or “incompletely” mourned losses of adulthood, emerge only later as prominent features of treatment. An example of the latter may be difficulty in establishing satisfying relationships with members of the opposite gender. Such a problem may reflect such diverse origins as difficulties with sexual material of an intrapsychic nature, a history of inappropriate sexualized relationships within the family or outside of it, or a familial pattern of strained relationships. Sometimes, however, a continuing involvement in a covert relationship with a deceased figure of childhood or adulthood may be the source of the difficulty. Depending on the significance or centrality of loss as the cause of the difficulties, the content and structure of the therapeutic process will often vary.

The significance of the relationship to the therapist will generally be monitored and used as a central axis of the treatment, allowing the therapist and client the ability to experience together, significant elements of the client’s inner and interpersonal world as they recreate themselves within the therapy. In focused bereavement work, the significance of the relationship with the therapist may be less central than in other treatments. This goes beyond what may be the time-limited nature of the work and its tendency to limit the transference and its analysis. Instead, one can say that in bereavement work, it may be more useful to view the deceased as the dominant transference figure, and treat accordingly. The effort that is often devoted to the analysis of the transference may be more effectively diverted to the relationship with the deceased. The dominant figure in the client’s intrapsychic world in cases of bereavement may often be the deceased, and many of the transference observations and interpretations normally focused on the therapist may have greater meaning and greater potential for client change when they are directed toward the bereaved’s relationship with the deceased.

When the bereavement experience is notable for the bereaved’s intense involvement with the deceased, there may be a turning away from involvement in the other relationships and tasks of life. While considered as normative for a limited time, continued attention to the loss and the deceased at the expense of other emotional involvements has traditionally been seen as maladaptive or pathological. Whether in cases of chronically manifested or chronically avoided grief, the centrality of the all-embraced or all-avoided figure is paramount to understanding the current symptom picture of the bereaved. Not surprisingly, in such situations the role of the therapist as a figure of “transference” may not reflect the therapeutic reality of the treatment relationship. In many such
situations, the bereaved is unable to become heavily involved intellectually or emotionally with anyone but the bereaved. To remain in tune with the client, the therapist may usefully examine what has been "transferred" to the deceased. This exploration may well focus on the meaning of the representations of the deceased—in association with, and in opposition to, the self representations. This may occupy a significant part of the treatment.

The emotional experience of the therapist, who is "neglected" or set aside in working with the bereaved, can serve as a source of understanding important aspects of the treatment (via the "real" relationship and the countertransferential reactions that develop) (Tansey & Burke, 1989). In ways that may be strikingly similar to the client's disregard of all else in order to concentrate on the deceased, the therapist may be ignored and the real relationship and the transferential aspects denied or relegated to inferior status (Rubin, 1990). However, the further development of this experience by the therapist may be most helpful if it assists the therapist in understanding the representation of the deceased, and the meanings it has for the functioning and internal self-image of the bereaved, and in understanding the reactions of those in the interpersonal environment of the bereaved. Competition with the representation of the deceased who may be idealized, or a sense that the bereaved is unavailable to discuss anything but the loss and the lost, can provide important information (and often serve as a source of tension and frustration for the therapist).

CASE STUDY:

INTRUSIVE GRIEF MASKING HIDDEN CONFLICT

Amit was a twenty-three-year-old art student who had lost his father in a car accident two years previously. He was referred by his mother who was concerned about his son's refusal to marry his belle. Amit indicated that he did not know why he was referred to a therapist, as things were working out fine from his point of view. He himself had no wish to change and felt that he had the right to live his life as he saw fit without interference from his mother.

Amit was the second of three children of a religiously observant Jewish family. His sister (5 years older) was married and living away from the city, and his brother (1 year younger) was away at college and doing well. The mother was a fifty-year-old professional woman who had devoted herself to raising a family for many years before returning to work several years before her husband's death. Asked to explain his comments about "maternal interference," Amit indicated that his mother was interfering with Amit's plan to devote himself to helping her. For some reason that Amit could not fathom, his mother objected to this plan, and also to the idea that he continue to live at home so that his mother would not come home to an empty apartment. To begin to put his plan in action, Amit had broken off with his girlfriend and for the foreseeable future had given up the idea of marriage or striking out on his own.

The history of Amit's response to the death was consistent with what has been described as delayed or disordered mourning (Bowby, 1980; Jacobs, 1993). When Amit had been told by his uncle of his father's sudden death in a car crash, he became emotionally numb while simultaneously becoming very active in responding to the external demands of the situation. He notified relatives, cared for his mother, and took the role of the caregiver for the extended family. He did not cry, but comforted the others. Six months after the father's death, an acquaintance of Amit's was killed in a recreational accident, and he broke down in tears. Soon after this, Amit was flooded by emotion, pictures of his father, and strong guilt about not having responded emotionally to his father's death sooner.

Before we address issues of conflict, relationship, and transference, we shall organize this description from the perspective of the Two-track Model of Bereavement (Rubin, 1984, 1993; Rubin, Malkinson, & Witzum, in press). This model requires an analysis of the bereaved along the axes of dysfunction and relationship to the deceased. When asked about current functioning (Track I), Amit described himself as often anxious and "compelled" to stay at home with mother for a number of reasons including fears for her safety. Amit was concerned that an accident might befall her or other family members and that his being nearby reduced his tension about this. As a further precaution, Amit had taken to carrying a paperback Book of Psalms with him so that he could pray for his family members' safety whenever he had a spare moment. Rounding out the picture of his life, he indicated that he felt little joy and pleasure, being preoccupied with worrying, praying, and trying to do well in his studies. Even from this brief description, the depressive and anxious symptomatology that underlay Amit's functioning are evident. Although he did not identify himself as in need of therapy, it was clear he was suffering (Volkan, 1981).

On the axis of relationship to the deceased (Track II), Amit gave the following description of how he thought of his father. His current feelings about his father were such that he thought about him virtually every moment of his spare time, and felt guilty when he did not think of him. His visual images of his father were not a source of solace but of expectation and pressure. By way of explanation, he indicated that "my father lives on in my imagination." In the course of the previous year and a half, Amit felt that the chronic intensity of preoccupation with his father and his loss were unchanged. Asked what he thought about all this, he made it clear that while he personally had no complaints, his behaviors and his anxieties were major changes that had begun some six months after his father's death.

There was one other block of information related to Amit's image of his father (and also of his mother), which was intimated at the intake meetings but was more fully developed in the treatment. As the middle child, Amit alluded to having been a little different from everyone else in the family. His artistic interests were not particularly valued in a family dedicated to scientific and academic pursuits. At the time of his father's sudden death, Amit responded with caregiving
instead of grieving, which shielded him from his ambivalent feelings to both of his parents. When his grief finally broke through, in connection with his friend's death, the guilt around his angry feelings toward father and mother propelled him to a kind of compulsive holding on to the father's image on the one hand, and staying with mother on the other. On matters associated with his relationship with the deceased, disorder was evident in his constant preoccupation with his father's image which intruded often, his sense that his father was disapproving of him, and a form of denial of his death reflected in his phrase that his father was "alive in my imagination."

On the basis of the information provided, and given his reticence to enter therapy at all, a twelve-session short-term therapy contract was offered to Amit. The goals of such a treatment were not focused on separating him from his mother or tenderly rejoining him with his girlfriend, but toward understanding the anxiety, guilt, and preoccupation with his father's image that he experienced constantly. The short-term contract was also favored because it made planned termination and loss (of the therapist) a major parameter of the treatment at this time (Mann, 1975). Yet therapy would be of limited benefit if it did not address the warded-off anger and disappointment that Amit felt with both father and mother for their "rejection" of his interests and their favoring his other siblings.

The short-term treatment model is one that often necessitates using the transference but not setting out to explore it (Sifneos, 1987). In the case of Amit, there was a comfortable alliance between therapist and client from the beginning, which boded well for the treatment. In terms of opening qualities, Amit found himself in treatment with an academic-clinical psychologist, whose lifestyle and religious outlook also resonated with features of his family. From the viewpoint of the transference predisposition, the comfort and familiarity Amit experienced with the therapist were also linked with an inchoate expectation that here too, as in his family, he would be misunderstood, overlooked, and undervalued. It seemed to me that focusing on the internalized image of, and relationship to, Amit's father, would be the focus and core of the treatment approach. The fuller the description of father and what Amit's view of him and experience with him had been like, the greater the likelihood that we could address the ambivalence and mixed feelings that were involved in this wayward response to loss. If the description of father could be opened up, it would be possible to follow up with his experience of the living mother, and ultimately with what his experiences were in interaction with these internalized and real-life figures.

Therapy with Amit turned out to be rich with a wide range of things mentioned and included. Amit spoke of his schooling, his mentors in art, his girlfriend, his deceased friend, his recitation of Psalms, and of much else. In addition, he gradually began to spend more of his time describing incidents and interactions with his family members that gradually acquired a complexity that had been absent initially. I wondered aloud and commented on what his feelings and experience of himself might have been. When he described interactions with his parents, fuller descriptions of the incidents and of the feelings he had were uppermost in the therapy.

The relevance of the conflict focus was apparent in his struggle to manage feelings of anger and love toward his father. As time went on, Amit was able to paint a coherent and complex picture of his father. He had been a kind and tolerant academic, who did not directly confront Amit for his difficulty with academic subjects. Amit went to great length to stress how tolerant his father had been of his failures in school. That was the opening description. The focal point of Amit's experience appeared to revolve around Amit's negative view of himself, and his unexperienced experience of his anger at father and mother because of their view of him. Instead of confronting his mother he was doing nice things for her and so avoided acknowledging his disappointment and anger. I felt that his self-perceived badness was driving him to heroic efforts to undo the damage he had done. In terms of classical theory, the anxiety and fear of something happening to his loved ones could be seen as a transformation of his own anger, which moved the "danger" far away from him and made him the protector. In more experiential terms, however, he was struggling to hold onto the only people who could dissolve his badness, the parental figures who so disappointed and enraged him. The more subtle disappointments, and the more subtle anger, came out in the way that Amit described how his parents had treated his brother and sister. Their accomplishments were not merely accepted, they were praised and heeded. Mother still continued to consult with the other children and to ignore him. Amit indicated that he sometimes "resented a little" the way he was dismissed at home and the way his siblings were valued over him. As the image of father and mother became more lifelike, the preoccupation with danger to the family gradually relaxed, so that by the ninth session, he felt no necessity to remain home with mother or to recite Psalms. Furthermore, he indicated that the unbidden pictures of father were not as strongly accusatory. Amit's self-image began to shift from that of a guilty son who had not grieved for his father during the Shiva (the 7-day mourning period in Jewish tradition) nor for six months more.

The extent to which the conflict had colored his relationship with the deceased (and his living mother) was apparent as the conflict was addressed and defused. The relational themes took precedence. "I used to think that mother thought I didn't mourn, and my father, perhaps he was thinking that I did not cry or care much either. I used to think that if I let myself get angry at father, I would forget him, and I would never have him accept me the way I am. Now I feel that it is okay to be sad and angry that he never told me he loved me, and that I never told him that I wanted him to respect me." As Amit began to expand on his feelings and thoughts, he began to argue with his mother a bit more, and also to leave her on her own.

There began to emerge associations of memories of family times when father was alive, memories of joy and conflict in the home, and a greater amount of attention to the relationship with his girlfriend, namely whether to break off
actively or become engaged to her. By the end of therapy Amit had accepted a six-month scholarship to study art in London, and had announced his engagement to his girlfriend. He was much less preoccupied with images of father or concerns about danger to his family members.

By way of explanation, it appears that the sudden loss of his father had joined with his anger (and attack against his father), threatening to complete the job of destroying him. This was too much for Amit. What began as the short circuiting of the awareness of loss by caring for others rapidly consolidated as the absence of felt grief and unconscious mourning. Only the loss of another friend was able to restart the grief and mourning process, and by then the internal guilt over the grief not consciously experienced, and the unconscious guilt over the further assault on father arising from his own anger at him, were too much for Amit. In the session where Amit made the connection and recounted several episodes of anger at his father, he was surprised to find himself weeping. In the sessions that followed, he reported a gradual easing of his preoccupation with father, and an increasing interest and freedom to do things not related to the family.

Amit completed the twelve-session therapy course, which had allowed him to explore some of his anger at father and mother. The exploration of his self-image, and what lay beneath the idealized images of father and mother, brought about significant change in functioning and preoccupation with caring for mother and remembering father.

The main treatment focus was along the lines discussed. Although making conscious the unconscious conflicts of Amit was important for the therapeutic process, allowing the relationship with the deceased to become the major focus of the therapy was even more so. The relationship of client to therapist was likewise important and undoubtedly served to make Amit’s exploration of the relationship with his father possible. The support, gentle encouragement, and prodding confrontations all served to make therapy a series of meetings between two people engaged in the task of creating meaning, and not merely sessions where one watched the other go through the exploration of inner self from a safe distance. Of course, more subtle elements were present as well. By successfully completing treatment, Amit pleased the therapist, and so pleased the parent figure that the therapist always represents to some degree. The elements of short-term work may not focus on the impact of such features, but they are acknowledged and often serve to aid the treatment (Mann, 1975; Omer, 1994). This does not change their role as facilitating and background features of this treatment, rather than foreground or central features of the therapy.

CONCLUSIONS

The working through of significant interpersonal loss cannot reach a fixed end-point (Rubin, 1984, 1985a,b). We may say that a loss has been assimilated and that the bereaved has become available for present and future relationships, but there is always a link to the relationship with the deceased. In the case presented, the relationship to the loss and the lost were freed to continue on: not the severance of a bond, but its relegation to a place of importance without dominating or derailing of a life was sought (Rubin, 1996).

In line with the thinking of the Two-track Model of Bereavement (Rubin, 1984, 1993; Rubin & Schechter, 1997), one can conceptualize, assess and intervene in the response to loss along the track of behavioral function or the track of relationship with the deceased. Psychodynamic psychotherapy has generally focused on the relationship with the deceased as the nexus of dysfunctional response to loss (Freud 1953/1917). This article suggests that the analysis of the relationship with the deceased, embracing the conflictual and relational features of that attachment, are central to the treatment. The third feature, that of the transference relationship, will often be subversive to the analysis of the relationship between the bereaved and the deceased.

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