# Facilitation of Mourning During Childhood

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Here you will meet several children helped by Cornerstone who suffered from tragic losses and tragic circumstances. This chapter is essentially practical in its orientation to technique, describing several forms of treatment of bereaved children, with a minimum of theoretical essay. Probably the best definition of "mourning" for our current purposes is, "the totality of reaction to the loss of a loved object." We omit from this definition any immediate consideration of whether mourning can occur at various stages in childhood, and if so, to what extent one or another investigator judges it has occurred, although such consideration is worthy of volumes. To simplify the task somewhat, because it is actually of extreme complexity, Freud's (1915) definition of the work of mourning will be used, with no detailed reference at this time to the more modern contributions such as those of Bowlby (1960). Since considerable review of literature on childhood mourning, including the few clinical cases reported in the literature in any detail, has been made elsewhere by me (Kliman, 1968), a repetition will be avoided here.

The Center for Preventive Psychiatry (White Plains, New York) was created to assist adults and children in dealing with severe emotional burdens and situational stresses and strains. Over 1000 persons came to the Center during its first 12 years of operation. Many were victims of severe, traumatic sudden crises other than the loss of a loved one (object loss). Some were children who were sexually molested, or who had been badly beaten, or who had witnessed murders in their families. Some were suffering adverse effects of their involvement in highly over-stimulating experiences, such as witnessing romantic involvement with adults of the same sex, or incestuous relations within their own families. Some were severely physically ill. Some had sustained psychological trauma, developmental derailment and loss of home and property due to sudden, mass disasters such as floods or tornadoes. No patients however, attracted more of our systematic professional interest and consumed more of our professional energies than adults and children who suffered the sudden and then chronic strains of bereavement.

Never a momentary injury, loss of a loved person is often a long-enduring pathogenic influence. It deserves preventive intervention whenever the loss has occurred early in life, and especially when the early loss is that of a parent. From its beginning, the Center for Preventive Psychiatry had been interested in helping healthy orphans in order to develop techniques of primary prevention of mental illness. Data concerning a series of 18 untreated orphans show that few orphans are free of neurotic symptomatology. Often we found that even orphans referred to us very soon after bereavement ─specifically for preventive support─ already presented important neurotic symptoms. In fact, the majority of recently bereaved children suffered recognizable symptoms of neurosis, and in some cases, psychosis.

On the other hand, children often become able to express deep loss and longing creatively, giving voice to the inexpressible. The Cornerstone team who worked with Ellie, an

orphaned child, will never forget her singing, roughly to the tune and with the mournful cadence of *Kum Ba Yah*, an old spiritual by Marvin Frey (popularized by Joan Baez in the 60's). Fortunately, she sang directly into a tape recorder so that we were able to transcribe her creative expression. She repeated the first few lines many times before continuing her song:

*Where, oh where is my mother?*
*She's down in the ground—*
*graveyard and deep asleep.*

*Where, oh where is my aunt Eliza?*
*She's down in the graveyard,*
*dead asleep.*

*I want to be with my mother*
*in the grave. Oh, Lord!*
*Where oh where is my mother?*

*My mother hit her head on the stove.*
*And then she died. God, please—*
*bring my mother back.*

*Please, Lord. Please, Lord. Please Lordy.*

*We put a plant on her grave.*
*We put a plant on her grave.*
*Aunt Eliza is in a grave next to my mother.*

*O Lord, I want to be there too.*
*O Lord, O Lord. Please, O Lord.*

*Bring my mother back to me.*
*Bring her back, O Lord! Bring her back.*
*O Lordy, bring her back.*

In an extraordinary demonstration of resilience, she showed us her readiness and willingness to transfer her needs for mothering and nourishment to an appropriate and available love object, almost immediately after singing this dirge. After a brief hesitation, she sang these new verses into the tape recorder with marked energy:

*Where's my Granny, Lord?*
*She's at home cooking.*
*O Lordy, kum ba yah.*

*Hello, Granny. Hello Granny!*
*What are you doing there?*
*He, Granny What are you doing there?*

*You home cookin'. Hey, Granny!*
*Hey, Granny, can I have some Cheerios?*

*Oh, my goodness—Man! Man, I want it.*

It is the task of caregivers to create and cherish opportunities for children to express their grief in order to release it. Doing so in the therapeutic context of a Cornerstone classroom affords the child with an adult network which magnifies beneficial emotional resonance by verbalizing the emotional content of creative expressions. This gives the child an acknowledged place to stand where she feels that she is understood and from which she can be encouraged to move forward. Specific feedback on this child's engagement with the present, including her current primary caretaker, "Granny," reinforced her recognition of present time love and support.

Just as bone fractures are a categorical damage from which children may successfully recover untreated, the same is also theoretically true of orphans. But evidently, a break in a love relationship early in childhood usually needs help in healing. It is our position that means for healing such fractures in a child's love-life are extraordinarily undeveloped, little used and, indeed, sometimes shunned. The Cornerstone Method is particularly well suited to filling this void in the treatment of childhood bereavement and its related neuroses.

The major and often statistically significant works of Beck (1963), Barry (1960). Kliman (1968), Gregory (1965), Bowlby, (1980), Furman (1974), Krantzler (1996) and others amply demonstrates the long standing, common-sense impression of many clinicians working with children that death of a parent is a severe insult to psychological health. Especially when bereavement occurs during early childhood, there is an excessive incidence of psychopathology within a few months, and it endures noticeably throughout adult life when left untreated.

Terr (1991) has correctly in my opinion noted that both loss and trauma are involved in various combinations in the production of serious psychiatric disorders. She puts it in terms of the long term effects of experiences like the set of children described in this chapter have gone through:

> Childhood psychic trauma appears to be a crucial etiological factor in the development of a number of serious disorders both in childhood and in adulthood. Like childhood rheumatic fever, psychic trauma sets a number of different problems into motion, any of which may lead to a definable mental condition. There are. four characteristics related to childhood trauma that appear to last for long periods of life, no matter what diagnosis the patient eventually receives. These are visualized or otherwise repeatedly perceived memories of the traumatic event, repetitive behaviors, trauma-specific fears, and changed attitudes about people, life, and the future.
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> Terr divides childhood trauma into two basic types and defines the findings that can be used to characterize each of these types. Type I trauma includes full, detailed memories, "omens," and misperceptions. Type II trauma includes denial and numbing, self-hypnosis and dissociation, and rage. Crossover conditions often occur after sudden, shocking deaths… In these instances, characteristics of both type I and type II childhood traumas exist side by side…

The above opinions about bereavement have been well established, using controlled and anterospective and retrospective series of non-bereaved children and adults from comparable social, ethnic, racial and economic strata. Clearly then, society has much to gain by carefully attending to the problems of each orphan in the adaptation to his or her loss. Furthermore, the readily detected

nature of this pathogenic factor makes it a prime target for the too often neglected field of *preventive* psychiatry.

Deutsch's studies (1937) suggest that the problem, amidst all its kaleidoscopic complexities, includes excessive childhood defensiveness against the emotion of grief. This is especially pernicious when the child's grief is for a dead parent. Defensiveness against affective charge may become a life-long pathogenic style for a bereaved child. To the extent that Deutsch has correctly discerned a major etiologic component in the emotional disorders following bereavement, one major part of the preventive task is to facilitate mourning by helping release a bereaved child's grief, including sad, yearning feelings and associated memories. This must be done in a fashion compatible with the child's defensive repertoire, his developmental state, and his life framework. Then he or she can experience further development and avoid fixation to the psychosexual stage at which the damaging loss occurred.

The illustrations of mourning facilitation provided in this chapter are gathered mainly from orphaned children treated with varying degrees of intensity at the Center for Preventive Psychiatry, especially in the Cornerstone School. The Center has a busy situational crisis service, to which many recently traumatized children come every month. There is preventive value in the community's recognition that bereaved children need special help right away and that a place exists where appropriate help can be obtained. The children referred have ranged in age from infancy to 18 years and were bereaved for periods of a few hours to as long as five years before coming to the Center. Some of the children were known to the therapist before the parental death occurred, so that some baseline knowledge was available at the outset of treatment. We also drew upon a deep source of information about childhood bereavement — our Cornerstone treatment of dying children.

## The Special Problems of Double Orphans

Proceeding further into seldom explored areas of bereavement research, our experience with children who have lost both parents is illuminating. Their immediate grief tends to be open, in the literal sense of prolonged anguished crying. Conscious feelings of grief also attend later remembering of the dead parents, more openly and more frequently than with orphans bereaved of one parent. Although causally different, the phenomenological situation of double orphans is like that of Bender's (1954) psychotic orphans, who grieved profusely and even wildly. The double orphans, like psychotic children, lack adequate defenses. But the lack is in proportion to the great quantity of affect being stimulated by the double loss rather than because of the intrinsic deficiency of defense. Or, we could say the proportional relationship of affect to defense is disturbed by excess over the "average expectable" life stress rather than by the inadequacy of their defenses due to any disease. But the double orphans may also have suffered some actual weakening or exhaustion of defense due to the first loss, on which the second loss is now heaped. The task with double orphans is, therefore, how to facilitate the management of extraordinary quantities of affect becoming detached from two major objects, and specifically how to manage this task without the development of gross deformities and breaches in the testing of perception and in the adaptation to new objects.

One of the double orphans whom we treated would frequently hallucinate. This was a major presenting problem, although in follow-ups he was not apparently psychotic. One task with this four-year-old boy was to provide interpretations to produce a framework of insight, so that he could understand the nature of his hallucinations, especially their wishful, loneliness-induced

origin. In a twelve-year-old double orphan, a main accomplishment was to allow more boldness in his adaptation to peer social objects. His high dose of affectively charged conscious memories of both parents became more manageable when catharsis occurred repeatedly in twice-a-week sessions over a ten-week period. For an entire year, his love-life had been confined to going over memories of his parents, morbidly pouring over photo albums, and prolonged silent weeping with regret for the lost and now idealized life he and his parents had had together. After catharsis in treatment, the mournful ruminations diminished and social life increased, apparently using the now more available energy for loving (sometimes technically called "libido") to make new attachments.

Elsewhere (Feinberg 1970), Kliman 1979) a Cornerstone colleague described related work: the task of preparing two older sisters for the impending death Charles and facilitation of their adaptation to the actual loss when the child died. Special attention is given by me in another report to therapeutic support for feminine identity development in the case of a maternally bereaved girl (Kliman 1979, pages 86-88). Still another report of ours (Kliman, 1968) discusses a boy who lost his father and provides data concerning the interrelationships of mourning problems with the multiply-determined symptoms of unusual hallucinations, perceptual and memory impairment.

The following brief survey of the techniques used in treatments of bereaved children will move from customary techniques to those less customary.

Parent Guidance Issues

Nothing can be more critical to a child's mourning than the mourning work of the adults around him and their attitudes toward the child's work. A major part of the preventive and therapeutic task can often be efficiently focused on parent guidance. Because such guidance techniques are widely practiced and well-known, we will not dwell on them except for some insufficiently appreciated and essential points.

Parent guidance in cases of childhood bereavement should include at least some check on the possibility that a remaining parent may be out of synchronization with the very difficult mourning rhythms of his or her child. For example, forceful evidence dysrhythmia within a family is often found when a widow is ready to remarry, particularly if her remarriage is planned for a year or less after bereavement. She may need assistance to realize that her children are much slower than she to give up the lost love object, because of their greater defensiveness against permitting the work of mourning to proceed. During latency, mourning is apt to be particularly silent and slow. Throughout childhood, the tardy pace with which the old object is decathected is one cause of poor acceptance of substitute parents. It also accounts for the otherwise surprisingly higher incidence of certain psychopathology, as Gregory's large-scale study reports (1965). Among families where the surviving parent has remarried, there is actually a higher incidence of truancy, school failure and school dropout than among families where the surviving parent remains single**.** We must take these unpleasant facts very seriously, as they come from indisputable anterospective study over a decade with 10,000 school children. The unmistakable implication is that we must guide parents preventively to help their bereaved children with utmost tact when a remarriage is impending. However, our sketch of technique need not dwell on what is already common practice.

The surviving parent also needs guidance and support to avoid surprisingly regular tendencies to use the child as a partial replacement for the lost spouse. Our series of 18 non-patient

orphans (Kliman, 1968) showed that seven out of eight families had one child who was chosen as bed companion for the surviving parent. Nine out of these 18 untreated orphans began a pattern of bed-sharing with the surviving parent. This occurred in families which had no previous pattern of inter-generation bed-sharing. A six-year follow-up showed that the tendency, generally manifest within a few weeks after bereavement, continues to be a major one. It is unquestionably an obstacle to full mourning, in the sense of moving on to healthy substitutes for the lost object. One of the initial study's bed sharers (then age 11) was over six feet tall by age 17. He had an active adolescent heterosexual life, but still shared the mother's bed several times a week!

Since a large fraction of bereaved children become parent bed-sharers, we can speculate reasonably that the incestuous impulses of many bereaved children—particularly when the bereavement is of the same sex parent—are a major obstacle to the progress of mourning. To mourn —and be thereby freed for the loving of other persons— is dangerous when the most available other person is the surviving opposite sex parent who is also a tempting bed partner. Bed sharing is, of course, only one form of erotically tinged distortion of parent-child interaction after a death in the family.

## Timeless Interviews

Before discussing techniques of the Cornerstone method as it serves bereaved children, a fascinating technique for mourning facilitation developed and used with adults in Mexico is helpful to mention as an introduction. Remus-Araico (1965) has reported excellent results with a series of 12 adult analysands orphaned during childhood. These patients generally suffered from repressed sad affect and fixation to developmental stages at which the childhood bereavements had occurred, with evidence of a '"traumatic neurotic" process. Remus-Araico's data confirm and enrich the finding of Fleming and her coworkers (1963) in Chicago and provide an interesting innovative contribution to the facilitation technique. That contribution is in the form of what Remus-Araico calls "timeless interviews." He found it very useful to arrange that several times during the course of analysis he would meet with the patient for an interview of a duration limited only by the interest and willingness of the patient and analyst. These interviews, which frequently endured several hours, induced a state of remembering with extremely intense detail and high emotional charge. Remus-Araico frequently felt that the analyst and patient "were standing at the side of the grave together." We believe that such cathartic remembering is indeed difficult to facilitate in adults as well as in children. Yet, to some extent, it appears feasible even in children of preschool age, as well as those who are older. A necessary condition is a positive transference and ample time in which to set the mental stage.

## Cornerstone Method-Specific Techniques

The Center for Preventive Psychiatry regularly used the Cornerstone Method which, in this setting, involved working 15 hours a week with orphans (and other young patients) in a prevention-oriented nursery school with the analyst present in the classroom for six of those hours. This technique appears as powerful for giving psychological aid to orphans of preschool age as it has been for neurotic and psychotic children. While the teachers conduct educational activities, the analyst works right in the congenial and communication-evocative classroom setting. He transacts with one child and then moves on to work with another, and then another. In this setting, he is able to interpret material the children express to teachers or to each other, as well as the play and verbal communications made directly to him. When the analyst leaves the classroom after an hour and a half of work each morning, the six or eight child patients who constitute the

class remain at work with their teachers. The teachers are well-trained specialists in early childhood education, working under the analyst's supervision, as well as the supervision of an educational director (Mrs. Doris Ronald, whose name was originally Doris Gorin). They observe and cultivate, but do not interpret the communications of the children made after the analyst leaves. Thus, while educational activities work continue for the remaining hours of the morning, many fantasies and playful expressions set in motion by the interpretive work of the first 90 minutes continue to emerge and are later reported to the children's analyst. At the same time, these expressions are channeled into ego-building social and educational activities.

Many essential features of a regular child analysis tend to occur despite the unorthodox setting. With the orphans among our Cornerstone patients, a considerable amount of vivid, affectively expressive and ideationally rich energetic mourning work takes place. We mean to include in this emphatic statement all elements included in Freud 's *Mourning and Melancholia* (1917) definition: the working over of ideas and affects associated with the lost object, the cathecting and decathecting of the mental representative of that object, testing for the reality of the object's permanent absence, increased identification with the lost object, and use of liberated cathexis (psychological energy) for investment in new objects (Freud, 1917).

Time and time again, in the Cornerstone Project's daily sessions with orphans, we find that the orphaned child's feelings and thoughts about the analyst are clearly and continuously linked to thoughts, memories and feelings about the dead parent. Even thoughts about extremely frightening and shocking experiences in the past can emerge in the classroom setting, as part of the transference-linked working over. An example is provided by Quentin,\ a five-year-old who was alone with his father in a car when the father had a heart attack and died. Quentin entered the Cornerstone Project about six months later; the following excerpt from his work shows some of the interplay between the pathogenic past and the transference present.

Quentin went to a great deal of trouble to pull the analyst's beard, and made a drawing of the analyst with a very long beard. The analyst was required to help, and to draw Quentin going for a ride on the analyst's beard, straddling the beard. Quentin then began playing automobile riding games and speaking of his father. He placed some paint in a bowl of water and said it reminded him of blood, saying, "This is very dangerous. It's my daddy's blood." Continuing to develop the blood theme, Quentin thought about how the blood in a person's heart could stop moving and then a scientist could stick the person in the heart to make it work again. He spoke of good and bad scientists and whether other things besides caterpillars could go into a cocoon and come out butterflies.

Up to this point, we can see that the analyst's person, particularly his beard, was transitional in the series that led to his father and thoughts of his father's death and fantasies of metamorphosis or reincarnation. Quentin proceeded to thoughts about cars crashing, wondering if his now late school bus had been in a crash, and what that would sound like. He grew tired, wanted to nap, and draped some play jewels over his head. They were "the flowers you put on a dead person." Lying very quietly he then said, "Would you be sad if a friend died?" and hastened to explain, "I thought my daddy was fooling. I asked the man who came if Daddy was alive or dead, but 1 thought he was just fooling, but he wasn't."

The next day, Quentin demonstrated a marked continuity of theme in his Cornerstone work. He approached the teacher with the same colored beads, this time announcing, "I'm an angel." The analyst briefly recapitulated the work of the previous day for Quentin, to point out

the relevance of this remark. Quentin then offered further details of the fatal episode: "A man came and pulled me by the shoulders and I cried." The analyst interpreted that Quentin must have wanted to stay with his daddy, and was still hoping that his daddy was just fooling.

The child responded with some further ideas about needles that could start a heart working again, which the analyst interpreted as thoughts which come because it would have been wonderful if Quentin could still have his father living, and Quentin would like to be a person who could have saved his father. In response, Quentin had two sets of thoughts. First, Quentin asked if the school could get him an oxygen gauge, which he wanted to keep in the doll house he was now furnishing. Then he spoke of houses which are nice and houses which are not nice; scientists who are good and scientists who are bad. Scientists who are good save people and scientists who are bad keep people tied up.

In later work, this theme of goodness and badness was interpretable in terms of his anger at the father for having left him by dying, and his dread that if the father knew how angry Quentin was, the father would be angry at Quentin. The Cornerstone work proceeded, with increasing clarity of linkage and equation between the father and the male analyst, who was openly loved and died many times in the child's fantasies.

## Evocation of Yearnings for an Unknown Father

The opportunity to work with a child born after the father's death is rare. At the Center, it was approximated by the presence in the school of David, a child whose father had died when he was several weeks old. He had never actually known his father and it is of some interest to note the vicissitudes of his work, by means of which he arrived at a useful awareness of what was missing in his life. The presence of a male therapist (Myron Stein, M.D.), within a heterosexual team of constructively collaborating adults, was probably a facilitator of his yearnings. In that emotionally nourishing setting, where his need for a father was to some extent actually met by the frequent presence of the analyst, he could dare to let the desire for a father emerge. The procedure is, of course, not strictly the 'same as the work of helping a child mourn for a loved person he has actually known, but is reported because of its relevance to the general problem of childhood bereavement.

David entered the Cornerstone Nursery at the age of three years, five months. Not only had he been paternally bereaved several weeks after birth, but his mother also had a chronic, presumably fatal illness. His two brothers were two and five years older than he. This was a family in which a great deal of high drama went on, but always in terms of actions, veiled hints, without direct acceptance, recognition of or communication about these matters.

Issues regarding separation, being left behind and death came up rapidly and in many ways during the first year of David's treatment. Initially, the matter of separation from the mother arose. This was a mother who wanted to leave the classroom immediately, who found it an intolerable burden to have to put in time staying with David in school. She was constantly referring to the issues of being there or not being there, and separation, but always in a displaced fashion, not directly relating it to the bereavement or to her own illness. She would do this with jokes. When David was shy one day, hiding behind his mother's skirts rather than relating directly to the teachers, she made the joke, "I think I left David at home today." This reference to his not being there, being elsewhere, or being lost, was repeated in many ways.

We did insist that the mother stay on with David a bit rather than abruptly leaving him for several weeks. During that time, he focused repeatedly on his fear of her leaving. It was possible to point out to him his sadness, his fearfulness, his sudden noninvolvement when she left the classroom. This was sufficiently helpful so that soon, when his mother did separate, he was able to stand it. David's concern about people being sick or away was expressed by a shocked reaction whenever anyone was ill or absent. If a teacher, a therapist or other children were away, David was very upset, and this upset was also pointed out to him in terms of his being worried about something happening to people. When his mother went for a periodic examination at the hospital, he was also upset and focused on the fear that something would happen to the mother. The therapist discussed the child's awareness of the mother being followed in the hospital because of an illness, and where she was being treated and cared for as much as possible. David's concern about his own body integrity came up in terms of his worries about his own physical examination, linked to thoughts of his seriously ill mother.

The actual fact of David's father's absence and of his missing his father came up for the first time some months after he had been in the nursery. This was previously a completely avoided subject, and when the patient finally brought it up at home, his older brother's reaction was to turn to the mother and say, "Morn, this kid's nuts." In school, David made a magic potion of mud, water and paint. He was able to express exactly what the magic potion was in terms of, "Magic to bring a father back." Thus he was able to express his loneliness for his father and his wish for a father as expressed in his magic potion. He built a snowman outside and when a few of the children broke it down, he showed real despondency. He said that this was a real man. The analyst pointed out to David that he wished so much that he could have a real man, like a father, that when his substitute for the real man, namely the snowman, was destroyed, he missed it badly. He was able to agree with and seemed relieved by the interpretation.

After this, there was a distinct change in David's typical way of functioning, Previously had behaved in imitation of a big man, puffed up, talking in a loud voice, denying anxiety and depression, instigating fights, and generally behaving like a little sheriff in the classroom. After admitting his sadness and his missing having a father, he was able to be more of a little boy, feeling and expressing a little boy's need of his father, missing his father, and sadness about not having his father. He initiated games with the therapist in which they would prepare meals together, eat together and trade gold with one another. Much of the work seemed related to his deep longing for identification with a father or a male.

Vacations from the therapeutic classroom were difficult for all of the children, as were holidays, and David also found these separations difficult, in line with material discussed above. Transference interpretations were made in terms of David having to be tougher, more abusive, and less communicative just before and immediately following vacations and holidays . In response, David initially showed minimal changes, but then became able to demand the therapist's attention more directly and less directly avoided it.

For a long time, this rough, tough little man had needed to deny positive feelings towards the analyst. He referred to the analyst as stupid or "dootie." After the interpretations about missing the father, wanting to make a father through the magic potion or the snowman, when David became able to become more of a little boy, he was also able to directly express his positive feelings towards the analyst and became more receptive to the therapist's nurturing support.

Technical Separation Reactions as Facilitators of Mourning

The case of Jay's Cornerstone recovery is discussed in detail in a previous chapter of this book but it is useful to review it briefly here, in terms of therapeutic facilitation of mourning in children. The necessity to help this child deal with the death of his father was unexpected as the death was the sudden as a result of an airplane crash about six weeks after Jay began Cornerstone treatment. . A feature of his immediate reactions to the death of his father was a combination of heightened positive transference with considerable expression of sad affect and yearning for the return of his father. The child made steady clinical progress. Overcoming his difficulties with male identification and aggressive behavior, he experienced a rather vigorous mourning process, including conscious and unconscious identifications with his father, much remembering associated with sad affect, and a gradual surrender of hopes for the father's return. Throughout the treatment process, a major feature was close attachment to the male analyst, Dr. Kliman, as well as female teachers. In retrospect, it seems that the prolonged presence of a heterosexual team, and especially the many hours of intersubjective relationship with a real male substitute for the lost male parent, permitted the expression of what might otherwise have been an unbearable yearning and sense of emptiness in his life.

Jay expressed his sadness upon the death of his father both overtly at a conscious level and in multiform unconscious expressions at a level of symbolic, verbal, playful, creative and dream activities. The father's death appeared to increase the intensity of transference to both teachers and the analyst. Simultaneous with passionate attachments to the therapeutic team members, Jay dwelled on thoughts of his lost father, experiencing powerful sadness and increasing identification with the father's traits. His clinical progress was excellent after two years in the school, and he continued working with the analyst twice a week on a regular individual basis thereafter. When his recovery had progressed so far that his treatment was about to be reduced still further, he gave dramatic evidence of how a bereaved child can experience resonance of the loss of a parent when confronted with treatment separations and loss.

At the end of three years treatment, Jay and the analyst discussed his progress; Jay talked about how well he was doing socially and in his school work. Together they then made plans to reduce his treatment to once a week after a vacation. At that point, Jay experienced a momentary loss of balance, while reaching up to a high shelf from his perch on the table. He became frightened that he was about to fall, and the analyst moved over toward him, saying that this was a way of letting us know that he still needed help with his accident trouble, which he had been talking about quite a bit lately. Jay said that it sure was a trouble that he needed help with. In a few moments, Jay said he was frightened because he was seeing "a dark shadow man" in the doorway, adding, "I think I'm having hallucinations. I get this feeling when I look into a dark room or a closet, or I walk by a doorway, the feeling that I'm seeing a dark shadow man in there —a scary man." Jay and the analyst then discussed the way this "hallucination" had come up when talking about something that would make Jay lonely for the analyst—not seeing him in his office. At first, Jay denied there was any connection, but then further elaborated his fearfulness, saying that he also was afraid that he was having hallucinations sometimes because on a couple of occasions he thought he was seeing flying saucers—once at night and once in the middle of a foggy day. Again the analyst reminded Jay of the connection previously established to lonely feelings and outer space monsters, a connection which at first Jay denied by saying that the fears had started before his father died, and they also came on when he did not feel lonely. Later he said it was funny though, that such feelings came over him when talking about not seeing the analyst as often. He would not like that. He wanted to come more often, three times a week, at least twice a week, and not just once a week.

This appears to be an example of transference neurotic process. The hallucinatory experience was precipitated by a separation pending in the form of a vacation to be followed by a reduction in frequency of sessions. There was technical utility in the separation, which could be analyzed in the light of the transference from father to analyst. The symptom of flying saucer and outer space men fears was transferred into the analytic session and appeared specifically in relation to the separation experience, which could thus be better understood by the child because of its narrow framework.

The session ended with Jay's feeling much more relaxed and clearly aware that he feared and resented the reduction in treatment but could tolerate it.

## Cornerstone Case Study: Marvin, A Double Orphan

Marvin, age four years and six months at onset of treatment, was from a severely impoverished African American family; both parents were physically very ill for several years. His mother died of chronic hypertension and a cardiac failure when Marvin was three years and eleven months. His father, who had been an invalid due to kidney disease and homebound most of Marvin's life, died only one month after the mother. Severe prior stress compounded the tragic fracturing of Marvin's life. Especially pathogenic had been his mother's insidious dementia as she succumbed to hypertension. Becoming a recluse, suspicious of visitors to her sad and increasingly unkempt home, she was unable to toilet train her children, who often ran naked and excreted on the floor. When able to shop, she would leave the children in the care of their weakening, bed-ridden and finally blind father. On one such dreary occasion, Marvin and his one year older sister played with matches under the stove and set a blaze which, however, brought the fire department before any serious damage occurred. Neighbors and firemen who rescued the helpless father and children called the New York Society for the Prevention of Cruelty to Children on finding the floors strewn with old feces. The parents' deaths occurred a few months later.

Marvin's maternal grandmother, then freed from the prohibiting suspicions of her now deceased daughter, came to assume the care of the two children. Marvin was almost without useful language and still not toilet trained. Soon enrolled in a day-care center, Marvin was disruptive, restless, and unmanageably aggressive, Marvin was referred to Cornerstone for treatment. His initial examination revealed him to be agitated, incoherent, and very anxiously responding to hallucinations seen on the classroom ceiling.

In his first five months at Cornerstone, Marvin continued to hallucinate, and spoke of fire in the ceiling. He gradually became very attached to the analyst, the teachers, and the handyman. The hallucinations cleared concurrently with completion of the first major interpretative work. The handyman happened to be African American and Marvin began to misidentify the handyman as his father. When the therapist was able gradually to interpret the lonely, wishful quality of the delusion for Marvin, a significant change occurred. Marvin was then able to cling physically to the teachers, whom he called "Mother," in contrast to his formerly hostile and disruptive relations to teachers. The availability of new people on whom Marvin could transfer some of his old investments of love appeared highly useful.

After five months with his first therapist (Myron Stein, M.D.), the project's financial necessities required that two groups be reduced to one. The remaining group had a different analyst (Gilbert Kliman, M.D.). The transition was used with surprising advantage. Marvin insisted that

the new analyst was really the first one. It was feasible to point out the similarity of this delusion to the handyman-father delusion. Thereupon Marvin began to speak to his grandmother and sister about how the first doctor "wasn't coming back anymore," and for the first time spoke of his mother and father in this same realistic way. It thus appeared that Marvin was able to assimilate the loss of the first doctor; this dose of loss was moderated by the immediate availability of a replacement. Improved reality testing was feasible and further growth occurred.

With the second analyst, obvious questing for the analyst as father occurred, with open anger, sadness and weeping on many days when the analyst would end his 90-rninute participation in the classroom procedures. The small daily dose of loss was digestible with the sweetening vehicle of two maternal teachers who remained in the classroom during Marvin's sessions and after the analyst left each day. Genetic interpretation of the transference expressions of protests and sadness led to many relevant memories being evoked of Marvin's life with his parents, charged with protest and anguished grief over their absence. The process of identification with some of their now remembered activities and traits was clear. For a while, a feminine identity trend began to hold sway (dressing in ladies clothes) along with a powerful yearning to learn to cook in school associated with talk of the wonderful pies, cakes and pancakes his mother used to make for him.

At this point a synergism of educational and analytic techniques occurred, as often happens in the Cornerstone situation. The teachers helped Marvin to learn to cook, while the analyst helped him understand his wish to become a cook like his mother so that he would not be lonely for her. This work led to his falling in love with the teachers, his sister and grandmother, all of whom he wished to marry. He then became very focused on one teacher and one girl in the Cornerstone group, making many gentlemanly and some not so refined romantic overtures and voyeuristic approaches.

Marvin's intellectual development then proceeded vigorously, as he reached the oedipal phase. He now appears non-psychotic and of good intelligence. After 14 months, he went into a public school No aspects of his treatment were as important as the dynamic and genetic interpretations of transference separation reactions. Therapeutic induction of mourning occurred through analysis of transference.

## Discussion and Conclusion

There is general agreement that the process of mourning is much more difficult and often much less complete for young children than it is for adolescents and adults. Some believe that successful or complete mourning is not possible until adolescence. We believe we have documented reasons for an optimistic view when intervention occurs to facilitate the process. We also view optimistically the immediate testability and analyzability of bereaved children. In contrast, Freud emphatically stated in his *Analysis Terminable and Interminable* that psychoanalysis proceeds most effectively "if the patient's pathogenic experiences belong to the past, so that his ego can stand at a distance from them. In states of acute crisis analysis is to all intents and purposes unusable. The ego's whole interests are taken up by the painful reality and it withholds itself from analysis, which is attempting to go below the surface and uncover the influences of the past" (Freud, S., 1937). Many analysts today still believe that adults should not be taken into analysis in the midst of an ongoing love affair, or after the death of a loved person, especially during the period of acute mourning. Anna Freud goes further and suggests that child analysis will be less effective than ordinarily to the degree that "the threat, the attacker or the seducer is a real person, in contrast to

situations where the child's fears, fights, crises and conflicts are the product of his inner world" (A. Freud, 1968). Our conclusion differs with that of the Freuds, although based upon reasoning which is similar up to a point.

It is our experience with children of a very young age (as well as with adults and adolescents in acute bereavement situations) that this crisis itself often forces or facilitates the tendency of a person to go below the surface of his daily conscious life and deal inexorably and regressively with influences of the past. The particular crisis of bereavement is an exceptionally strong potentiator of the emergence of the past, and therefore, we submit, makes the patient (adult and child alike) unusually available if the therapist is willing to accept the full range of communications brought to him and deal with them unflinchingly as material for scrutiny rather than as reasons to reject the task. Indeed, crisis patients generally have an exceptionally strong disposition to form strong, rapidly developing transferences which can facilitate analytic treatment and are best handled with analytic technique.

The flow of love and hate in transference provides an exceptional opportunity for a patient to experience manageable doses of the same emotions he experienced with love and hate objects in real life outside of treatment. The therapeutic situation, whether by design or not, usually imposes new demands for reaction to loss. When the loss reactions occurring in treatment are deliberately scrutinized and focused upon, a bereaved child has a new chance to work through the reaction to the death of a parent, because the end of transferred reaction is more easily bearable than the original end of life for which the child grieves. Because the transferred reaction is subjected to the therapist's interpretation, the child is provided with an increased repertoire of means at his disposal for mastery, including mourning and going forward with life's new loves and tasks.

In other respects, we are in agreement with Anna Freud, who stated (1968) that we still cannot know how far the neglect of developmental needs can *be* undone by treatment. She apparently includes in this suspension of judgment how far the absence of a parent and its myriad consequences may be undone by treatment. She points out that in a situation such as parent loss, therapists may be (wisely) unwilling to restrict themselves to analysis and may find other avenues of approach. One such approach, incorporated into the Cornerstone method is to turn the treatment situation itself into an "improved version of the child's initial environment and within this framework aim at the belated fulfillment of the neglected developmental needs." Another approach is an endeavor to share the work with parents, who may be able to undo some of the harm they or circumstances outside their control have caused. With some cases, we have added considerable effort to induce a change in the surviving parent's behavior, using parent guidance, particularly where fresh pathogenic insult was added to the previous loss. This is true, for example, when a parent begins a dangerously seductive custom.

After so much technical detail, we would like to close this chapter on a missionary note. Any early-age group which suffers from a common variable likely to increase the incidence of psychopathology is a prime target for the development of preventive mental health services. Such a group can readily be found among bereaved preschool children. For such children, we emphasize the Cornerstone method as a means to multiply efficiency in use of psychiatric hours, making preventive efforts practical.

In addition, we think that parent guidance for the surviving parent has not received adequate scientific opportunity for assessment of effectiveness. Programs of even more superficial approach, such as parent education without guidance, also have been prematurely written off as hopelessly

weak and ineffective. Parent guidance should be assessed in situations likely to yield a very high incidence of pathology in untreated states. Although parental involvement is almost universally touted as desirable and beneficial, we are still wanting in studies which support their structured inclusion in therapeutic work with young children as a critically valued necessity.

To date, fewer resources are available for prevention as opposed to remediation. Unless we systematically explore, control and assess the effectiveness of applied psychoanalytically oriented means for large-scale prevention, we shall have defaulted in using the most obvious measures while immersing ourselves mainly in matters of great professional fascination without great hope of social yield.

Postscript

After this essay was first published, I mounted several preventive intervention studies of populations of foster children, with significant and encouraging findings concerning the measurable effects. Some of the projects follow in this book.