CLINICALLY SIGNIFICANT DIFFERENCES BETWEEN GRIEF, PATHOLOGICAL GRIEF, AND DEPRESSION

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ABSTRACT

Differentiating between grief, pathological grief, and depression is important for health professionals because significant differences exist in the treatment of these conditions. This paper describes clinically observable differences between these diagnoses and suggests intervention and counselling strategies appropriate to each. In many instances grief can best be facilitated by a nonjudgmental, warm, and open companion or health professional who does not intrude unnecessarily into the bereaved's need for solitude but who can monitor physical health. Depression and pathological grief, on the other hand, frequently require the skilled intervention of a mental health professional.

INTRODUCTION

With the notable exception of Freud's [1] classical work, "Mourning and Melancholia," the distinction between depression and grief has only recently become a focus in mental health literature.[2–9] Before 1968, according to Averill,[2] discussions of grief were conspicuously rare, mainly because the behavior of the bereaved could not be explained in terms of most theories of emotion. Even Freud's work and his later revisions seemed not to find their way into larger analytic writings on the topic. Bowlby [10 (pp. 26–27)] noted, "A reading of the psychoanalytic literature shows that, as a rule, separation anxiety, mourning, and defense have been considered a piecemeal. The reason . . . is . . . in the history of medicine it is the end result of a pathological sequence that is noted first. Only gradually are the earlier phases identified, and it may be years before the exact sequence of the process is identified." As Parkes [11] has noted, the outcome of this end-result focus of medicine is that most individuals who have experienced a recent loss and are seen by physicians, nurses, social workers, or mental health professionals still may be labeled as reactive depression and treated accordingly.

Grief and depression are different phenomena. Grief is a normal reaction to a significant loss and is characterized by sadness, loneliness pangs, and exhaustion. It is generally self-limiting. This capacity to mourn, which is not fully possible until at least age 10,[12] can serve a major integrative function. According to Smith,[7 (p. 21)] "It is likely that every step in growth—every new integration—is preceded by some degree of being undone at a loss."

Depression, on the other hand, is generally seen as a clinical syndrome characterized by negativism, helplessness, lowered mood, and reduced self-esteem. While depression can be self-limiting and may occur only once in an individual, the duration of incapacitation (four to 13 months), the morbidity of its symptoms, and the consequences (including suicide) have made it a significant focus of the clinician.[13] Depression has been characterized as the inability to grieve.[7]

A third distinction, that of pathological grief, was made by Volkan,[14 (p. 334)] who noted that a significant loss "may precipitate recognizably connected mental disturbances, the form of which may range from neurosis to psychosomatic disease to psychosis." Pathological grief tends not to be self-limiting, and it significantly disrupts the individual's capacity for functioning. Volkan asserted that "established pathological grief is an entity in its own right."

Professionals in all helping roles are likely to find such distinctions useful clinically. Mental health professionals, while more likely to encounter and treat depression and pathological grief, are increasingly employed in medical settings where grief issues predominate. Other health professionals, such as nonpsychiatric physicians, nurses, and physical therapists, are more likely to encounter grief as a reaction to the

multiple losses associated with illness and injury, being a patient, and anticipating death. Depression and pathological grief as a disruption of normal grief, however, are not uncommon in such settings, even though their comprehensive treatment may be beyond the scope of the primary care professionals and require specialized attention. Thus mental health professionals would be called on to diagnose and treat the more pathological conditions, while normal grief may best be facilitated by those involved in primary care settings.

This paper will discuss both the clinically observable distinctions between grief and depression or pathological grief and the corresponding counselling strategies that can be utilized by those in the helping professions.

SIMILARITIES AND DIFFERENCES BETWEEN GRIEF AND DEPRESSION

The more clinically useful distinction would be between grief and reactive depression. The more endogenous depressions are easily recognized by the chronicity of symptoms and the frequent absence of a known recent precipitating event. In most reactive depressions, as in grief, a definable change or loss is the precipitating factor.

Peretz [3] has discussed the range of responses to loss, which includes grieving or the inability to grieve—one form of which is depression. They include: 1) normal grief, 2) anticipatory grief, 3) inhibited, delayed, and absent grief, 4) chronic grief (such as the inability to terminate mourning), 5) depression, 6) hypochondriasis and exacerbation of preexisting symptoms and illness, 7) development of medical symptoms and illness, 8) psychophysiological reactions (such as sweating or palpitations), 9) acting out (sociopathic or promiscuous behaviors), and 10) specific neurotic and psychotic states. These reactions often occur in combination. Although each reaction requires the attention and often the intervention of a health professional, the distinction between normal grief and depression is probably the most difficult and important to make.

Grief and depressive reaction have certain similarities Smith [7(p. 18)] observed that grieving and depressed individuals are alike in that "both are in despair, whether agitated or withdrawn. For the most part, both are unable to be interested in anything other than that which further increases their pain. Either can scarcely believe that pain and emptiness will ever cease; both can feel his or her life to be over or wish it to be. For both time stands still. For both, the usual cycle of life may be meaningless in which world events pass unnoticed."

A number of clinical observers [1,3,7] point to significant differences between the grieving and the depressed person, especially when observations are made over several hours or days.

Presence of a Loss

Peretz [3] noted that in uncomplicated grieving there is a meaningful loss to the griever, while in depressive reactions there may or may not be an immediate precipitating loss. When losses are noted and seen as related to his emotional state, the depressed individual is likely to consider the loss "deserved" or as punishment for some real or assumed transgression This phenomenon has been noted among Viet Nam veterans, for example, who assumed their physical illness was punishment for "what I did in 'Nam." Individuals who are aware of the connection between a recent loss and what they are experiencing, who may experience some guilt but do not consider the loss as punishment, are more likely to be grieving. Depressed individuals who have not made such connections often have difficulty seeing the relationship between loss and their feelings, even when pointed out. As Freud observed, "If depression involves an object loss, it is at an unconscious level."

One general difference observers may note is that the reaction of one who is grieving seems appropriate to the loss experienced, whereas the reaction of a depressed person seems too intense. A limitation of this distinction occurs when the bereaved or depressed individual has experienced a loss that is greater than any the health professional has personally experienced. The professional may then view any reaction as appropriate, for he cannot imagine himself being able to handle such a loss.

It is helpful to know the individual's history, such as what previous losses were experienced and how they were handled, the culturally or sociologically acceptable ways of expressing grief that apply, and any previous treatment with psychoactive drugs for grief reactions. Along with the pretrauma personality of the individual, these factors will affect what is observed.

Table I summarizes some of the key differences between grief and depression. As with most differential diagnoses, the distinctions are not always clear in practice. When a mixed picture is presented, it is probably best to assume that the ego functions necessary for uncomplicated grief have been disrupted. Thus treatment of any depressive symptoms becomes the first priority.

Mood States

A person who is grieving usually shows a greater range of feelings than one who is depressed.[3] These can in-

Table I. Key differences between grieving and depression.

	Grieving	Depression
Loss	There is a recognizable loss by the bereaved.	There may not be a recognizable loss by the depressed, or the loss is seen as punishment.
Mood states	Quickly shifts from sadness to more normal state in same day.	Sadness mixed with anger.
	Variability in mood, psychomotor activity, level, verbal communication, appetite, and sexual interest within same day/week.	Tension or absence of energy.
		Consistent sense of depletion, psychomotor retardation, anorexia with weight loss; sexual interest is down, verbal communication is down; *or* agitation, compulsive eating, sexuality or verbal output.
Expression of anger	Open anger and hostility.	Absence of externally directed anger and hostility.
Expression of sadness	Weeping.	Difficulty in weeping or in controlling weeping.
Dreams, fantasies, and imagery	Vivid, clear dreams, fantasy, and capacity for imagery, particularly involving the loss.	Relatively little access to dreams; low capacity for fantasy or imagery (except self-punitive).
Sleep disturbance	Disturbing dreams; episodic difficulties in getting to sleep.	Severe insomnia, early morning awakening.
Self-concept	Sees self as to blame for not providing adequately for lost object.	Sees self as bad because of being depressed.
	Tendency to experience the world as empty.	Tendency to experience self as worthless.
	Preoccupation with lost objects or person.	Preoccupation with self.
		Suicidal ideas and feelings.
Responsiveness	Responds to warmth and reassurance.	Responds to repeated promises, pressure, and urging or unresponsive to most stimuli.
Pleasure	Variable restrictions of pleasure.	Persistent restrictions of pleasure.
Reaction of others to affected person	Tendency to feel sympathy for griever, to want to touch or hold the person who is grieving.	Tendency to feel irritation toward depressed. Rarely feels like touching or reaching out to depressed.

clude confusion, restlessness, anger, disgust, sadness, hopelessness, and helplessness but also reflection, savoring, animation, and a sense of humor when with others. While there is evidence of the interspersing of periods of relative equilibrium and distress during both grief and reactive depression,[15, 16] the periods of distress in grief usually occur when one is reminded of the loss.

The bereaved person also exhibits more variability in mood and activity level, in willingness to communicate with others, and in appetite and sexual interest. As Parkes [11] noted, "The most characteristic feature of grief is not prolonged depression but acute episodic 'pangs.' A pang of grief is an episode of severe anxiety and psychological pain." These pangs have corresponding physiological effects in the form of episodic elevations of corticosteroid excretion.[15, 16]

While a person in grief may be immobilized, if someone else initiates an activity, he or she is more likely to respond than one who is depressed. Thus moods can vary as a function of interpersonal stimulation, particularly by individuals already known to the bereaved.

Dreams, Fantasies, and Imagery

Individuals who are actively grieving appear to differ from those who are depressed in their access to the levels of consciousness represented by fantasies and dreams. There is evidence that depressed individuals

have a marked decrease in REM cycle sleep, which is usually associated with dreaming.[17] Depressed individuals also have difficulty using their fantasies or engaging in imagery in any positive manner. Any access that exists is usually self-punitive, which in itself may be an ominous sign of physical vulnerability. In cancer patients, for example, Achterberg and Lawlis [18] found that successful imagining of the white cells of the body defending against and defeating the cancer cells was highly correlated with remission, stabilization, or advancement of the illness ($r=.71$; $n=58$). This may be one aspect of the common observation that episodes of depression frequently precede physical illness.[17–20]

Most actively grieving persons, even months or years after the loss, report vivid dreams representing the deceased or lost object in a way that acknowledges the loss.[11] In addition, bereaved individuals in their fantasies and daydreams are frequently able to focus on who or what was lost or what they were doing and feeling at the time of the loss,[20] which often represents a significant way of grieving. Morrison [20] reported that persons progressing through grief frequently have daydreams and are able to use imagery exercises to facilitate awareness of what they have lost.

Self-concept

The self-concept of both someone in grief and someone who is depressed is assaulted by a loss. Depressed individuals, however, often see the loss as confirming that they are bad, that they deserve what has happened, that fate is against them, and that they are indeed worthless. They appear to use the loss to prove a negative self-image. Thus someone with a poor self-concept before a loss is more vulnerable to depression as a reaction to loss.

The person who is grieving, on the other hand, may wonder if the loss occurred because they are bad, worthless, etc., but this exploration is usually discordant with their typical self-image, and they will have difficulty reconciling it with what else they know about themselves. As Freud [1] noted, "In mourning, it is the world which has become poor, in depression it is ego itself."

The person in grief is more likely to search for a cause of the loss and may seek to blame himself or others for what has happened. Individuals who are not prone to forming fixed, unquestioned beliefs can usually respond to warmth, reassurance, and logical questioning about issues of blame and guilt, while depressed individuals are more likely to resist attempts to either gain perspective or change their negative self-image.

Both bereaved and depressed individuals often appear preoccupied, but the focus of the preoccupation differs. Persons in grief generally are preoccupied with the lost objects, persons, or illusions and their relationship to them; depressed individuals generally are preoccupied with themselves, their inner feelings, and what the loss says about them.

Responsiveness

There are, obviously, times when grieving persons are unresponsive to others. They want to be left alone, and many will request this. Solitude is frequently seen as a necessary part of grieving, particularly in reflecting on the loss and gaining perspective. Other times, however, they are clearly responsive, able to experience and express what for them is a typical range of involvement with others. The depressed individual is more likely to be either frightened of being left alone or unresponsive to the presence of others.

Pleasure that was exclusively associated with the lost person, goal, or object (such as going to favorite restaurants, participating in sports, school, sexual intercourse) may be absent until grieving has been completed, but other types of enjoyment are often open to the bereaved. They may initially feel guilty or unfaithful or wish to share the experience with those they have lost, but they can frequently be persuaded to do something and enjoy it. In contrast, depressed persons generally restrict all pleasure and are usually unable even to fantasize pleasurable acts without guilt (anhedonia).[21] They usually seem immune to attempts to persuade them otherwise. In cases of agitated depressions or acting out, the pleasure-seeking behavior frequently takes on compulsive dimensions with little reported pleasure involved.

Effects on Others

There is a strong tendency to feel sympathy for the bereaved, to want to touch, hug, or otherwise provide him with some measure of protection and nurturance. There is often a softness, responsiveness, a vulnerability about someone in grief that is usually absent in someone who is depressed. The health professional initially may feel the same desire to nurture the depressed individual who has experienced a loss, but the person's incapacity to respond, pervasive despair, anhedonia, and passive rejection of nurturance often provokes irritation, helplessness, and a sense of detachment in the helping individual.

DIFFERENCES BETWEEN NORMAL AND PATHOLOGICAL BEREAVEMENT

Although pathological grief reactions are not as common as depressive reactions, their distinction from normal grief is also important. This section will dis-

cuss observations of both normal and pathological grief.

Volkan [11, 22] examined the characteristics of the pathologically bereaved as part of his general studies on death and grief. He noted, "Uncomplicated grief may be seen as nature's exercises in loss and restitution. It involves pain, but it is worked through and ultimately resolved, offering no drastic obstruction to the conduct of daily life after an average time of six months . . . Established pathological grief . . . may be continuous, or it may appear periodically at the anniversary of the death or when a symbolic loss reminds the patient of the death. I consider this diagnosis when, six months or more after death, I observe an attitude toward the loss indicative of an intellectual acknowledgment of its occurrence accompanied by emotional denial. . . ."

Hodge [23] went further in stating, "If the grief work is not actively pursued, the process may be fixated, aborted or delayed, with the patient feeling that he may have escaped it. However, almost certainly a distorted form of grief work will appear at some time in the future." Lindemann,[21] in observing those who had pathological grief reactions, noted, "One of the big obstacles of this work seems to be the fact that many (people) try to avoid the expression of emotion necessary for it." The result is pathological grief, which Lindemann regards as an inability to terminate the process.

Ramsay [25] reported similar conclusions in his observations of phobias and pathological grief reactions. The main similarity he saw was in the avoidance behavior, where the bereaved avoids situations that evoke the sense of loss. As with Lindemann's observations, the result is a phobiclike reaction from which there is no resolution, only continued restrictions of behavior.

Table II lists some of the distinctions Volkan and others make between normal and pathological grief. Six months seems to be a minimum time necessary to determine if the bereaved will be able to mourn and resolve the loss and begin to move on in life. Even after that, those going through normal bereavement will still experience loneliness pangs, occasional periods of fatigue or preoccupation, or minor anniversary reactions (except for the first Christmas, for example, or the first anniversary of the loss) and may require a long time to understand the meaning of the loss. Those in normal grief, however, will generally be able to carry on a preloss style of living with whatever adaptations are necessary to acknowledge the reality of the loss within the first year.[26]

Reality Testing

Characteristic of pathological bereavement is an avoidance of reality testing. This is manifested in an active seeking of reunion with the lost person or

Table II. Key differences between normal and pathological grief.

	Grief	Pathological grief
Time since loss	Most intense reactions are seen prior to six months.	Intense reactions last longer than six months with little sign of resolution or relief.
Reality testing of the loss	Holding on strategies: wants to believe the loss can be restored but knows it cannot. Reality-testing (after initial phase of shock) is intact.	Continues to operate as if loss was still there. Chronic, continuing hope for return of lost person or object. Refusal to actively reality test.
Preoccupation	Variable: can be intensely focused on loss or able to function. Acute awareness of what happened at time of loss: emotionally, physically, and cognitively.	Active: seeking reunion with lost object or person or clear ongoing disruption and dysfunction in daily routine; acute awareness of what happened at the time of the loss is usually cognitive only.
Dreams/imagery	Manifest content of dreams is variable but contains recognition of the absence of what has been lost.	Manifest content focused on attempts to save or destroy what (who) was lost.
Approach/avoidance behaviors	Ambivalent about dealing with loss but willing to do so.	Avoids situations which would remind bereaved of the loss.
Intellectual/emotional integration	Intellectual and emotional awareness of loss.	Intellectual awareness only or emotional awareness without linking to intellectual awareness.

object long after the loss has occurred or the active avoiding of acknowledging the existence of the person who has been rejected or incorrectly assumed to be deceased. One example of this failure at reality testing is the typical use of the present tense when referring to the lost person or object ("We always do it that way," rather than, "We always did it that way."). Another example is the total absence of mention of a rejected child by a parent, with hostility directed at anyone who risks mentioning such a person.

Length of Preoccupation

Intense preoccupation with the loss is a clear sign of mourning. If this preoccupation maintains intensity for longer than six months, however, or increases to the point where "the thread of daily life is lost," [14] the grief has reached pathological proportions. One example is a woman whose everyday life still focused on her deceased husband. She maintained his clothes, prepared meals for him, and planned joint ventures. She had not adapted her behavior to account for the reality of his absence.

Part of this preoccupation in pathological grief is focused on searching through the events surrounding the loss event repetitively and without a sense of relief. Most people in grief experience a catharsis in telling the story of their loss. The pathologically bereaved, however, often describe the events without linking feelings and actions that occurred at the time. Usually they report little or no relief from relating the details of their loss. Those listening to the story may experience feelings of distress and, as a result, assume that the pathologically bereaved must also be experiencing the same. Careful observation usually reveals that the pathologically bereaved are relatively unmoved and seemingly detached in relating the story.

Dreams/Imagery

Many persons have disturbing dreams after a loss. In pathological grief, however, the manifest content repeatedly deals with attempts to save or destroy the lost person or object.[14] Often the same dream is repeated. Generally, in pathological grief, these dreams have the associated feelings of anxiety or guilt, and there is little, if any, release experienced after awakening. In normal bereavement, the manifest content is more likely to acknowledge the loss [20] or to facilitate grieving the loss. For example, a young man described a dream in which he had dinner and a particularly meaningful conversation with his deceased father, something he had not been able to have while the father was alive. The dream was experienced as releasing and satisfying and a sign of progress in grieving.

Approach/Avoidance Behaviors

Most grieving individuals are ambivalent about discussing their losses and the resulting feelings because of the pain and helplessness they experience in bringing their memories to awareness. In situations that they perceive as facilitating and safe, however, they are often willing to share these feelings. The pathologically bereaved individual tends to avoid situations that are reminders of the loss, including contact with people who might evoke feelings of grief. They will resist or avoid discussion of their loss, often stating that it only brings up the pain, it does not do any good, or they do not want to feel sorry for themselves.

Intellectual/Emotional Integration

Normal grieving involves a reintegration process, which brings together the intellectual awareness of a loss, its implications and consequences, and the physical and emotional experience of deprivation, mourning, and healing. In a general sense, Gendlin [27] viewed this integrative process as necessary for any growth process. The integration is clearly absent in pathological grief. There may be intellectual awareness in the absence of feeling, or there may be feelings (often seen as chronic grieving) with little or no insight into their source, meaning, or implications and with little more than temporary relief.

With such distinctions between grief and pathological grief and depression, there are corresponding differences in the treatment of these conditions.

TREATMENT DIFFERENCES BETWEEN GRIEF, PATHOLOGICAL GRIEF, AND DEPRESSION

As stresses on the adaptive function of the organism, grief, pathological grief, and depression all need monitoring of the physical aspects by a health care professional. Loss is a stress event in anyone's life. Individuals are vulnerable, physically and emotionally, after a loss. Engel's [28] work on sudden death after a loss is dramatic evidence of this. Parkes [19] and Weiner's [29] summaries of studies on increases in post-loss illnesses and increased visits to physicians in the six months after a loss also support this point of view. Thus monitoring signs and symptoms of illness after loss is important to prevent unnecessary complications, regardless of whether the individual's condition is primarily grief or depression.

Grief, however, does not require psychiatric intervention but rather a facilitation of what the person already is experiencing.[21] As Frankl [30] pointed out, effective treatment requires acceptance of the crisis of meaning and attachment the bereaved is facing.

Depression requires altering the person's overwhelming feelings of helplessness, hopelessness, dejection, and lack of meaning in his pain. Depression frequently requires intervention in the form of psychotherapy, hospitalization, antidepressant medication, resocializing, and, in the case of some psychotic depressions, electroshock therapy.[18, 21, 31] Recent approaches have emphasized cognitive intervention or vigorous treatment of the biological basis of depression.[1, 25, 28, 32]

The work of grief generally involves minimal intervention, the presence of an ongoing supportive relationship, solitude, and time for healing.[33] Counselling persons in grief generally involves helping the mourners pay attention to whatever might be connected with their loss and providing comfort and companionship during periods of acute awareness.[26] Grief generally is best aided by existing relationships rather than by establishing new relationships. Referral to a mental health professional can be frightening to the bereaved.

The pain of grief is considered a useful experience in acknowledgment of the loss. In normal grief, this experience need not be forced or brought out by confrontation. Often the mere presence and openness of a trusted professional or a friend can be sufficient to facilitate progress. Touch, in the form of hand-holding, reassuring hugs, and massage, can also be therapeutic in grief.[31]

Counselling the pathological griever often involves actively helping him review the circumstances of the loss and "emotional reliving." [35] It is an active process of supportive confrontation clearly described by Volkan,[11] which can include looking at old photos, visits to cemeteries or childhood homes, and inclusion of other family members. It also may involve active counselling and advice to the bereaved to avoid precipitous and unwise decisions, such as moving away, alienating friends, or locking up the belongings of the deceased.[24]

By treating a grieving person as one who is depressed or in pathological grief (such as by intervening), natural healing processes could be inhibited. Such interventions as medications that cloud consciousness, confrontations however supportive, hospitalizations, and electroconvulsive therapy could convince the bereaved that their experience is pathological and they could be persuaded *not* to trust themselves. The suggestion or use of treatments appropriate for depression or pathological grief could deprive the grieving person of access to full awareness of his feelings and the associated significance of the loss, since any of these treatments suggest to the bereaved that the process he is experiencing is not natural. In addition, tricyclic antidepressants are contraindicated in grief,[8] as is the systematic use of any REM altering or suppressant drugs (such as most sedatives, major tranquilizers, barbiturates, amphetamines and alcohol)[36] that might alter the person's capacity to utilize dreaming in grief and that might also create a further stress in the person's life.

Many individuals who are grieving fear their unpredictable moods as signs of "craziness." As a result, they often avoid seeing mental health professionals. Yet they are likely to be seen by other professionals in the health care system.[37] Thus recognizing signs of normal grief in a patient seeing a physican for physical problems or in a medical hospital by a nurse or social worker may be a significant step in providing the necessary support and reassurance. Incorrect labeling and treating of grief as depression can inhibit, delay, or interrupt the mourning process.

On the other hand, treating severe depressive reactions as grief or providing simple support and availability to someone whose grief is of pathological proportions ignores the morbidity of the process that must be interrupted. Depression results when the feelings associated with a major loss have broken through the person's defenses (as in grief). At the same time there is a continuing denial or inability on the part of the person to acknowledge the loss or the need to grieve. Because of the helplessness and hopelessness of depression, these individuals frequently lack the necessary ego functions to permit grieving. Encouraging depressed individuals to trust their feelings when they are experiencing dejection, helplessness, hopelessness, and self-depreciation can be frightening. Although encouraging self-trust may be important in grief counselling, such an approach with the depressed person can also lead the helper to ignore important signs and symptoms, such as temporary mood elevation, or getting the house in order, which may be a sign that ambivalence has been resolved but in a way that suicide risk is increased.[38] Such facilitative techniques usually do not lead the care provider to look for a possible biological basis for the depression [28] or to actively treat this biological base vigorously [32] with monoamine inhibiting drugs and the tricyclic antidepressant drugs.

Treating pathological grief as normal grief reinforces the avoidance behaviors and permits the maintenance of dysfunctional behaviors. For example, to remain silent when a person discusses a deceased spouse in the present tense can be perceived by the pathologically bereaved as support for the belief that the spouse is still alive.

When dealing with the pathologically bereaved, the attitude of support and sympathy, which is effective in helping those who are grieving normally, creates in the supportive person stronger feelings of pain and helplessness than it does in the bereaved. Sympathetic grieving on the part of the helping professional can be

exhausting, discouraging, and even a source of irritation when it is realized that the pathologically bereaved reports no relief or no feelings.

Because it frequently is not clear whether the bereaved is in a period of normal mourning or depressed or in a state of pathological grief, it is important that the helping professional attend to the potential abnormality first. Grieving demands all the ego strength the individual can muster. When a person experiences a significant loss, the goal of the helping professionals is to help that person mobilize his strength to meet the challenge. Bowlby[39] summarizes well the needs of normal grief:

> Sadness is a normal and healthy response to any misfortune. Most, if not all, more intense episodes of sadness are elicited by the loss, or expected loss, either of a loved person or else of familiar and loved places or of social roles. A sad person knows who (or what) he has lost and yearns for his (or its) return. Furthermore, he is likely to turn for help and comfort to some trusted companion and somewhere in his mind to believe that with time and assistance he will be able to re-establish himself, if only in some small measure. Despite great sadness, hope may still be present. Should a sad person find no one helpful to whom he can turn, his hope will surely diminish; but it does not necessarily disappear. To re-establish himself entirely by his own efforts will be far more difficult; but it may not be impossible. His sense of competence and personal worth remains intact.

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