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Loss, Stress, and Mental Health

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Erich Lindemann in 1944 reported on a study of the adjustment process of a group of normal people who had just been involved in a fire in a Boston night club. In the fire and the panic that followed, many people were killed or injured by burning, asphyxiation or trampling. Most of the survivors were treated at the Massachusetts General Hospital of Harvard Medical School, where Lindemann and his psychiatric colleagues joined the surgeons in caring for them and for members of their families. Lindemann identified a dominant syndrome of normal grieving that seemed characteristic of those survivors whose loved ones had been killed, and that was minimally moulded by idiosyncratic personality factors. He also identified a subgroup of cases where this orderly pattern of grieving was not seen. He felt that in this latter group there was a defensive refusal to suffer the pain of grieving; and this appeared to be linked with the emergence of psychopathology or psychosomatic disease. Characteristic of his approach was his immediate application of his findings to work out ways of encouraging what he theorized to be healthy patterns of grieving, thereby interrupting the possible development of mental ill health resulting from the bereavement.

Lindemann spent the rest of his life studying the significance of maladaptive responses to bereavement in the etiology of mental disorder, and ways of organizing services to help people adjust to the death of those they loved in such a way that there would be no deterioration in

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their mental health. He particularly emphasized the role of community caregiving professionals, especially clergymen, in offering guidance and support to the bereaved.

In 1952 I came to Harvard University and joined forces with Lindemann. Since 1948 I had been working in Israel developing a similar approach to preventing mental disorder in a normal population by helping people grapple constructively with a current stressful situation that temporarily overtaxed their coping resources. I did my research with immigrants trying to adjust to a new country and culture, and with parents and children in prenatal and child welfare clinics, who were caught up in stressful life events. In our joint research at Harvard, we began to widen Lindemann's original focus beyond the possible pathogenic importance of bereavement, to include other significant episodes of stress that often upset people for a period of time, during which they may accomplish their adaptive work constructively and emerge mentally healthy, or, if they behave maladaptively, they are apt to develop psychopathology. Lindemann and I began to talk of these periods as "psychological crises," precipitated by "hazardous circumstances" that lead to a temporary upset in the normal homeostatic balance of forces that characterizes transactions between an individual and his environment. We thought of these crises as way stations that might shunt the individual toward either health or illness, and that would provide opportunities for intervenors, such as community professionals, to influence the outcome by guiding the individual to make use of productive ways of solving the crisis tasks.

As we studied such situations, we were impressed that during crisis, people become temporarily more dependent on others and more open to their influence; interventions at such times have a greater effect on them than when the individuals are in stable psychological equilibrium.

These findings led us to advocate programs to promote mental health in the community by providing services for people during crisis. We developed methods of "anticipatory guidance" to prepare people ahead of time to handle expectable crisis more effectively, and methods of "preventive intervention" to support them during the actual crisis period. We offered training to such community caregivers as clergymen, family doctors, public health nurses, welfare workers, and teachers to equip them with the skills to intervene constructively as a routine part of their daily practice whenever they identify that one of their clients is currently in crisis or is about to encounter a predictable hazardous event, such as a scheduled surgical operation or childbirth (Caplan, 1964).

We also developed sophisticated techniques of "mental health consultation" (Caplan, 1970) to help professionals master expectable burdens of involvement in this work, which is particularly demanding both cognitively and emotionally.

Over the following years, our studies focused on a number of common life predicaments, including the death of a spouse and the experiences of widowhood, the birth of a premature baby, the impact of pulmonary tuberculosis, and the upsets of normal pregnancy and delivery (Caplan, 1961, 1964). We tried to identify the generic features of these situations. Hazardous circumstances seemed to lead to psychological disequilibrium in many of the people exposed to them because their previous coping skills were not adequate to gain rapid mastery over the predicament. The hazards appeared to have in common a loss either of a loved person or of a source of essential psychosocial supplies or of bodily integrity, the threat of such a loss, or a challenge that promised greater psychosocial satisfactions but at increased cost in terms of the need for knowledge, skills and resources that were not currently available.

Colin Parkes of London's Tavistock Institute of Human Relations, where he worked with John Bowlby in his studies of attachment and loss (Bowlby, 1969, 1973, 1980), joined our Harvard team for a time to direct our research on widowhood. He developed a new formulation of our concepts in an effort to introduce greater precision (Parkes, 1970). He suggested replacing the terms "crisis" and "stress" by the term "Psychosocial transitions." He pointed out that in all the examples we had studied, as well as in similar stressful situations studied by other researchers, the essential element seemed to be a sudden change in the individual's "life space," i.e. in the physical world that was of direct significance to him. This change usually involved the loss by death or by rejection of a loved person, but also possibly the loss of home, job, status, money, or bodily integrity. Such a loss forces the individual to change his view of the world and of his place in it, what Parkes calls his "assumptive world," which includes not only his intrapsychic maps of external reality but also his internal guidance system for defining his aims in life and how to achieve them with the assets and within the constraints of his own capacities and resources. For Parkes, the crucial mental health element was how the individual manages to reorganize the pattern of his assumptive world in painfully giving up his now outdated ideas about his reality, and replacing them by new ideas that would lead to adopting new missions in life and new ways of behaving.

Further light has been thrown on our topic by a large body of research that has focused on the concept of "stress." Unfortunately, this term has

been used differently by many workers, who have not always clearly differentiated between its possible meaning as a physical stimulus, a bodily response, a psychological stimulus or response, or a physiological or psychological interactive process between a person and a changed situation in his physical or psychosocial environment. (Selye, 1956, 1975. Mason, 1975(a), 1975(b). Dohrenwend and Dohrenwend, 1974. Holmes and Masada, 1975, Burchfield, 1979). Despite this semantic confusion, these researchers have clarified a number of issues of direct relevance to today's discussion. These include the following:

1. One or more of a long list of specific biopsychosocial events or continuing states met currently or in the past by members of a particular population are associated with a higher frequency of psychopathology, a reduced sense of well-being, or a lowered capacity to study, work, love and play, than in a similar population that has not been so exposed (Caplan, 1986). This list includes natural disasters, such as floods and earthquakes (Tyhurst, 1957), pregnancy problems (Sontag, 1966), birth trauma (Minkowsky & Amiel-Tison, 1977), prematurity (Rubin et al, 1973), congenital anomalies (Lansdowne & Pollack, 1975), accidents (Jacobson, 1968), bodily illness (Mattesen, 1977), hospitalizations in childhood (Douglas, 1975), family discord or disruption by death or divorce (Rutter, 1976), parental mental illness (Anthony, 1974), poverty (Tarjan, 1970), and cultural deprivation and stigmatization (Willie et al., 1973).
2. The intensity and duration of such hazardous circumstances seem to influence the degree to which the incidence of psychopathology will be increased in the exposed population. For instance, concentration camp survivors, such as those studied by Shamai Davidson (Davidson, 1980a, 1980b), almost all suffer for the rest of their lives from chronic depression, and are likely to damage the mental health of their children and grandchildren by involving them in their own sense of helpless victimization, guilt, and forebodings of future inevitable doom.
3. Particularly harmful are distressing episodes or continuing privations that are felt to be entirely outside the control of the victims. This may induce a continuing feeling of helplessness and passive surrender, which may itself reduce adaptive competence. Research on "learned helplessness" in animals and humans (Seligman, 1975) shows that individuals exposed to intermittent painful stimulation that they can neither control nor predict become

chronically passive and inert, and do not struggle against a situation that they might otherwise be expected to master.

4. Apart from experiences of massive and devastating misfortune of long duration that also erode bodily competence, such as those suffered by concentration camp inmates, these biopsychosocial hazards lead to psychopathology in only a minority of the population exposed to them. The rest seem to suffer no noticeable ill effects, or may emerge from the experience even stronger than before. When individuals repeatedly master misfortune, they appear to develop a condition of learned fortitude and resilience to adversity that seems to be the opposite of "learned helplessness."

During the last fifteen years a number of researchers have tried to identify the reasons why part of a population exposed to misfortunes that would be expected to increase morbidity instead emerge from the experience unharmed or even strengthened (Caplan, 1986).

One factor that has received considerable attention is an enduring characteristic of certain individuals that makes them resilient in the face of adversity (Rutter, 1985). This characteristic has been termed "competence" (White, 1979). Individuals with high competence seem to glory in struggling against stressful situations or misfortunes. They seem to welcome the excitement of challenge and change, and to be able quickly to work out novel ways of confronting problems that can not be solved by their previous repertoire of coping skills. They have a high tolerance for the frustration and discomfort of the phase of disorganization that is an inevitable feature of a psychosocial transition, and they persevere in constructive grappling with the problems despite confusion.

Competence incorporates both constitutional and acquired elements. Some children seem more robust than others from birth, and so do some families; but of special interest to us are the acquired elements that are learned, and that therefore can be taught. These consist of two sets of factors. The first has been named "self-efficacy" (Caplan, 1986). This is a quality of the individual's self image that can be observed developing from infancy onwards, and that may continue to develop throughout life on the basis of experiences of overcoming adversity by successful coping. This quality centers on the individual's expectation that he will master any difficult situation by exerting personal effort and by obtaining the support of others. It also includes the conviction that he will persevere in grappling with a currently insoluble problem despite frustration, confusion, and physical or mental discomfort.

The second main feature of competence is a rich repertoire of effective skills for solving problems in the interpersonal and material world, as well as the ability to innovate and to invent novel ways of solving new problems for which existing skills seem inadequate.

Shure & Spivack (1987) have reviewed ten years of their experience in identifying and teaching such skills to preschool children. They have defined three major "Interpersonal Cognitive Problem Solving Skills," namely "Causal Thinking" (The child asks himself "why the problem came to be?"), "Alternative Solution Thinking" (The child asks himself "what are all the things a hypothetical child could do or say to solve the problem?"), and "Consequential Thinking" ("What might happen next if particular acts were carried out?") (Ibid, p. 130).

An additional factor that may be of even greater significance in determining which members of a population exposed to stressors will emerge unharmed from their ordeal is the operation of psychosocial supports. The epidemiologist, Cassel, reviewed several relevant studies both on animal and human populations (Cassel, 1974). A number of researchers have exposed a population of animals, such as rats, to rising stress that causes bodily and mental illness, through increasing population density in a confined colony, with all other relevant factors such as genetic stock, diet, temperature and sanitation, kept constant. In such experiments it is regularly reported that certain subgroups in the population appear immune to the increased morbidity that characterizes the others. The immune animals seem to be protected by being members of cohesive groups. Apparently the rise in general morbidity in a congested colony is linked not to overcrowding *per se,* but to the increased likelihood that animals in their daily journeys in search of food or drink will often encounter strangers whose social cues they do not recognize. They must therefore remain in a continual state of autonomic arousal to be prepared to fend off possible attacks. This leads to metabolic depletion that causes increased morbidity. Members of cohesive sub-groups apparently travel along particular paths that are kept safe by being regularly used by other members of their own group, and are less frequented by strangers. This provides a semi-private functional domain in which the protection of the group allows its members to relax, and thus to avoid the unremitting autonomic arousal that is pathogenic to other members of the colony.

In 1981 I published an article on the mastery of stress in which I reviewed a number of researches that indicated that if individuals exposed to various types of severe stress received psychosocial support

during the stress experience, they were likely to emerge relatively unharmed, in contrast to unsupported individuals exposed to the same type and intensity of stress who were likely to be psychologically damaged by the experience (Caplan, 1981). The stresses that were studied included the vicissitudes of old age, job loss, complications of pregnancy, severe asthmatic attacks, surgical operations such as hysterectomy, cholecystectomy and tonsillectomy, traumatic road accidents, and hospitalization for cardiac infarction. The findings of these studies were uniform: High stress in unsupported individuals significantly increases the risk of psychiatric sequelae, whereas similar levels of stress in similar individuals who were concomitantly supported by helpful individuals or groups did not result in psychopathology. As in the case of the animals in the experiments described by Cassel, membership in a supportive group seems to protect against stress-induced damage to mental health.

Before trying to understand how psychosocial support protects against the harmful effects of stress, let us consider some new insights that have emerged in recent years from our studies of crisis.

First, our most recent bereavement studies (Weiss, 1987) have helped us to realize that the duration of normal grieving is usually much longer than we thought at the time of the early Lindemann research. Then we believed that the crisis usually lasted only a month or two, and that by the end of this period a bereaved person could be expected to return to normal functioning if he did his grief work properly. Nowadays we realize that the pain caused by the loss of a spouse, for instance, usually continues at high intensity for a year or so, and then diminishes gradually, but with ups and downs, for a similar period. The readjustment period, during which the mourner eventually renews his capacity for normal functioning and for developing new stable attachments, overlaps the phase of painful acceptance of the loss, and usually takes a year or more to reach a level that permits really normal functioning. In the early stages after a loss, many bereaved persons are numbed and relatively unfeeling, and they use denial or emotionally detached withdrawal as a defense to distance themselves from a situation that they feel to be temporarily beyond their capacity to bear, until they feel that little by little they can confront the tragic reality. Such temporary strategic withdrawal is not to be regarded as a sign of abnormality, so long as it is given up within a few months, and does not lead into the syndrome of prolonged absence of grieving, originally described by Lindemann. Similar reactions of initial temporary strategic with-

drawal are found in other crises where the misfortune is massive and strikes suddenly and unexpectably, as with a natural disaster, a terrorist attack, or an unanticipated major illness.

Wallerstein & Kelly (1980) have reported that in their study of reactions of children to the divorce of their parents, they found that adolescents who used strategic withdrawal during the first months were among those who eventually made the healthiest adaptation to the breakup of their home.

The second finding in our research on widowhood was that, contrary to the expectations derived from our early studies, professional caregivers in fact play only a minor role in supporting the bereaved. In particular, widows report that they got little help from clergymen, who, unless they are among the very few who have been specially trained for such work, tend to become uncomfortable when called upon to maintain close contact for a long period with an actively grieving person. Instead, we discovered that widows report getting their most useful help and guidance from other widows, who offer continuing support for as long as is necessary on the basis of shared experience and mutual identification, and not as an occasional short professionalized intervention. This finding, which was replicated in our studies of other crises, particularly those associated with major illness, has influenced us to focus much of our intervention effort on fostering non-professional services through mutual help programs, such as widow-to-widow associations and mutual help groups of war orphans or of children of divorce. We began to appreciate the powerful influence of the supports by family members, neighbors, friends, and the so-called "natural helpers" in the community, namely, the untrained people of good will who help others in trouble on an informal basis; and we began to see one major contribution of the professional caregivers as enabling and promoting such types of helping (Caplan, 1974. Caplan & Killilea, 1976).

The third and most important set of findings relates to the nature of the crisis upset itself. We were originally impressed by the signs of distressing emotional arousal during a crisis. These are obtrusive: the sadness and anger, the feelings of emptiness, misery, anxiety, insecurity, guilt, shame, helplessness, and desperation of people in most crises. But gradually we began to realize that accompanying these vivid emotional expressions are cognitive changes of even greater significance (Caplan, 1981. Hansell, 1976). These take the form of a characteristic erosion of the stressed individual's customary cognitive and other problem-solving capacities, particularly his will to persevere with his adaptive efforts. The magnitude of this change appears to be related

to the intensity and duration of emotional arousal. The regularly occurring phenomena include reduced capacity for attention, scanning, information collection, access to relevant memories that associate meaning to perception, judgment, planning, implementation of plans, and evaluation of feedback to guide replanning (Hansell, 1976). This incapacity occurs precisely when it is most important for the individual to operate with maximum effectiveness in order to resolve the problems of his changed life situation.

I still have no clear understanding of the cause of this phenomenon; but the mainly cognitive deterioration may well be linked with the neuro-endocrine processes of distressing emotional arousal, which initially stimulate improved alertness and cognitive effectiveness, but when they rise above a fairly low threshold, cause increasing disorganization (Caplan, 1981).

In addition to the disorder of externally directed cognitive functioning, a person under stress also characteristically manifests a deterioration in the clarity of his self-concept. He not only loses orderly access to memories that lend meaning to perceptions of the outer world, but he also is not able to recall those memories that help him appreciate his own identity (Hansell, 1976).

Capacity for effective problem-solving action is much influenced by the individual's awareness of his identity that is linked with his expectation that he is likely to succeed in achieving at least part of his goals. He remembers that he was successful in the past in situations of similar difficulty, and that he had the fortitude to overcome attendant obstacles. This gives him the hope and the will to go forward.

We are now in a position to consider the mental health implications of psychosocial transitions. My recent thinking about this issue has been much influenced by John Bowlby's monumental work on Attachment Theory (Bowlby, 1969, 1973, 1980) and by the contributions of my colleagues at Harvard, particularly Colin Parkes (1970), Norris Hansell (1976) and Robert S. Weiss (1987).

The loss of an important attachment seems to involve three interlocking negative elements: (a) the psychic pain of the rupture in the bond and the agony of coming to terms with the loss; (b) the handicap of the missing assets and guidance that used to be forthcoming from the lost person or resource; and (c) the cognitive erosion and reduced problem-solving effectiveness linked with the distressing emotional arousal.

The intensity of these three elements will vary differentially over time, but the loss and its aftermath may well cause distress and reduce the individual's competence intermittently for a year or more. It is

likely to lead to a poor self-image and to a feeling of pessimism and helplessness, as the individual becomes preoccupied with his current incapacity. These feelings may have a degenerative vicious spiral effect by inhibiting the initiative to reorganize and rebuild the assumptive world on new foundations. They may also promote efforts to escape by the irrational pseudo-solutions of psychoneurotic symptoms. Or equally irrationally, the loss may be completely denied or repressed, in which case the individual will be chronically crippled, because neither in his inner assumptive world nor in the outer real world will he be impelled to replace or compensate for the lost attachment.

Another type of unhealthy outcome that is not uncommon is a state of chronic grieving (Weiss, 1987), in which the individual continues to be preoccupied with the pain of his loss, but in a ruminative way and without any movement toward resolution. This may be caused by his cognitive erosion rendering him ineffective not only in dealing with his external life problems but also with those of reordering his inner assumptive world; his chronic emotional distress reduces his cognitive capacity, and this in turn produces an awareness of ineffectuality and failure; failure that is further exacerbated by exhaustion that comes from his prolonged emotional arousal and its neuroendocrine accompaniments. Left to themselves it is well nigh impossible for people caught up in this vicious circle to pull themselves out of their self perpetuating hopeless ineffectiveness; and their efforts may be further hampered by the development of bodily malfunctioning linked with their high level of emotional tension. Moreover, it is not unusual for individuals caught up in such processes to become restless and to engage in meaningless overactivity in an attempt to release tension; and this adds further to their fatigue and ineffectuality.

How then do people initiate the intrapsychic activities that lead to the reorganization of their assumptive world and to the building of new attachments to replace those they have lost? Central to such an initiative is a feeling of hope that after coming to terms with the misery of the loss of the old attachment it will be possible to begin a new life.

The second element of the rebuilding phase consists of beginning regular activity that has meaning in its own right as a form of participation in ordinary living, even though to begin with it may feel like an empty process of going through the motions. Routine forms of everyday behavior, getting up on time and adhering to an orderly daily schedule of work and leisure activities, and eventually of social interaction, after a while become once again related to the accepted missions of life, and will find meaning as a personal contribution to achieving social goals.

In this connection, people who have an abiding commitment to a supra-personal ideology such as religion or social and political affiliations usually have an easier time investing meaning in routine activities that act as bridges in linking them to the larger social framework, within which they may eventually develop new individual attachments. For example, a religious Jew has to pray three times a day, and to pronounce a series of blessings in connection with all the details of daily living. Some of these rituals demand that he carry them out not alone, but in a congregation. Such a person acts within a religiously ordained framework that provides him with an orderly matrix that automatically links him with others. After a while this prepares him to re-invest his daily activities with meaning in regard also to his individual values and goals.

I have also been impressed by the importance of repeated acts of remembering the lost person or resource that is required by many religions, but may also be undertaken as a private matter. Despite being hampered by his stress-induced memory erosion, the individual manages through these acts of remembering to continue to relate, at least in thought, to his lost attachment object, whether person or system. In doing so he experiences some sense of personal mastery over his fate. Despite the pain that is aroused each time he revives a memory, because of the fresh realization of his actual loss in the real world, he nevertheless re-experiences a link with those abstract aspects of the attachment that are not dependent on current interaction. Thus he may feel that although, for instance, it is no longer possible for him actually to get advice on what to do, he can nevertheless imagine what the dead person would have been likely to say in such circumstances; he can recall his philosophy of life, his values, precepts and aphorisms, his sayings and his songs. Lindemann interpreted such acts of remembering as ways of coming to terms with the actuality of loss. I am emphasizing the other side of the coin, the maintenance of abstract links in spite of the concrete loss; on a psychological level, all is not, in fact, lost.

In extreme forms this process may be counter-productive, since it may lead to a complete denial of the death or of the loss of possessions, status, or bodily integrity; more usually the sufferer knows that he is replacing in thought what he has lost in reality, and this allows him to find an anchor for his renewed endeavours in memories of past situations and practices.

In the final analysis the individual has to rely on self-help in reorganizing his assumptive world, by what the Americans term "pulling himself up by his own bootstraps." Therefore, people who are in general

very competent may also be better able to withstand and overcome the deleterious effects of loss and stress. They have a deep faith in their own invincibility, and this enables them to persevere on the basis of their own efforts, regardless of outer obstacles or the absence of external buttresses. They also have developed a capacity to control their expressions of emotion in the face of adversity and to keep their feelings of distress within limits so that these do not unduly weaken their cognitive skills. Kurt Hahn (Hahn, 1958, 1967) in his Outward Bound training programs, has shown how this self control in situations of stress can be taught by progressive exposure of a trainee to a graduated series of increasing stresses and challenges, each of which is a little beyond his current capacities, while the trainee is at the same time given educational guidance and support. This allows him, step by step, to extend his adaptive capabilities. Such training also equips the individual with the skill to isolate his awareness of distress so that he restricts his conscious attention to dealing with the practical tasks of the stressful predicament; to climb the mountain without allowing himself to think about his fear of the abyss.

The other personal asset that characterizes highly resilient individuals is their ability to invoke and profit by the support of others in grappling with difficulties. They freely augment their own strengths, high though these may be, by recruiting external resources to complement and supplement their efforts. Paradoxically, the individuals with the greatest capacity for self-help often show the least reluctance to call for help from others. Their security in regard to their own autonomous strength frees them to ask for help and to profit from help without feeling that this is a sign of weakness. If external support is not available, they are very willing to struggle on their own, but if it is available they use it. What is the nature of this help?

In a series of publications, I and members of our Harvard group have examined in detail the operations of supportive individuals and groups, particularly natural helpers and members of non-professional mutual help organizations, who are reported by individuals undergoing psychosocial transitions to be the people they have found to be most helpful to them in their hour of need (Caplan, 1974, 1981, 1986. Caplan & Killilea, 1976).

We found that effective supporters usually do the following:

1. They incorporate the stressed individual into a concerned, warm, accepting group that gives him personalized nurturant attention. They bind him to their group by expressing understanding for his individual needs and by trying to satisfy these. The group

inculcates its ordered view of the world to dissipate the chaotic confusion of the psychosocial transition.
2. The supporters promote and maintain hope.
3. They encourage strategic withdrawal at peaks of stress, and at other times they foster the stressed person's problem-solving activity at a pace that is most comfortable to him; thus showing sensitivity to his level of tolerance of discomfort.
4. They offer detailed guidance on how best to deal with the predicament.
5. They act as a communication channel between him and his social surround, through the collection, interpretation and funneling of information in both directions.
6. They remind the individual of his own identity and of the fortitude he has shown in the past in struggling with difficulties despite current discomfort.
7. They help with tasks by providing material help and services.
8. They assist him to contain his feelings of distress by reassurance, comforting, and expressions of solidarity and acceptance.
9. They counteract fatigue by ensuring adequate rest periods.
10. They foster mutual support among family members, and they mobilize support by relatives, friends and community professionals.

In summary, the supporters supplement adaptive capacity by incorporating the stressed individual in a group that on a temporary basis makes up for the lost attachment. They bolster problem solving by replacing cognitive functions that have been eroded by emotional arousal, while at the same time counteracting this erosion by damping down the intensity of distressing feelings. They maintain hope as a spur to the will to continue the struggle. The supporters thus counteract all the elements associated with the responses to loss and stress that endanger mental health, and they contribute auxiliary resources that enable the individual in psychosocial transition to behave like a person who is competent and resilient.

PRACTICE IMPLICATIONS

Robert S. Weiss concludes his 1987 paper "Recovering from bereavement: Findings and issues": "Since Lindemann's paper was written (in 1944), we have learned a great deal about the nature and course of the recovery process . . . We cannot prevent loss . . . grief in response to loss

is an inescapable consequence of caring. We will not ever learn to prevent pain of loss, nor should we aim to do so. We can, however, better understand the grief the bereaved experience and improve our ability to help."

My daughter, Ruth Caplan-Moscovich, in 1976 in a paper, "Deathbed scenes and graveyard poetry," wrote of 18th century attitudes and practices among Christians, especially Non-conformists, as described in the English literature of the time. She showed that there was an effort to surround people on their deathbed by a group of believers, who supported and encouraged the dying person. This person, in turn, acted as a kind of leader and teacher who modelled for the group how to leave this world for the next in a meritorious, God-fearing way. In effect, the deathbed scene represented a mutual help group. The dying person was helped to die with dignity and in the hope for rewards in the world-to-come; and the group of believers received training and anticipatory guidance in how best eventually to meet their own inevitable end.

She ended her paper:

> Everyone dies, but everyone dies alone. The eighteenth-century writers on death sought to dispel that loneliness. In their writings, only villains die alone. The good are lapped about with company. They are helped, even drilled to face their own end, and in support of this, they have helped others to die. (Caplan, R.B., 1976).

The centrality of combating the loneliness of dying is shown equally in Jewish religious tradition. In a poignant prayer on the holiest day in our calendar we say "Cast us not off in old age; when our strength is ended do not forsake us." This prayer is addressed to the Almighty; but it is equally directed to our fellow Jews; and it is a religious duty for Jews to accompany the dead person to his final resting place as it is to participate in community rituals to console the bereaved. These rituals include detailed social prescriptions that enshrine the wisdom of the ages about effective ways of supporting the bereaved in their painful process of mourning, through its expectable succeeding stages.

Religious prescriptions and traditional practices provide a valuable framework that has in general stood the test of time. Can science in our day help us to develop guide-lines that may be more precisely relevant to modern secular life, and that are not necessarily wedded to particular systems of faith?

Over the past ten years I have been working in Jerusalem to confront this challenge, and I have succeeded in developing a series of new techniques designed for use by caregiving professionals who seek to

support people in mastering stressful life events and to help promote the activities of natural supporters.

I am currently publishing my findings in a book (Caplan, 1989, from which the following examples are taken:

One case I described was that of a 15 year-old son of immigrants from Kurdistan, who was about to have his right leg amputated because of sarcoma of the femur. I was called in by the social worker of the orthopedic ward on an emergency basis the day before the scheduled operation, because the surgeons had not yet told the boy what was about to happen. During the three days of his final diagnostic investigations in hospital he had been so rebellious and uncontrollable that they feared he would run away if they told him of the planned amputation. I advised the senior surgeon on duty to convene an emergency conference with the boy, his mother and some members of his family who were visiting him, together with all the doctors and nurses who could be spared from other ward duties; I took part in this meeting to guide and support the surgeon as he explained to the boy that there was no alternative but to begin at once a course of drastic treatment, which would include amputation of his leg, followed by chemotherapy and rehabilitation, as the only way to get rid of the tumor, which might otherwise kill him. The important message was that although the treatment would be very difficult for him, all the staff intended to help him cope, and they expected a good outcome. My role in this meeting was to validate by my presence its crucial importance, and to reassure the surgical and nursing staff that I would control any possible irrational outbursts by the boy.

The meeting lasted over an hour, which on a busy orthopedic ward was itself a sign that all of us regarded the issue of psychosocial support for the boy and his family to be of major importance; and that we were making a clear commitment to helping him in his impending ordeal. In fact, the immediate reaction of the patient was positive; he started by angrily rejecting the treatment and by threatening to run away, but as he began to appreciate the steadfastness and the solicitude of the group, he quieted down and started to stroke his leg and weep, as the first steps in his mourning process.

His mother was a widow, her husband having died of heart disease three years earlier, so after the meeting I arranged for an emergency call to be made to secure the release of his older brother from his army unit to share with his mother a vigil at the boy's bedside during the next few weeks. When the brother arrived that evening, I organized a roster system to allow him and the mother alternately to get away from

the hospital to rest. And since their home was several hours distant, and they had no local friends or relatives, I asked the social worker to arrange for people in the Jerusalem Kurdish community to invite the mother to lodge with them when she could be spared from the hospital.

During the following four weeks of the acute treatment program, I visited the boy briefly, 2–4 times every day; on each visit I talked not only to him and his relatives but also to the medical and nursing staff, from whom I obtained an updated report on his progress that I interpreted to the boy with an emphasis on its hopeful aspects. I stimulated the development of a warm, solicitous, quasi-child-parent relationship between the boy and myself, and I also arranged for a young student nurse to be assigned to him. She followed the case when the patient moved from orthopedics to oncology and later to the rehabilitation department, where he was fitted for a prosthesis and had his first lessons in walking with a temporary artificial leg. When the boy felt well enough, she took him for rides in his wheel chair along the hospital corridors, and to have coffee with her in the cafeteria.

When the time approached for the boy to begin his chemotherapy, which was of the type that causes agonizing nausea and vomiting, I intensified our supportive contacts. In particular, I urged the mother and brother to overcome their reluctance to stay in his room and hold him close while he was vomiting. I alerted the oncologists to the need to give the boy anticipatory guidance about his impending loss of hair. He got more upset about the latter than he had been since being told that his leg was to be amputated; nobody could convince him that his baldness would be a temporary phenomenon and that his luxuriant head of hair of which he was very proud, would eventually grow back. So I asked the physiotherapist to bring in a youth who had in the past had a leg amputated for malignancy, and she recruited a 17 year-old who had been successfully rehabilitated after a similar operation two years earlier. This young man readily agreed to help, and he quickly established an intense mutual help relationship with our patient. The older boy provided a living demonstration that hair does grow back after chemotherapy, and that it is possible to walk well on an artificial leg, and to return to school and undertake a wide range of normal social activities. This mutual help couple was based on mutual identification. Our patient saw in the older boy how one could expect to emerge at the end of the ordeal, and was able to question him about the details of what lay ahead and how one might deal with the problems involved. The older boy identified with our patient's feelings of passive helplessness and was able to re-experience vicariously the state he himself had

been in two years previously, but with the knowledge that he had weathered the storm and that now as the veteran preceptor he was a role model of active mastery, which reinforced his own feelings of confidence and pride.

It is of interest that when our patient returned to the hospital for an oncological check-up a year after his discharge and sought me out to report with satisfaction how well he had done, he told me that two things had been of particular help to him during his hospital treatment. First was the support he had received from the older boy because of the authenticity of his guidance, which our former patient told me had carried more weight with him than the pronouncements of all the high status professional experts. Second was the relationship he had built up with the student nurse, with whom he had regularly exchanged personal letters since his discharge. Her continued interest in him apparently reassured him that losing his leg and for a time his hair had not damaged his masculinity and his sexual attractiveness.

My intervention in this case might have been considered by an unsophisticated observer to have been just a spontaneous form of traditional "tender loving care," but actually in all its details it was guided by a pre-planned set of professional supportive techniques based on the considerations discussed earlier in this lecture.

Participants in the International Conference of Grief and Bereavement held three years ago in Tel Aviv may remember that I gave a lecture there in which I described similar techniques that I used in supporting the parents of a 5-year-old child who died in hospital following an operation for a brain tumor. In my book's final chapter I report on supportive techniques I have been using during the past three years in a community-based program to prevent psychological and social disorder in the children of divorcing parents.

During the three years, I have dealt with 247 divorcing couples and their 644 children under the age of 18. These cases have been referred by a network of agencies and professionals, such as divorce courts, welfare agencies, family doctors, teachers, and psychologists, a network I have built-up by canvassing or by giving lectures and seminars. Many parents have come to me on their own after reading about my work in the newspapers or hearing me talk on the radio, or after learning about our center from former clients. Analysis of the information I have accumulated from parents has enabled me to identify a number of specific sources of stress that plague many children during and after family breakup.

These stressors include efforts by parents to persuade the children to

side with one against the other, conflicts of interest between parents and children about breaking up the home, distorted communication between parents and children, children taking sides in parental conflicts especially if this leads them to rejecting one of the parents, abandonment of the children by a parent, the problems of a one-parent home, loss of family income after divorce, residential mobility, and the stigma felt by children of divorce. These stressors add up to the loss by the children of their basic source of security in a stable home where they are assured of a loving father and mother who can be relied upon to care for them and help them grow up. Of particular significance for their mental health is that because of the circumstances of divorce and its sequelae, the parents are likely to be so preoccupied by their marital conflicts or so burdened by depression because of the failure of their marriage that they may not be physically or psychologically available to offer the psychosocial support to their children that will protect them against the harmful effects of this stress. The combination of high stress and low parental psychosocial support significantly increases the risk of disorder in the children.

I have developed a number of techniques to remedy this situation by promoting supportive services to the parents and their children. One of my methods is to provide guide lines to parents who are contemplating divorce on how to prepare their children for what is about to happen and how to support them in facing their difficulties. Built into these guide lines is a series of detailed suggestions designed to reduce or buffer the commonly occurring sources of stress in the children. I use a two-page pamphlet to supplement my counselling; and eventually I hope that this will be handed out by the courts to all parents seeking divorce. This will provide official sanction for the guide lines. The deliberations leading to obtaining this sanction should also affect the thinking of the judges, and through them of divorce lawyers, who will be obliged to pay more attention than in the past to the needs of children embroiled in the divorce process.

This guidance program for the parents is mainly designed to help them focus special attention on supporting their children despite the parents' preoccupation with their marital problems. By offering them specific guidance and an orderly system of how to help, they are likely to feel more confident because they know that what they do has the backing of high status experts. I have also stimulated the caregivers of the community to enmesh parents and children in a supportive network, and I have offered systematic training to family doctors and welfare workers to provide them with the necessary knowledge and

skills to accomplish this. In addition, I have organized a mutual help group of divorced parents, and hope shortly to stimulate the initiation of mutual help among the children. I am currently identifying those children among my cases who are coping well; and several of these have already agreed to work as members of mutual help couples or as leaders of an organization in which they will act as role models.

All these efforts add up to building a widespread system of community supports so that divorcing parents and their children will no longer feel lonely, confused, and ashamed, but in the words of my daughter, Ruth, "lapped about with company" (Ibid p. 175) that will accept them, guide them, and help them to master their problems in a healthy way.

Finally, I hope that today's lecture, which has described the development of our thinking over the past forty years, has shown how we have progressed from global concepts about bereavement and grieving to precise ideas about mechanisms connecting loss with changes in mental health. These ideas have provided a rationale for innovating techniques of intervention. We are currently using these techniques in a variety of psychosocial transitions, and are trying them out in several different settings. We are also describing the techniques in sufficient detail that they can be replicated by other workers. We should soon be in a position to evaluate them as a basis for further refinement and for advocating the widespread use of those of the techniques that are shown to be effective.

SUMMARY

1. The loss of an attachment to a loved person or of some other significant attachment leads to a prolonged period of distress and disability.
2. The upset feelings are usually associated with reduction in cognitive effectiveness and problem-solving capacity, the magnitude of which is dependent on the intensity and duration of emotional arousal. There is a reduced capacity for collecting and processing information and for access to relevant memories that associate significant meaning to perceptions. There is also a deterioration in the clarity of the person's self-concept and in his capacity to assess his ability to persevere in the face of discomfort, which weakens his will to struggle.
3. The disability following loss of an attachment is the product of three interlocking factors: (a) the pain of the rupture in the bond

and the agony of coming to terms with this reality, (b) the handicapping privation of the missing assets previously derived from the lost person or resource, and (c) the cognitive erosion and reduction in problem-solving capacities and of the will to persevere.

4. These factors may lead to poor mental health in the form of an acute adjustment disorder, or else of chronic psychopathology if the individual uses maladaptive ways of trying to escape his burdens through alienation from reality or through the irrational mechanisms of psychoneurotic symptoms, or if prolonged emotional tension leads to malfunctioning of a bodily system. On the other hand, if the individual masters his problems by working out ways of effective coping, he may emerge from the experience with increased competence and resilience.
5. Eventual mastery of the burdensome experience involves reorganization of the individual's "assumptive world," namely of his intrapsychic maps of external reality and his internal system for guiding and motivating his behavior, which have been disorganized by the loss of their anchorage in the ruptured attachment.
6. This reorganization is helped by the following:
   a. The maintenance of hope of eventual personal mastery that provides a basis for continued striving.
   b. Regular activity through adhering to a daily schedule of work and social interaction, even though this initially provides little emotional satisfaction and seems empty and meaningless.
   c. Seeking support from other people in compensating for current deficits and in helping lower the intensity of emotional arousal.
   d. Repeatedly remembering the values and guidance the person used to derive from the old attachments.
   e. Asserting and reinforcing continuing ideological commitments or wider social allegiances that in themselves provide anchors and incentives for behavior, and are not dependent on the lost attachments.
7. An individual who is highly competent incorporates within his personality enduring traits that facilitate these mechanisms of mastery. In addition, he has usually learned to control upset feelings so that his distressing emotional arousal is kept within bounds and does not reduce unduly his problem solving capacity; he also has usually developed the skill of concentrating on specific tasks and keeping disturbing feelings out of his awareness when emergency action is needed.

8. The over-riding factor in influencing the mental health outcome of loss of an essential attachment is the operation of adequate psychosocial supports during the experience. Irrespective of his personality assets, an individual who benefits from such current support is likely to emerge from the psychosocial transition with unimpaired or enhanced mental health. The most significant supporters are not professionals. They include family, friends, neighbours, and informal or natural helpers. These people supplement adaptive capacity by incorporating the individual in a group that combats loneliness and that on a temporary basis makes up for the lost attachment. They bolster problem-solving by replacing cognitive functions that have been eroded by the stressful experience, while at the same time counteracting this erosion by damping down emotional arousal, and they maintain hope, which fuels the will to continue the struggle. They thus counteract the elements that endanger mental health and contribute auxiliary resources that enable the stressed individual to behave like a person who is highly competent and resilient.
9. By copying the operations of such natural supporters it may be possible to develop methods of fostering a mentally healthy outcome in individuals who lose essential attachments.

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