

Erich Lindemann

Symptomatology and Management of Acute Grief

Introduction

At first glance, acute grief would not seem to be a medical or psychiatric disorder in the strict sense of the word but rather a normal reaction to a distressing situation. However, the understanding of reactions to traumatic experiences whether or not they represent clear-cut neuroses has become of ever-increasing impor-

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tance to the psychiatrist. Bereavement or the sudden cessation of social interaction seems to be of special interest because it is often cited among the alleged psychogenic factors in psychosomatic disorders. The enormous increase in grief reactions due to war casualties, furthermore, demands an evaluation of their probable effect on the mental and physical health of our population.

The points to be made in this paper are as follows:

1. Acute grief is a definite syndrome with psychological and somatic symptomatology.

2. This syndrome may appear immediately after a crisis; it may be delayed; it may be exaggerated or apparently absent.

3. In place of the typical syndrome there may appear distorted pictures, each of which represents one special aspect of the grief syndrome.

4. By appropriate techniques these distorted pictures can be successfully transformed into a normal grief reaction with resolution.

Our observations comprise 101 patients. Included are (1) psychoneurotic patients who lost a relative during the course of treatment, (2) relatives of patients who died in the hospital, (3) bereaved disaster victims (Cocanut Grove Fire) and their close relatives, (4) relatives of members of the armed forces.

The investigation consisted of a series of psychiatric interviews. Both the timing and the content of the discussions were recorded. These records were subsequently analyzed in terms of the symptoms reported and of the changes in mental status observed progressively through a series of interviews. The psychiatrist avoided all suggestions and interpretations until the picture of symptomatology and spontaneous reaction tendencies of the patients had become clear from the records. The somatic complaints offered important leads for objective study

Symptomatology of Normal Grief

The picture shown by persons in acute grief is remarkably uniform. Common to all is the following syndrome: sensations of somatic distress occurring in waves lasting from twenty minutes to an hour at a time, a feeling of tightness in the throat, choking with lack of breath, need for sighing, and an empty feeling of lack of muscular power, and an intense subjective distress as tension or mental pain. The patient soon learns to

of discomfort can be precipitated by visits, by mentioning the deceased, and by receiving sympathy. There is a tendency to avoid the syndrome at any cost, to refuse visits lest they should precipitate the reaction, and to keep deliberately from thought all references to the deceased.

The striking features are (1) the marked tendency to sighing respiration; this respiratory disturbance was most conspicuous when the patient was made to discuss his grief. (2) The complaint about lack of strength and exhaustion is universal and is described as follows: "It is almost impossible to climb up a stairway." "Everything I lift seems so heavy." "The slightest effort makes me feel exhausted." "I can't walk to the corner without feeling exhausted." (3) Digestive symptoms are described as follows: "The food tastes like sand." "I have no appetite at all." "I stuff the food down because I have to eat." "My saliva won't flow." "My abdomen feels hollow." "Everything seems slowed up in my stomach."

The sensorium is generally somewhat altered. There is commonly a slight sense of unreality, a feeling of increased emotional distance from other people (sometimes they appear shadowy or small), and there is intense preoccupation with the image of the deceased. A patient who lost his daughter in the Cocoanut Grove disaster visualized his girl in the telephone booth calling for him and was much troubled by the loudness with which his name was called by her and was so vividly preoccupied with the scene that he became oblivious of his surroundings. A young navy pilot lost a close friend; he remained a vivid part of his imagery, not in terms of a religious survival but in terms of an imaginary companion. He ate with him and talked over problems with him, for instance, discussing with him his plan of joining the Air Corps. Up to the time of the study, six months later, he denied the fact that the boy was no longer with him. Some patients are much concerned about this aspect of their grief reaction because they feel it indicates approaching insanity.

Another strong preoccupation is with feelings of guilt. The bereaved searches the time before the death for evidence of failure to do right by the lost one. He accuses himself of negligence and exaggerates minor omissions. After the fire disaster the central topic of discussion for a young married woman was the fact that her husband died after he left her following a quarrel, and of a young man whose wife died, that he fainted too soon to save her.

In addition, there is often disconcerting loss of warmth in relationship to other people, a tendency to respond with irritability and anger, a wish not to be bothered by others at a time when friends and relatives make a special effort to keep up friendly relationships.

These feelings of hostility, surprising and quite inexplicable to the patients, disturbed them and again were often taken as signs of approaching insanity. Great efforts are made to handle them, and the result is often a formalized, stiff manner of social interaction.

The activity throughout the day of the severely bereaved person shows remarkable changes. There is no retardation of action and speech; quite to the contrary, there is a push of speech, especially when talking about the deceased. There is restlessness, inability to sit still, moving about in an aimless fashion, continually searching for something to do. There is, however, at the same time, a painful lack of capacity to initiate and maintain organized patterns of activity. What is done is done with lack of zest, as though one were going through the motions. The bereaved clings to the daily routine of prescribed activities; but these activities do not proceed in the automatic, self-sustaining fashion which characterizes normal work but have to be carried on with effort, as though each fragment of the activity became a special task. The bereaved is surprised to find how large a part of his customary activity was done in some meaningful relationship to the deceased and has now lost its significance. Especially the habits of social interaction—meeting friends, making conversation, sharing enterprises with others—seem to have been lost. This loss lends to a strong dependency on anyone who will stimulate the bereaved to activity and serve as the initiating agent.

These five points—(1) somatic distress, (2) preoccupation with the image of the deceased, (3) guilt, (4) hostile reactions, and (5) loss of patterns of conduct—seem to be pathognomonic for grief. There may be added a sixth characteristic, shown by patients who border on pathological reactions, which is not so conspicuous as the others but nevertheless often striking enough to color the whole picture. This is the appearance of traits of the deceased in the behavior of the bereaved, especially symptoms shown during the last illness, or behavior which may have been shown at the time of the tragedy. A bereaved person is observed or finds himself walking in the manner of his deceased father. He looks in the mirror and believes that his face appears just like that of the de-

ceased. He may show a change of interests in the direction of the former activities of the deceased and may start enterprises entirely different from his former pursuits. A wife who lost her husband, an insurance agent, found herself writing to many insurance companies offering her services with somewhat exaggerated schemes. It seemed a regular observation in these patients that the painful preoccupation with the image of the deceased described above was transformed into preoccupation with symptoms or personality traits of the lost person, but now displaced to their own bodies and activities by identification.

Course of Normal Grief Reactions

The duration of a grief reaction seems to depend upon the success with which a person does the *grief work*, namely, emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships. One of the big obstacles to this work seems to be the fact that many patients try to avoid the intense distress connected with the grief experience and to avoid the expression of emotion necessary for it. The men victims after the Coconut Grove fire appeared in the early psychiatric interviews to be in a state of tension with tightened facial musculature, unable to relax for fear they might "break down." It required considerable persuasion to yield to the grief process before they were willing to accept the discomfort of bereavement. One assumed a hostile attitude toward the psychiatrist, refusing to allow any references to the deceased and rather rudely asking him to leave. This attitude remained throughout his stay on the ward, and the prognosis for his condition is not good in the light of other observations. Hostility of this sort was encountered on only occasional visits with the other patients. They became willing to accept the grief process and to embark on a program of dealing in memory with the deceased person. As soon as this became possible there seemed to be a rapid relief of tension and the subsequent interviews were rather animated conversations in which the deceased was idealized and in which misgivings about the future adjustment were worked through.

Examples of the psychiatrist's role in assisting patients in their readjustment after bereavement are contained in the following case histories. The first shows a very successful readjustment.

A woman, aged 40, lost her husband in the fire. She had a history of good adjustment previously. One child, ten years old. When she heard about her husband's death she was extremely depressed, cried bitterly, did not want to live, and for three days showed a state of utter dejection.

When seen by the psychiatrist, she was glad to have assistance and described her painful preoccupation with memories of her husband and her fear that she might lose her mind. She had a vivid visual image of his presence, picturing him as going to work in the morning and herself as wondering whether he would return in the evening, whether she could stand his not returning, then, describing to herself how he does return, plays with the dog, receives his child, and gradually tried to accept the fact that he is not there any more. It was only after ten days that she succeeded in accepting his loss and then only after having described in detail the remarkable qualities of her husband, the tragedy of his having to stop his activities at the pinnacle of his success, and his deep devotion to her.

In the subsequent interviews she explained with some distress that she had become very much attached to the examiner and that she waited for the hour of his coming. This reaction she considered disloyal to her husband but at the same time she could accept the fact that it was a hopeful sign of her ability to fill the gap he had left in her life. She then showed a marked drive for activity, making plans for supporting herself and her little girl, mapping out the preliminary steps for resuming her old profession as secretary, and making efforts to secure help from the occupational therapy department in reviewing her knowledge of French.

Her convalescence, both emotional and somatic, progressed smoothly, and she made a good adjustment immediately on her return home.

A man of 52, successful in business, lost his wife, with whom he had lived in happy marriage. The information given him about his wife's death confirmed his suspicions of several days. He responded with a severe grief reaction, with which he was unable to cope. He did not want to see visitors, was ashamed of breaking down, and asked to be permitted to stay in the hospital on the psychiatric service, when his physical condition would have permitted his discharge, because he wanted

further assistance. Any mention of his wife produced a severe wave of depressive reaction, but with psychiatric assistance he gradually became willing to go through this painful process, and after three days on the psychiatric service he seemed well enough to go home.

He showed a high rate of verbal activity, was restless, needed to be occupied continually, and felt that the experience had whipped him into a state of restless overactivity.

As soon as he returned home he took an active part in his business, assuming a post in which he had a great many telephone calls. He also took over the role of amateur psychiatrist to another bereaved person, spending time with him and comforting him for his loss. In his eagerness to start anew, he developed a plan to sell all his former holdings, including his house, his furniture, and giving away anything which could remind him of his wife. Only after considerable discussion was he able to see that this would mean avoiding immediate grief at the price of an act of poor judgment. Again he had to be encouraged to deal with his grief reactions in a more direct manner. He has made a good adjustment.

With eight to ten interviews in which the psychiatrist shares the grief work, and with a period of from four to six weeks, it was ordinarily possible to settle an uncomplicated and undistorted grief reaction. This was the case in all but one of the 13 Coconut Grove fire victims.

Morbid Grief Reactions

Morbid grief reactions represent distortions of normal grief. The conditions mentioned here were transformed into "normal reactions" and then found their resolution.

DELAY OF REACTION

The most striking and most frequent reaction of this sort is *delay* or *postponement*. If the bereavement occurs at a time when the patient is confronted with important tasks and when there is necessity for maintaining the morale of others, he may show little or

no reaction for weeks or even much longer. A brief delay is described in the following example.

A girl of 16 lost both parents and her boy friend in the fire and was herself burned severely, with marked involvement of the lungs. Throughout her stay in the hospital her attitude was that of cheerful acceptance without any sign of adequate distress. When she was discharged at the end of three weeks she appeared cheerful, talked rapidly, with a considerable flow of ideas, seemed eager to return home to assume the role of parent for her two younger siblings. Except for slight feelings of "loneliness" she complained of no distress.

This period of griefless acceptance continued for the next two months, even when the household was dispersed and her younger siblings were placed in other homes. Not until the end of the tenth week did she begin to show a true state of grief with marked feelings of depression, intestinal emptiness, tightness in her throat, frequent crying, and vivid preoccupation with her deceased parents.

That this delay may involve years became obvious first by the fact that patients in acute bereavement about a recent death may soon upon exploration be found preoccupied with grief about a person who died many years ago. In this manner a woman of 38, whose mother had died recently and who had responded to the mother's death with a surprisingly severe reaction, was found to be but mildly concerned with her mother's death but deeply engrossed with unhappy and perplexing fantasies concerning the death of her brother, who died twenty years ago under dramatic circumstances from metastasizing carcinoma after amputation of his arm had been postponed too long. The discovery that a former unresolved grief reaction may be precipitated in the course of the discussion of another recent event was soon demonstrated in psychiatric interviews by patients who showed all the traits of a true grief reaction when the topic of a former loss arose.

The precipitating factor for the delayed reaction may be a deliberate recall of circumstances surrounding the death or may be a spontaneous occurrence in the patient's life. A peculiar form of this is the circumstance that a patient develops the grief reaction at the time when he himself is as old as the person who died.

For instance, a railroad worker, aged 42, appeared in the psychiatric clinic with a picture which was undoubtedly a grief reaction for which he had no explanation. It turned out that when he was 22, his mother, then 42, had committed suicide.

DISTORTED REACTIONS

The delayed reactions may occur after an interval which was not marked by any abnormal behavior or distress, but in which there developed an *alteration* in the patient's *conduct* perhaps not conspicuous or serious enough to lead him to a psychiatrist. These alterations may be considered as the surface manifestations of an unresolved grief reaction, which may be classified as follows: (1) *overactivity without a sense of loss*, rather with a sense of well-being and zest, the activities being of an expansive and adventurous nature and bearing semblance to the activities formerly carried out by the deceased, as described above; (2) *the acquisition of symptoms belonging to the last illness of the deceased*. This type of patient appears in medical clinics and is often labeled hypochondriacal or hysterical. To what extent actual alterations of physiological functions occur under these circumstances will have to be a field of further careful inquiry. I owe to Dr. Chester Jones a report about a patient whose electrocardiogram showed a definite change during a period of three weeks, which started two weeks after the time her father died of heart disease.

While this sort of symptom formation "by identification" may still be considered as conversion symptoms such as we know from hysteria, there is another type of disorder doubtlessly presenting (3) a recognized *medical disease*, namely, a group of psychosomatic conditions, predominantly ulcerative colitis, rheumatoid arthritis, and asthma. Extensive studies in ulcerative colitis have produced evidence that 33 out of 41 patients with ulcerative colitis developed their disease in close time relationship to the loss of an important person. Indeed, it was this observation which first gave the impetus for the present detailed study of grief. Two of the patients developed bloody diarrhea at funerals. In the others it developed within a few weeks after the loss. The course of the ulcerative colitis was strikingly benefited when this grief reaction was resolved by psychiatric technique.

At the level of social adjustment there often occurs a conspicuous (4) *alteration in relationship to friends and relatives*. The patient

feels irritable, does not want to be bothered, avoids former social activities, and is afraid he might antagonize his friends by his lack of interest and his critical attitudes. Progressive social isolation follows, and the patient needs considerable encouragement in re-establishing his social relationships.

While overflowing hostility appears to be spread out over all relationships, it may also occur as (5) *furios hostility against specific persons*; the doctor or the surgeon is accused bitterly for neglect of duty and the patient may assume that foul play has led to the death. It is characteristic that while patients talk a good deal about their suspicions and their bitter feelings, they are not likely to take any action against the accused, as a truly paranoid person might do.

(6) Many bereaved persons struggled with much effort against these feelings of hostility, which to them seem absurd, representing a vicious change in their characters and to be hidden as much as possible. Some patients succeed in hiding their hostility but become wooden and formal, with affectivity and conduct *resembling schizophrenic pictures*. A typical report is this, "I go through all the motions of living. I look after my children. I do my errands. I go to social functions, but it is like being in a play; it doesn't really concern me. I can't have any warm feelings. If I were to have any feelings at all I would be angry with everybody." This patient's reaction to therapy was characterized by growing hostility against the therapist, and it required considerable skill to make her continue interviews in spite of the disconcerting hostility which she had been fighting so much. The absence of emotional display in this patient's face and actions was quite striking. Her face had a masklike appearance, her movements were formal, stilted, robotlike, without the fine play of emotional expression.

(7) Closely related to this picture is a *lasting loss of patterns of social interaction*. The patient cannot initiate any activity, is full of eagerness to be active—restless, can't sleep—but throughout the day he will not start any activity unless "primed" by somebody else. He will be grateful at sharing activities with others but will not be able to make up his mind to do anything alone. The picture is one of lack of decision and initiative. Organized activities along social lines occur only if a friend takes the patient along and shares the activity with him. Nothing seems to promise reward; only the ordinary activities of the day are carried on, and these in a

routine manner, falling apart into small steps, each of which has to be carried out with much effort and without zest.

(8) There is, in addition, a picture in which a patient is active but in which most of his activities attain a coloring which is *detrimental to his own social and economic existence*. Such patients with uncalled-for generosity, give away their belongings, are easily lured into foolish economic dealings, lose their friends and professional standing by a series of "stupid acts," and find themselves finally without family, friends, social status, or money. This protracted self-punitive behavior seems to take place without any awareness of excessive feelings of guilt. It is a particularly distressing grief picture because it is likely to hurt other members of the family and drag down friends and business associates.

(9) This leads finally to the picture in which the grief reaction takes the form of a straight *agitated depression* with tension, agitation, insomnia, feelings of worthlessness, bitter self-accusation, and obvious need for punishment. Such patients may be dangerously suicidal.

A young man aged 32 had received only minor burns and left the hospital apparently well on the road to recovery just before the psychiatric survey of the disaster victims took place. On the fifth day he had learned that his wife had died. He seemed somewhat relieved of his worry about her fate; impressed the surgeon as being unusually well controlled during the following short period of his stay in the hospital.

On January 1st he was returned to the hospital by his family. Shortly after his return home he had become restless, did not want to stay at home, had taken a trip to relatives trying to find rest, had not succeeded, and returned home in a state of marked agitation, appearing preoccupied, frightened, and unable to concentrate on any organized activity. The mental status presented a somewhat unusual picture. He was restless, could not sit still or participate in any activity on the ward. He would try to read, drop it after a few minutes, or try to play pingpong, give it up after a short time. He would try to start conversations, break them off abruptly, and then fall into repeated murmured utterances: "Nobody can help me. When is it going to happen? I am doomed, am I not?" With great effort it was possible to establish enough rapport to

carry on interviews. He complained about his feeling of extreme tension, inability to breathe, generalized weakness and exhaustion, and his frantic fear that something terrible was going to happen. "I'm destined to live in insanity or I must die. I know that it is God's will. I have this awful feeling of guilt." With intense morbid guilt feelings, he reviewed incessantly the events of the fire. His wife had stayed behind. When he tried to pull her out, he had fainted and was shoved out by the crowd. She was burned while he was saved. "I should have saved her or I should have died too." He complained about being filled with an incredible violence and did not know what to do about it. The rapport established with him lasted for only brief periods of time. He then would fall back into his state of intense agitation and muttering. He slept poorly even with large sedation. In the course of four days he became somewhat more composed, had longer periods of contact with the psychiatrist, and seemed to feel that he was being understood and might be able to cope with his morbid feelings of guilt and violent impulses. On the sixth day of his hospital stay, however, after skillfully distracting the attention of his special nurse, he jumped through a closed window to a violent death.

If the patient is not conspicuously suicidal, it may nevertheless be true that he has a strong desire for painful experiences, and such patients are likely to desire shock treatment of some sort, which they picture as a cruel experience, such as electrocution might be.

A 28-year-old woman, whose 20-month-old son was accidentally smothered, developed a state of severe agitated depression with self-accusation, inability to enjoy anything, hopelessness about the future, overflow of hostility against the husband and his parents, also with excessive hostility against the psychiatrist. She insisted upon electric-shock treatment and was finally referred to another physician who treated her. She responded to the shock treatments very well and felt relieved of her sense of guilt.

It is remarkable that agitated depressions of this sort represent only a small fraction of the pictures of grief in our series.

Prognostic Evaluation

Our observations indicate that to a certain extent the type and severity of the grief reaction can be predicted. Patients with obsessive personality make-up and with a history of former depressions are likely to develop an agitated depression. Severe reactions seem to occur in mothers who have lost young children. The intensity of interaction with the deceased before his death seems to be significant. It is important to realize that such interaction does not have to be of the affectionate type; on the contrary, the death of a person who invited much hostility, especially hostility which could not be well-expressed because of his status and claim to loyalty, may be followed by a severe grief reaction in which hostile impulses are the most conspicuous feature. Not infrequently the person who passed away represented a key person in a social system, his death being followed by disintegration of this social system and by a profound alteration of the living and social conditions for the bereaved. In such cases readjustment presents a severe task quite apart from the reaction to the loss incurred. All these factors seem to be more important than a tendency to react with neurotic symptoms in previous life. In this way the most conspicuous forms of morbid identification were found in persons who had no former history of a tendency to psychoneurotic reactions.

Management

Proper psychiatric management of grief reactions may prevent prolonged and serious alterations in the patient's social adjustment, as well as potential medical disease. The essential task facing the psychiatrist is that of sharing the patient's grief work, namely, his efforts at extricating himself from the bondage to the deceased and at finding new patterns of rewarding interaction. It is of the greatest importance to notice that not only over-reaction but under-reaction of the bereaved must be given attention, because delayed responses may occur at unpredictable moments and the dangerous distortions of the grief reaction, not conspicuous at first, may be quite destructive later and these may be prevented.

Religious agencies have led in dealing with the bereaved. They have provided comfort by giving the backing of dogma to the patient's wish for continued interaction with the deceased, have devel-

oped rituals which maintain the patient's interaction with others, and have counteracted the morbid guilt feelings of the patient by Divine Grace and by promising an opportunity for "making up" to the deceased at the time of a later reunion. While these measures have helped countless mourners, comfort alone does not provide adequate assistance in the patient's grief work. He has to review his relationships with the deceased, and has to become acquainted with the alterations in his own modes of emotional reaction. His fear of insanity, his fear of accepting the surprising changes in his feelings, especially the overflow of hostility, have to be worked through. He will have to express his sorrow and sense of loss. He will have to find an acceptable formulation of his future relationship to the deceased. He will have to verbalize his feelings of guilt, and he will have to find persons around him whom he can use as "primers" for the acquisition of new patterns of conduct. All this can be done in eight to ten interviews.

Special techniques are needed if hostility is the most marked feature of the grief reaction. The hostility may be directed against the psychiatrist, and the patient will have such guilt over his hostility that he will avoid further interviews. The help of a social worker or a minister, or if these are not available, a member of the family, to urge the patient to continue coming to see the psychiatrist may be indispensable

Since it is obvious that not all bereaved persons, especially those suffering because of war casualties, can have the benefit of expert psychiatric help, much of this knowledge will have to be passed on to auxiliary workers. Social workers and ministers will have to be on the lookout for the more ominous pictures, referring these to the psychiatrist while assisting the more normal reactions themselves.

Anticipatory Grief Reactions

While our studies were at first limited to reactions to actual death, it must be understood that grief reactions are just one form of separation reactions. Separation by death is characterized by its irreversibility and finality. Separation may, of course, occur for other reasons. We were at first surprised to find genuine grief reactions in patients who had not experienced a bereavement but who had experienced separation, for instance, with the departure of a member of the family into the armed forces. Separation in

this case is not due to death but is under the threat of death. A common picture hitherto not appreciated is a syndrome which we have designated *anticipatory grief*. The patient is so concerned with her adjustment after the potential death of father or son that she goes through all the phases of grief—depression, heightened preoccupation with the departed, a review of all the forms of death which might befall him, and anticipation of the modes of readjustment which might be necessitated by it. While this reaction may well form a safeguard against the impact of a sudden death notice, it can turn out to be of a disadvantage at the occasion of reunion. Several instances of this sort came to our attention when a soldier just returned from the battlefield complained that his wife did not love him anymore and demanded immediate divorce. In such situations apparently the grief work had been done so effectively that the patient has emancipated herself and the readjustment must now be directed towards new interaction. It is important to know this because many family disasters of this sort may be avoided through prophylactic measures.

References

Many of the observations are, of course, not entirely new. Delayed reactions were described by Helene Deutsch [1]. Shock treatment in agitated depressions due to bereavement has recently been advocated by Myerson [2]. Morbid identification has been stressed at many points in the psychoanalytic literature and recently by H. A. Murray [3]. The relation of mourning and depressive psychoses has been discussed by Freud [4], Melanie Klein [5], and Abraham [6]. Bereavement reactions in wartime were discussed by Wilson [7]. The reactions after the Cocoanut Grove fire were described in some detail in a chapter of the monograph on this civilian disaster [8]. The effect of wartime separations was reported by Rosenbaum [9]. The incidence of grief reactions among the psychogenic factors in asthma and rheumatoid arthritis has been mentioned by Cobb, *et al.* [10, 11].

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