Mourning in quarantine

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Abstract
This paper explores the effects of mourning in isolation. The authors posit that the pandemic-induced quarantine has impacted mourning processes in a negative manner, particularly insofar as the relational aspects of mourning are concerned. Through a phenomenological study based on a survey of 56 mental health care professionals, the authors examine individual experiences of living through the pandemic while enduring loss and subsequent bereavement in socially isolative conditions. The data, accompanied by several case examples, suggests that during the pandemic loss and mourning were complicated by isolation, the lack of communal grieving rituals and the presence of an increase in mental health disorders. Furthermore, the authors hypothesize that during the Covid-19 pandemic, the absence of positive relational support will result in a greater number of cases of delayed, stalled, and prolonged mourning, as well as Persistent Complex Bereavement.

KEYWORDS
bereavement, loss, relational mourning

1 INTRODUCTION

During the Covid-19 pandemic, billions of people worldwide were exposed to the possibility of infection, severe illness, death, and the loss of cherished others. Much of this suffering and loss was experienced in the context of quarantine, which, in itself, produced a profound sense of social and emotional isolation. Loss and the resulting mourning took place in the absence of the normal companionship of family, friends, and fellow mourners. As such, the relational aspects of mourning were either truncated or absent entirely. In this paper, we examine the effects of quarantine and associated social isolation on bereavement.

Before we do so, we want to acknowledge two important points. First, we are aware that the level of suffering during this pandemic was immeasurable and made even worse in many parts of the world by misinformation,
inadequate health care, and lack of access to equipment, medication, adequate nutrition and vaccines. Innumerable global inequalities were laid bare in the areas of health care, socio-economic wellbeing, and education. Second, it is important to note that the work we present here is no more than what can be called "instant research" done in the midst of an ongoing crisis. We acknowledge that there is much more to discover regarding the effects of this pandemic on mourning and many other aspects of the human experience during crises such as this one.

2 | LITERATURE REVIEW

In recent years, the classic formulations for mourning have been upended by new psychoanalytic theory. Re-conceptualizations of the process of adult mourning and bereavement have evolved out of the object relations, self psychology, and relational schools of psychoanalysis. As Baker (2001) stated, recent clinical data and empirical literature casts doubt on the assumption that the goal of mourning is or should be the detachment of libidinal ties from the deceased loved one (decathexis), as posited by Sigmund Freud and others. Baker suggested, as did Melanie Klein and John Bowlby before him, that mourning be viewed as a process of inner transformation that affects both the images of the self and the other. In the mourner's inner world, the tie to the lost loved one need not be broken but rather, in cases where there was a positive libidinal tie, the attachment can be transformed into a sustaining internal presence which operates as a nurturing and ongoing component in the individual's internal world. This is the aspect of internalization which will be referred to henceforth. However, in cases where the lost loved one was ambivalently held or even hated, the internalized presence may take on a critical or persecutory role. In talking about the internalization of the predominantly positively held object, Baker sought to lay to rest the years of debate regarding the question of whether internalization is a component of healthy or pathological mourning, positioning it squarely in the realm of health and normalcy (Masur, 2021).

Researcher and theorist, George Hagman (2001) supported a view of mourning as a psychosocial process in which the capacity of the bereaved person to communicate their feelings and to receive an adequate response from those surrounding them is crucial to the mourning process. He, like others within the relational and interpersonal schools, sought to redefine mourning. He said, "A model of isolated mourning does not recognize the important role of others in mourning … the intrapsychic focus of the standard [psychoanalytic] model of mourning does not convey the role [of] other people and the social milieu in facilitating or impeding recovery from bereavement" (Hagman, 2001, p. 21). Further, he viewed the capacity of the mourner to preserve a dialog with the lost loved one as crucial to the process of transforming what was an external relationship into an internal one—thereby effecting change within both the relationship with the lost loved one and the bereaved individual herself.

Mourning, then, has been reconceptualized as both an intrapsychic and relational process. Here, we posit that the relational aspect of mourning is both intrapsychic - the internalization of an ongoing relationship with the lost loved one, as mentioned - and external, insofar as the mourner needs interpersonal support and accompaniment in the mourning process. In all cases, relational partners are required who lend a listening ear and a sensitivity to the particulars of the loss. However, this is particularly so in cases where the loss is of an ambivalently held other.

In her work, "Relational Mourning", Adrienne Harris (2003) said, "accepting that a loved one has truly been lost is deep psychic work, entailing a thought process utterly dependent on emotional capacities in [the mourner] and [in the mourner's] surrounding communities or family" (p.145). Harris described a three-year-old girl who required her mother's support in order to begin a mourning process for her father who had died in the World Trade Center on 9/11, and a mother who required Harris's support in order to begin her own mourning. In this parallel process, both mother and daughter needed relational support to endure and to progress in their mourning.

Peskin (2019) emphasized the relational component of mourning to which Harris referred by noting that "grief is influenced by others' witness, acknowledgment and validation." For some, the acknowledgment of the loss by others cuts through the initial period of normative denial. For others, the validation of emotions is necessary to allow their full and continued expression.
Following traumatic events, such as those experienced the world over during the Covid-19 pandemic, most people experience an altered sense of self, heightened anxiety, hypervigilance and temporal discontinuity. Also commonly experienced are a loss of equilibrium and stability, as well a diminution of the ego capacity necessary to maintain customary defensive functioning. Under such circumstances, individuals may have an unusually difficult time embarking on the complex task of mourning and may require additional support. Stability, ego strength, well-functioning defenses and social support are all needed to perform the arduous work of mourning. So, what happens when individuals are fragile, lacking in stability and ego strength, and also have less, rather than more, positive relational support available?

During the portion of the pandemic which occurred before Covid vaccines were widely available, many people were largely socially isolated and alone for over a year. Others lived with their nuclear families while having very little contact with those outside the home. Still others lived within the small communities of multi-family homes or dormitories, but lacked the larger social community normally available to them. When a family member, friend, or colleague died, the social support systems usually available to help process the loss, and to validate grief - were largely absent. Traditional religious observances, funerals, and memorials were either postponed, attended only by a few family members, or carried out over Zoom. Countless individuals were forced to endure alone what should have been a relational process of shared mourning and bereavement. Furthermore, many were deprived of the opportunity to be with their loved ones as they were ill and as they died. Bedside conversations were missed, the ability to touch, soothe, and offer comfort to the ill was lost, and the opportunity to remember and process the end of the relationship together was foreclosed upon. The world over, people were deprived of the opportunity to say goodbye in person. And as the pandemic continues, as resistance to vaccination amongst certain individuals and populations continues, as new variants of the Covid virus develop, and as breakthrough infections rise, such conditions of isolation and isolated mourning may occur again.

In this paper, we aim to explore the effects of mourning in isolation. Through use of several case examples, as well as a phenomenological study based on a survey of mental health care professionals (n = 56), we examine the experience of living through the past 18 months in quarantine while enduring loss in socially isolative conditions.

3 | CASE EXAMPLES

3.1 | Case 1

M, a seventeen-year-old seen in twice weekly psychotherapeutic treatment, experienced the loss of her father two weeks into the pandemic. His death was sudden and unexpected but not due to Covid-19. Nine months later M was accepted into a very good college and she began looking forward, although anxiously, to going. At the same time, she said, "It's so strange. I lost him during the pandemic and I've been without him for almost a year. I've been mourning him - but it seems like nobody else really cares. My mother's family doesn't reach out to me, my step father (the biological parents were divorced) doesn't want to hear about it, nobody really cares how I feel. And in the fall, I'm going to make all new friends who won't ever have met my father. When I get to college, I think I'm going to have to go through mourning a whole second time".

This teenager thought she had been mourning her father - and indeed, she had. She had been, as Freud described, reviewing each of her hopes and memories about her father and comparing them to the reality that he was no longer alive. She had been sad and unmotivated and she had cried often. She had done most of this in her room, on her bed, in between online classes and FaceTime chats with friends. Her brother was at college and both her mother and stepfather were working, sometimes at home and sometimes in their offices. She was alone much of the time, and as the pandemic progressed, she described feeling less and less like leaving her bed. She got up just in time for class and took long naps after school was over. Once a varsity tennis player, her fall season was cut short first by the pandemic and then by an injury. Later in the year when she had the option to return to class in person, she decided
not to, preferring to stay at home on her bed. She became nostalgic for earlier times when her father was still alive, apprehensive about going to college, irritable about family interactions and angry at both her mother and stepfather. In short, 15 months after her father’s death, M was depressed, and her mourning process seemed to have stalled. This young woman might well have experienced difficulties in her mourning process without the pandemic and quarantine, given the existing family dynamic. However, online learning and the prohibition against get-togethers with friends caused some friendships to atrophy and contact with other friends became less frequent. Visits with relatives who were also in mourning for her father did not occur. M was mourning in relative isolation.

3.2 | Case 2

P was a widower in his mid-forties whose wife died approximately 21 months before the beginning of the pandemic. A professional man and father of two young children, he found the quarantine intolerable. While he was able to manage the needs of his children, his household and his work, what was most difficult for him was being at home all the time. He felt surrounded by reminders of his late wife. He said, “Everywhere I look are pictures, things that belonged to her, furniture and decorations she picked out. I can't get away from it”. He longed for the time to come when he could go back to his office full time so that he could be in an environment that was free from all the reminders of his late wife. He also yearned to be around colleagues with whom he could talk about work and matters other than his loss. “That’s what I did while she was sick; that’s how I survived - I could go to my office, do my work and see my colleagues - and at least have a little time that was not so painful - but now I just can’t do that”.

During the months of quarantine and stay at home orders, P was tortured by painful reminders of his wife all day, every day. His mourning had been progressing well prior to the pandemic. He dealt with his own sadness and that of his children honestly and with sensitivity. He dreamed of his wife, spoke of her in his treatment and with his children, he missed her, longed for her and wondered what she might have thought or done in many situations that arose with the children. But he also moved forward. A year and a half after his wife’s death he began to think about dating and having more of a life for himself. But the enforced time at home was excruciating for him - he could not get away from the external reminders of his wife and these external reminders triggered internal processes including memories and feeling states that were painful and more frequent than they might have been had life continued on as normal without the intrusion of the pandemic and the need to stay home.

3.3 | Case 3

K, a 39 year-old woman, was seen in weekly treatment for depressive symptoms following her 47 year-old partner’s cancer diagnosis. In treatment, K initially worked through intense anger related to her partner’s illness. She was in treatment for approximately four months before her partner was diagnosed with coronavirus. After two days of concerning symptoms, he was transported to the hospital by ambulance, where he died several days later. Safety protocol prevented K from being with him in the ambulance or at the hospital. K was unable to speak to her partner or see him prior to his death. After he died, K remained in her apartment for several weeks, maintaining her own isolation through avoidance of communication with family and friends. This isolation led to a protracted state of denial, throughout which K avoided treatment and was not seen for approximately four weeks.

When she was ready to resume treatment, K presented with significant anger. She began to work through the jarring nature of her partner’s passing, focusing on the theme of “aloneness.” She talked at length about how she and her partner had been completely alone throughout the experience of his brief, acute illness and death. In treatment, K often shared the immense frustration that came with the uncertainty surrounding her partner’s death, as well as a feeling of disconnection from his death, as she was unable to see or mourn his physical body. K's continued isolation, with the exception of treatment, held her in a suspended state of grief through which she was unable to move or
As her anger slowly diminished, K began to entertain the idea of ending the self-imposed isolation. Roughly four months after her partner’s death, K’s anger shifted to sadness, at which time she was able to reconnect with a sibling. This connection prompted K to begin to acknowledge her partner’s death outside of the confines of treatment, and initiated a course of bereavement that allowed her to use the support of her sibling relationship to grieve her tremendous loss.

4 METHODS

To further inform us as to the effects of loss and mourning during the period of quarantine, surveys regarding the experience of loss during this time were sent to a population of mental health practitioners who were self-selected members of two professional psychodynamic and psychoanalytically-oriented organizations. By agreeing to participate in the survey, all participants provided informed assent prior to their participation. They were provided with an explanation of the study, accompanied by a list of potential benefits and risks, and agreed voluntarily to participate. Survey items focused specifically on the experiences of loss, grief, and bereavement during the time between March 2020 and February 2021. The precise number of people who received this survey is unknown due to the organizations’ lack of clarity regarding which email addresses remain current on their distribution lists; however, based upon the information available to the authors, we estimate that the survey was sent to approximately 1885 clinicians and had a total of 56 respondents ($n = 56$).

We acknowledge that while the response rate was quite low ($n = 56$) in relation to the total number of clinicians to whom this survey was sent ($n = 1885$), there are several factors that may account for this. This survey was disseminated in February 2021, a time during which many were still unvaccinated, illness and mortality rates were high, and fear and uncertainty were prominent. It is possible that individuals did not wish to engage in self-reflection around mourning during a time when many were still actively experiencing illness, fear, and loss. It also is a possibility that logistics played a role, and individuals either did not have time to complete the survey, or they did not wish to prioritize participation in this research. While this response rate is not necessarily unusual for an online survey, the authors felt the low return rate should be addressed.

5 DATA ANALYSIS

The data set ($n = 56$) was analyzed through a phenomenological framework. The authors utilized both statistical measurements such as mean and mode, as well as the identification of prominent themes to understand the larger implications of social isolation on the individual mourning and bereavement processes.

Regarding overall exposure to Covid-19 illness, approximately 87.5% of respondents knew someone who had contracted COVID-19 ($n = 49$). Approximately 28.5% knew someone who died from COVID-19 ($n = 16$), and 8.92% of respondents ($n = 5$) indicated that they had contracted COVID-19 themselves.

Regarding the mental and emotional health of the practitioners surveyed, respondents were asked to utilize a Likert-style scale (1–10) - on which 1 represents “the worst you have ever felt” and 10 represents “the best you’ve ever felt” - to report their state of mental and emotional health during the pandemic. The mean response to the item asking what was the best they had felt during the pandemic was 6.53 (mode = 7). When asked how they felt at the “worst” point, the mean response was 3.23 (mode = 5).

Participants noted that this protracted state of feeling their worst ranged from lasting “several days” to approximately eight months, with the average response being 4–8 weeks. This suggests that some participants may have experienced periods of minor depression (Persistent Depressive Disorder) and a smaller number may have experienced episodes of major depression (Major Depressive Disorder). This is particularly significant for the 16 participants who endorsed losing a loved one to Covid-19, as studies of disordered mourning have indicated that mental illness...
including depressive disorders may interfere in the mourning process. Such mental illness may predispose mourners to the development of disordered variants of mourning including absent, delayed, or prolonged mourning and what DSM-5 called Persistent Complex Bereavement Disorder.

Of the 16 individuals who reported losing someone to Covid-19, 14 participants reported that at their "worst" they rated themselves as feeling four or below on a Likert Scale of 1–10; the two remaining participants endorsed their "worst" as a five and a seven respectively. Additionally, of these 16 individuals who lost a loved one to Covid-19, the minimum reported length of time of feeling their "worst" was 2 weeks, while the maximum reported was "it continues at present." While participants' responses place all 16 participants within the window of duration for the diagnosis of Major Depressive Disorder (as defined by the DSM-5), the researchers acknowledge the difficulty in accurately assessing the severity of these participants' symptoms and true level of interference with their functioning.

Respondents were asked to share differences in their experience grieving human loss during a pandemic versus grieving human loss pre-pandemic. The most prominent theme identified by approximately 17.8% of respondents was the absence of a funeral or formal gathering ceremony, which they stated impacted their subsequent bereavement experience. Due to social distancing measures, losses that occurred during the pandemic were often not collectively acknowledged, forcing the bereaved to grieve in isolation. Funerals, memorial services and other collective mourning were either postponed, attended by very few or took place on Zoom. Approximately 14% of respondents described their bereavement experience as "fragmented," "disjointed," "disembodied," "truncated," or “muffled." One respondent noted that this truncated bereavement process resulted in a protracted state of loss denial.

For a small number of participants, the converse was true. Approximately 5.3% reported that the social isolation resulting from the pandemic afforded them the opportunity to grieve alone, apart from the usual societal pressures to move through grief at a pace determined by others as appropriate. Two respondents stated that they were able to grieve in a manner and for a length of time that felt more "authentic" to them. One participant mentioned that the experience of grieving in solitude prompted them to contemplate and process their own mortality in a way they felt they might not have in normal times. We acknowledge that these participants' experiences somewhat challenge our hypothesis around isolative grieving. However, expressions and experience of grief vary widely amongst individuals. It is possible that for some people, the mourning process can be accomplished independent of the typical mourning rituals and relational support and the successful internalization of aspects of the relationship with the lost loved one may help this to be so.

6 | DISCUSSION

Mourning presents an extraordinary challenge under any circumstances, as it is an arduous, complex, and multiphasic process. Described by Freud (1917), Lindemann (1944), Kubler-Ross (1969), Bowlby (1980) and many others, mourning cannot be confined by any one definition. Within the mourning process, there is a layering of tasks that must be accomplished. There is the experience of feeling alternating with defense, the experience of wish confronted by reality, the experience of hope contradicted by fear, and the experience of pain and anger oscillating with comfort and serenity in repeating cycles. Grieving involves the need for deep intrapsychic work as well the need for multiple forms of external support, including the relational.

As Harris (2003) described, the mourner needs a steadying partner who can help her to reflect and contain her pain while she begins to find and make new meaning. To take this a step further, the mourner may need several such partners as well as some compatriots to share her pain and to experience it alongside her, people who are also confronted by the same loss and similar states of hurt and sadness. In loss as in life, it is an extraordinarily stabilizing and gratifying experience to have someone say, "me too" or “I feel that same way". To hold someone, to talk with someone, to cry with someone who shares the same feeling, in this case the same pain of loss, is a comfort in itself.

The people described in the case reports above, as well as a portion of the mental health practitioners surveyed, all endured the complex task of mourning loved ones during an extraordinary time of quarantine-induced profound
social isolation. While quarantining was vital to slow infection and death rates, it remains to be seen what pre-existing physical, emotional, and psychological concerns were exacerbated by the resulting social isolation and what physical, emotional and psychological difficulties came about de novo during this time. As demonstrated by the data presented here, some mental health concerns such as depression may have altered the experience of loss due at least in part to the limited opportunity for social contact and community gathering.

It is also important to mention that the experience of bereavement varies widely from individual to individual. Our data reflect a spectrum of experiences during this recent period of quarantine and isolation. While many individuals highlighted the difficulties resulting from mourning without relational support, several individuals identified their appreciation of the opportunity to mourn free from social expectation. It remains to be seen what effect mourning in isolation may have on individual manifestations of grief.

7 | CONCLUSION

As stated, it is likely that for many people worldwide, the mourning process has been made vastly more complicated by the Covid-19 pandemic. Quarantine and the resulting isolation, the inability to comfort the sick and to say goodbye to the dying, the absence of the normal grieving rituals, the lack of customary social supports, the presence of stress and, in some cases, the existence of mental health symptoms or disorders which preceded the pandemic or which resulted from the pandemic experience will all have increased the likelihood of disordered and prolonged grief and mourning processes. It is our hypothesis that the altered circumstances of quarantine fostered multiple obstacles to mourning for some people so that many more instances of delayed, stalled, and prolonged mourning, as well as Persistent Complex Bereavement - formerly known as “Complicated Grief” - will be seen in the coming months and years.

In the same vein, we hypothesize that a global mental health pandemic will result from the altered life circumstances combined with innumerable types of deprivation and loss suffered during this pandemic. We suggest that mental health providers and mental health systems worldwide prepare themselves for a deluge of patients requiring psychological and emotional support. In order to prepare for this inevitability, we suggest that medical, psychological and social work training programs, mental health systems, and private practitioners prioritize their own education on the mourning process, as well as the treatment of trauma, traumatic loss and bereavement, and disordered mourning.

Finally, we would like to highlight the fact that a variety of societal conditions are, and will continue to be, laid bare by the ongoing pandemic. Inequities in accessibility to resources including the availability of adequate nutrition, childcare, healthcare, medical equipment and vaccine regimens are being made even more obvious both within the US and globally. Greater awareness has also been brought to pre-existing conditions of loneliness and isolation among many populations in Western societies including single adults, and the elderly. The demands put upon individuals for self-sufficiency and on nuclear families for childrearing and childcare are only increasing as we enter the 21st century. We propose that in forthcoming studies on the effects of isolation brought on by the pandemic, the effects of the increased atomization of society in general should be acknowledged and examined. The level of social recognition that people have been mourning alone during the pandemic can and must be generalized to include the recognition that many people have been mourning in relative isolation for years - and moreover, that the majority have been living lives less influenced by community than at any time in human history.

CONFLICT OF INTEREST
We have no conflicts of interest to disclose.
REFERENCES

Baker, J. E. (2001). Mourning and the transformation of object relationships: Evidence for the persistence of internal attachments. *Psychoanalytic Psychology, 18*(1), 55–73.

Bowlby, J. (1980). Loss, sadness and depression. In *Attachment and Loss* (Vol. 3). Basic Books.

Freud, S. (1917). *Mourning and melancholia* (Vol. 14, pp. 237–258). Hogarth.

Hagman, G. (2001). Beyond decathexis: Toward a new psychoanalytic understanding and treatment of mourning. In R. A. Neimeyer (Ed.), *Meaning Reconstruction & the Experience of Loss* (pp. 13–31). American Psychological Association.

Harris, A. (2003). Relational mourning. In S. W. Coates, J. L. Rosenthal, & D. S. Schechter (Eds.), *September 11: Trauma and Human Bonds* (pp. 143–163). Analytic Press.

Kubler-Ross, E. (1969). *On death and dying*. Scribner.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry, 101*(2), 141–148.

Masur, C. (2021). *When a child grieves*. Phoenix Press.

Peskin, H. (2019). Who has the right to mourn? Relational deference and the ranking of grief. *Psychoanalytic Dialogues, 29*(4), 477–492. [https://doi.org/10.1080/10481885.2019.1632655](https://doi.org/10.1080/10481885.2019.1632655)

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**How to cite this article:** Masur, C., & Wertheimer, S. R. (2021). Mourning in quarantine. *International Journal of Applied Psychoanalytic Studies, 1*–*8*. [https://doi.org/10.1002/aps.1735](https://doi.org/10.1002/aps.1735)