Understanding Grief

Grief and Bereavement

Grief is a multi-faceted response to loss. Although conventionally focused on the emotional response to loss, it also has physical, cognitive, behavioral, social and philosophical dimensions. Common to human experience is the death of a loved one, be they friend, family, or other. While the terms are often used interchangeably, bereavement often refers to the state of loss, and grief to the reaction to loss. Losses can range from loss of employment, pets, status, a sense of safety, order, possessions, to the loss of the people nearest to us. Our response to loss is varied and researchers have moved away from conventional views of grief (that is, that people move through an orderly and predictable series of responses to loss) to one that considers the wide variety of responses that are influenced by personality, family, culture, and spiritual and religious beliefs and practices.

Bereavement, while a normal part of life for us all, carries a degree of risk when limited support is available. Severe reactions to loss may carry over into familial relations and cause trauma for children, spouses and any other family members: there is an increased risk of marital breakup following the death of a child, for example. Many forms of what we term 'mental illness' have loss as their root, but covered by many years and circumstances this often goes unnoticed. Issues of personal faith and beliefs may also face challenge, as bereaved persons reassess personal definitions in the face of great pain. While many who grieve are able to work through their loss

independently, accessing additional support from bereavement professionals may promote the process of healing. Individual counseling, professional support groups or educational classes, and peer-lead support groups are primary resources available to the bereaved. In the United States, local hospice agencies may be an important first contact for those seeking bereavement support.

Stage Theories and Processes

Some researchers such as Dr. Elisabeth Kübler-Ross and others have posited sequential stages including **denial**, **anger**, **bargaining**, **depression** and **acceptance**, which are commonly referred to as the "grief cycle". As research progressed over the past 40 years, many who worked with the bereaved found stage models too simplistic and instead began to look at processes, dynamics, and experiences common to all. John Bowlby, a noted psychiatrist, outlined the ebb and flow of processes such as Shock and Numbness, Yearning and Searching, Disorganization and Despair, and Reorganization. Bowlby and Parkes both note psychophysiologic components of grief as well. Included in these processes are:

Shock and Numbness

Feelings of unreality, depersonalization, withdrawal, and an anesthetizing of affect. These feelings often occur early in grief, and may be a self-protective way of getting through the facts of the death. Persons often remark on how someone appears stoic or strong when they are actually in shock.

Yearning and Searching

The grieving person tries to locate the lost person. Normally this is a functional endeavor, as the 'lost' person is found, but in bereavement the searching is fruitless. This process has also been referred to as 'pining.' Common reactions include feelings and even cognitions of 'seeing' the deceased for fleeting moments, hearing the door at the time they used to come home, or even incorrectly 'finding' the person, for example in a crowd, although intellectually realizing this is not so. Actually feeling that one 'sees' or 'hears' the deceased ranges in report from 90% in Asian cultures to 10-15% in western cultures, although this may be more a factor of reporting bias than of actual experience, as many in Western cultures may simply deny these experiences in order to suppress or prevent reliving the negative experience, while in Eastern cultures this may be much more encouraged and openly discussed. This process appears to be an attempt of the person to cognitively and emotionally begin to let go, by coming to terms with the reality of the loss.

Disorganization and Despair

These are the processes we normally associate with bereavement, the mourning and severe pain of being away from the loved person. There are no easy answers to assuage this difficult experience: it must simply be endured, although it may take years of all of the above experiences overlapping, waxing and waning before the last process takes place. Also this is dangerous. Some people have thoughts of committing suicide to end the pain. Some have done that. Others

suffer as though they were being tortured. People are tired and numb. This is difficult to cope with.

Reorganization

Reorganization is the assimilation of the loss and redefining of life and meaning without the deceased. Many times, in widowhood, one is so much a part of their spouse, that new definitions of identity must take place for healing. For the elderly after a lifetime of defining themselves in terms of their marriage relationships, this may take the rest of their lives.

Risks

Many studies have looked at the bereaved in terms of increased risks for stress-related illnesses. Colin Murray Parkes in the 1960s and 1970s in England noted increased doctor visits and real illnesses such as colitis, breathing difficulties, and so forth in the first six months following a death. Others have noted increased mortality rates (Ward, A.W. 1976) and Bunch et al found a five times greater risk of suicide in teens following the death of a parent. Grief puts a great stress on the physical body as well as on the psyche, resulting in wear and tear beyond what is normal. Further, grief is often accompanied by crying, lack of sleep, loss of appetite, and ceasing to care for one's physical and emotional wellbeing. All these can contribute to a predisposition for illness in bereavement, a finding which has been replicated often since the Lindemann studies of the Cocoanut Grove fire survivors in 1942. Other problems in social relations may arise: some people believe that there is an increase of divorce following the death of a child, but recent studies commissioned by the Compassionate Friends have shown this to be untrue and indicate that parents who have lost a child are actually less likely to divorce. Children may exhibit signs

of delinquency, rage, introversion or other problems. Further, grief can insidiously work in family relationships as individual members sort or act through their feelings about the death. The risks following a death in the family are as great as or greater than for any other traumatic life event.

Normal and Complicated Grief

Complicated grief can be differentiated from normal grief, in that, normal grief typically at least two of Elisabeth Kubler-Ross' 5 grief stages, though not necessarily in any order. Complicated grief typically cycles through these 5 stages and then some, processing them out of order and often much more rapidly. Some people commit suicide to end the pain and suffering of grief. Examples of complicated grief can be found in those who have survived a suicide (Hsu, 2002). While the experience of grief is a very individual process depending on many factors, certain commonalities are often reported. Nightmares, appetite problems, dryness of mouth, shortness of breath, sleep disorders and repetitive motions to avoid pain are often reported, and are perfectly normal. Even hallucinatory experiences may be normal early in grief, and our usual definitions will not suffice, necessitating a lot of grace for the bereaved. Complicated grief responses almost always are a function of intensity and timing: a grief that after a year or two begins to worsen, accompanied by unusual behaviors, is a warning sign, but even here, caution must be used; it takes time to say goodbye.

Types of Bereavement

Differing bereavements along the life cycle may have different manifestations and problems which are age related, mostly because of cognitive and emotional skills along the way. Children will exhibit their mourning very differently in reaction to the loss of a parent than a widow would to the loss of a spouse. Reactions in one type of bereavement may be perfectly normal, but in another the same reaction could be problematic. The kind of loss must be taken under consideration when determining how to help.

Childhood Bereavement

When a parent dies, children may have symptoms of psychopathology, but they are less severe than in children with major depression (Cerel, 2006). The loss of a parent, grandparent or sibling can be very troubling in childhood, but even in childhood there are age differences in relation to the loss. A very young child, under one or two, may be felt to have no reaction if a caregiver dies, but this is far from the truth. At a time when trust and dependency are formed, a breakeven of no more than separation can cause problems in wellbeing; this is especially true if the loss is around critical periods such as 8-12 months when attachment and separation are at their height in formation and even a brief separation from a parent can cause distress. (Ainsworth 1963) A change in caregivers can have lifelong consequences, which may become so blurred as to be untraceable. As a child grows older, death is still difficult to assimilate and that fact affects the way a child responds. For example, younger children will find the 'fact' of death a changeable thing: one child believed her deceased mother could be restored with 'band-aids', and children often see death as curable or reversible, more as a separation. Reactions here may manifest themselves in 'acting out' behaviors: a return to earlier behaviors such as sucking thumbs,

clinging to a toy or angry behavior: they do not have the maturity to mourn as an adult, but the intensity is there. As children enter pre-teen and teen years, there is a more mature understanding. Adolescents may respond by delinquency, or oppositely become 'over-achievers': repetitive actions are not uncommon such as washing a car repeatedly or taking up repetitive tasks such as sewing, computer games etc. It is an effort to stay 'above' the grief. Childhood loss as mentioned before can predispose a child not only to physical illness but to emotional problems and an increased risk for suicide, especially in the adolescent period.

Death of a Child

Death of a child can take the form of a loss in infancy such as stillbirth or neonatal death, SIDS, or the death of an older child. In all cases, parents find the grief devastating and while persons may rate the death of a spouse as first in traumatic life events, the death of a child holds greater risk factors. This loss also bears a lifelong process: one does not get 'over' the loss but instead learns to assimilate and live with the death. Intervention and comforting support can make all the difference to the survival of a parent in this type of grief but the risk factors are great and may include family breakup or suicide. Feelings of guilt, almost always unfounded, are pervasive, and the dependent nature of the relationship disposes parents to a variety of problems as they seek to cope with this great loss. This, coupled with normal experiences of grief, can be overwhelming.

Death of a Spouse

Although the death of a spouse may be an expected change, particularly as we age, it is a particularly powerful loss of a loved-one. A spouse, though, often becomes part of the other in a unique way: many widows and widowers describe losing 'half' of themselves, and after a long marriage, at older ages, the elderly may find it a very difficult assimilation to begin anew. Further, most couples have a division of 'tasks' or 'labor', e.g. the husband mows the yard, the wife pays the bills, etc. which in addition to dealing with great grief and life changes means added responsibilities for the bereaved. Social isolation may also become eminent as many groups composed of couples find it difficult adjust to the new identity of the bereaved. When queried about what in life is most troubling, most rate death of a spouse first, although the death of a child presents more risk factors.

Death of a Parent

Responses and reactions of older children or adults to the death of a parent include feelings of guilt, loss of role e.g. that of a caregiver. There is also an increase in awareness of one's own health and mortality.

Death of a Sibling

Responses and reactions of older children or adults to the death of a sibling. There is a saying that if you have lost your parents, you have lost your past; if you lost your children, you have lost your future; if you have lost your spouse, you have lost your present; and if you have lost your sibling, then you have lost your past present and future

Loss of Children through Divorce or Kidnapping

Responses of parents accepting permanent loss of children through the reality of the divorce system, or through kidnapping. This loss differs from the death of a child in that the grief process is prolonged or denied because of hope that the relationship will be restored. This is often not the case.

Other Losses

Many other losses predispose persons to these same experiences, although often not as severely. Loss reactions may occur after the loss of a romantic relationship (i.e. divorce or break up), a vocation, a pet (animal loss), a home, children leaving home (empty nest), a friend, a favored appointment or desire, etc. While the reaction may not be as intense, experiences of loss may still show in these forms of bereavement.

Psychological Trauma

Psychological trauma is a type of damage to the psyche that occurs as a result of a traumatic event. A traumatic event involves a singular experience or enduring event or events that completely overwhelm the individual's ability to cope or integrate the ideas and emotions involved with that experience. Trauma can be caused by a wide variety of events, but there are a few common aspects. It usually involves a complete feeling of helplessness in the face of a real or subjective threat to life, bodily integrity, or sanity. There is frequently a violation of the person's familiar ideas about the world, putting the person

in a state of extreme confusion and insecurity. This is often seen when people or institutions depended on for survival violate or betray the person in some unforeseen way.

Psychological trauma may accompany physical trauma or exist independently of it. Typical causes of psychological trauma are abuse, violence, the threat of either, or the witnessing of either, particularly in childhood. Catastrophic events such as earthquakes and volcanic eruptions, war or other mass violence can also cause psychological trauma. Long-term exposure to situations such as extreme poverty or milder forms of abuse, such as verbal abuse, can be traumatic (though verbal abuse can also potentially be traumatic as a single event). In some cases, even a person's own actions, such as committing rape, can be traumatic for the offender as well as the victim, especially if the offender feels helpless to control the urge to commit such crimes.

However, different people will react differently to similar events. One person may perceive an event to be traumatic that another may not, and not all people who experience a traumatic event will become psychologically traumatized.

Symptoms of Trauma

People who go through traumatic experiences often have certain symptoms and problems afterward. How severe these symptoms are depends on the person, the type of trauma involved, and the emotional support they receive from others. This section is a general listing of possible symptoms, and is not exhaustive. Reactions to and symptoms of trauma can be wide and varied, and differ in severity from person to person. A traumatized individual may experience one or several of them.

After a traumatic experience, a person may re-experience the trauma mentally and physically. Because this can be uncomfortable and sometimes painful, survivors tend to avoid reminders of the trauma. They may turn to alcohol and/or drugs to try and escape the feelings. Re-experiencing symptoms are a sign that the body and mind are actively struggling to cope with the traumatic experience. Emotional triggers and cues act as reminders of the trauma and can cause anxiety and other associated emotions. Often the person can be completely unaware of what these triggers are. In many cases this may lead a person suffering from traumatic disorders to engage in disruptive or self-destructive coping mechanisms, often without being fully aware of the nature or causes of their own actions. Panic attacks are an example of a psychosomatic response to such emotional triggers.

Intense feelings of anger may surface frequently, sometimes in very inappropriate or unexpected situations, as danger may always seem to be present. Upsetting memories such as images, thoughts, or flashbacks may haunt the person, and nightmares may be frequent. Insomnia may occur as lurking fears and insecurity keep the person vigilant and on the lookout for danger, both day and night.

In time, emotional exhaustion may set in, leading to distraction, and clear thinking may be difficult. Emotional detachment, also known as dissociation or "numbing out", can frequently occur. Dissociating from the painful emotion includes numbing all emotion, and the person may seem emotionally flat, preoccupied or distant. The person can become confused in ordinary situations and have memory problems.

Some traumatized people may feel permanently damaged when trauma symptoms don't go away and they don't believe their situation will improve. This can lead to feelings of despair, loss of self-esteem, and frequently depression. If important aspects of the person's self and world understanding have been violated, the person may call their own identity into question.

These symptoms can lead to stress or anxiety disorders, or even post traumatic stress disorder, where the person experiences flashbacks and re-experiences the emotion of the trauma as if it is actually happening.

Situational Trauma

Trauma is well-known in genocide, war, and crime situations. It is almost always seen in torture victims and targets of mobbing (see psychology of torture). It also occurs in natural and man-made disasters, catastrophic mishaps, and medical emergencies. Here treatment for trauma is often either not sought, or is not available. It is common, but less often identified in situations of domestic violence, pedophilia, and incest. It also occurs in victims of child or elder abuse. Victims in situations of pedophilia, domestic violence, and neglect are often not identified by caregivers and are also unlikely to receive proper treatment for ongoing trauma.

Trauma is often defined as a coping response to and a consequence of overwhelming situations. However, as an individual's sense of being "overwhelmed" is subjective, the occurrence of trauma is also subjective. There is evidence to suggest that how people cope with extremely stressful situations is associated to the amount of trauma suffered from such events.

There are several behavioral responses common towards stressors including the proactive, reactive, and passive responses. Proactive responses include an attempts to address and correct a

stressor before it has a noticeable effect on lifestyle. Reactive responses occur after the stress and possible trauma occurred, and are aimed more at correcting or minimizing the damage of a stressful event.

A passive response is often characterized by an emotional numbness or ignorance of a stressor. Those who are able to be proactive can often overcome stressors and are more likely to be able to cope well with unexpected situations. On the other hand, those who are more reactive will often experience more noticeable effects from an unexpected stressor. In the case of those who are passive, victims of a stressful event are more likely to suffer from long term traumatic effects and often enact no intentional coping actions. These observations may suggest that the level of trauma associated with a victim is related to such independent coping abilities.

There is also a distinction between trauma induced by recent situations and long-term trauma which may have been buried in the unconscious from past situations such as childhood abuse. Trauma induced from recent situations is known as 'simple' trauma while trauma from long past situations is known as 'complex' trauma. However, there is nothing simple about either form of trauma as both are usually induced by extreme situations.

Trauma is often overcome through healing which can be done by recreating or revisiting the origin of the trauma.

Trauma in Psychoanalysis

French neurologist Jean-Martin Charcot argued that psychological trauma was the origin of all instances of the mental illness known as hysteria. Charcot's "traumatic hysteria" often manifested as a paralysis that followed a physical trauma, typically years later after what Charcot described as a period of "incubation".

Sigmund Freud, Charcot's student and the father of psychoanalysis, examined the concept of psychological trauma throughout his career. Jean Laplanche has given a general description of Freud's understanding of trauma, which varied significantly over the course of Freud's career: "An event in the subject's life, defined by its intensity, by the subject's incapacity to respond adequately to it and by the upheaval and long-lasting effects that it brings about in the psychical organization".

Trauma and Stress Disorders

In times of war, psychological trauma has been known as shell shock or combat stress reaction (CSR). Psychological trauma may cause acute stress disorder (ASD) which may lead on to posttraumatic stress disorder (PTSD). PTSD can also develop without an antecedent ASD and may come on months or years after the trauma. Both ASD and PTSD are specific disorders in which the traumatized individual may experience nightmares, avoidance of certain situations and places, depression, and symptoms of hyper-activation. PTSD emerged as the label for this condition after the Vietnam War in which many veterans returned to their respective countries demoralized, and sometimes, addicted to drugs.

Psychological trauma is treated with therapy and, if indicated, psychotropic medications. Recent studies try to show the effect of trauma on human memory. This kind of study is useful in order to verify the accuracy of eyewitnesses involved in criminal acts.

Therapies used in the treatment of psychological trauma include: Cognitive therapy (CBT), Brief therapy, Psychodynamic psychotherapy, Play therapy, Traumatic Incident Reduction (TIR), EMDR and Dialectical Behavioral Therapy (DBT).

Following traumatic events, persons involved are often asked to talk about the events soon after, sometimes even immediately after the event occurred in order to start a healing process. This practice may not garner the positive results needed to recover psychologically from a traumatic event. Victims of traumatic occurrences who were debriefed immediately after the event in general do fare better than others who received therapy at a later time. Yet, there is one indication that forcing immediate debriefing may even distort the natural psychological healing process.

Growth Aspects of Trauma

Though the idea of trauma is most frequently thought of in negative terms, it is also often seen to have positive aspects. Many people, such as Christopher Reeves and Rick Hansen, have overcome traumas and moved on to become inspirational figures. This growth, first called *posttraumatic growth* in 1996 by psychologists Richard Tedeschi and Lawrence Calhoun, can involve changes in how people think of themselves, their relationships

with others, including all of humanity, as well as profound philosophical, spiritual, or religious changes.

According to Lawrence G. Calhoun and Richard Tedeschi, both professors at the University of North Carolina at Charlotte, trauma experiences can lead to growth, though this is not inevitable. They have found that "reports of growth experiences in the aftermath of traumatic events far outnumber reports of psychiatric disorders." They state that these changes can include:

- Improved relationships, new possibilities for one's life, a greater appreciation for life, a greater sense of personal strength and spiritual development. There appears to be a basic paradox apprehended by trauma survivors who report these aspects of posttraumatic growth: Their losses have produced valuable gains.
- They also may find themselves becoming more comfortable with intimacy and having a greater sense of compassion for others who experience life difficulties.
- Still, they add, "posttraumatic growth does not necessarily yield less emotional distress."
- Posttraumatic growth occurs in the context of suffering and significant psychological struggle, and a focus on this growth should not come at the expense of empathy for the pain and suffering of trauma survivors. For most trauma survivors, posttraumatic growth and distress will coexist, and the growth emerges from the struggle with coping, not from the trauma itself.

They point out that "there are also a significant number of people who experience little or no growth in their struggle with trauma."

Managing Grief after Disaster

The recent terrorist disasters left many people suddenly bereaved of spouses, children, parents, close friends, and coworkers. In the immediate aftermath, some have been numb or unable to accept the loss. Many have felt shocked, lost, anxious, depressed, and physically unwell as a result of this loss. For many, the pain has been intense and unrelenting. In the acute aftermath of the violent death of a loved one, a sense of disbelief or intense, uncontrollable emotionality is very frequent. Distressing physical symptoms are also common (Lindeman, 1944; Stroebe & Stroebe, 1993). These emotional and bodily reactions may be very strong and can be traumatizing, especially if they are unfamiliar and unexpected. Such a secondary reaction can further amplify the pain caused by the loss and can be mitigated by information about grief and stress reactions. It is important to realize that intense and unfamiliar emotionality is entirely normal and does not necessarily have implications for long-term emotional stability or health.

The fact that a popular Internet book site lists 2,776 titles on the topic attests to the fact that grief is both common and difficult. In ordinary, peaceful times millions of people die every year, each leaving friends and family bereaved. Many experience numbness or intense pain in the immediate aftermath. For most, this initial reaction subsides with time, and the bereaved person finds a way to again engage fully in life. However, studies show bereaved individuals, in general, are at risk for longer term mental and physical health problems. It is a good idea to provide

ongoing support, monitor the outcome of grief, and know that professional intervention can be helpful.

Given the universality of bereavement, there has been relatively little research to characterize its course, develop a nosology for bereavement problems, identify risk factors, or guide treatment. The information provided below draws upon what ha`s been done and upon ongoing work.