LEARNING MODULE I

Seminar # 20

Bereavement

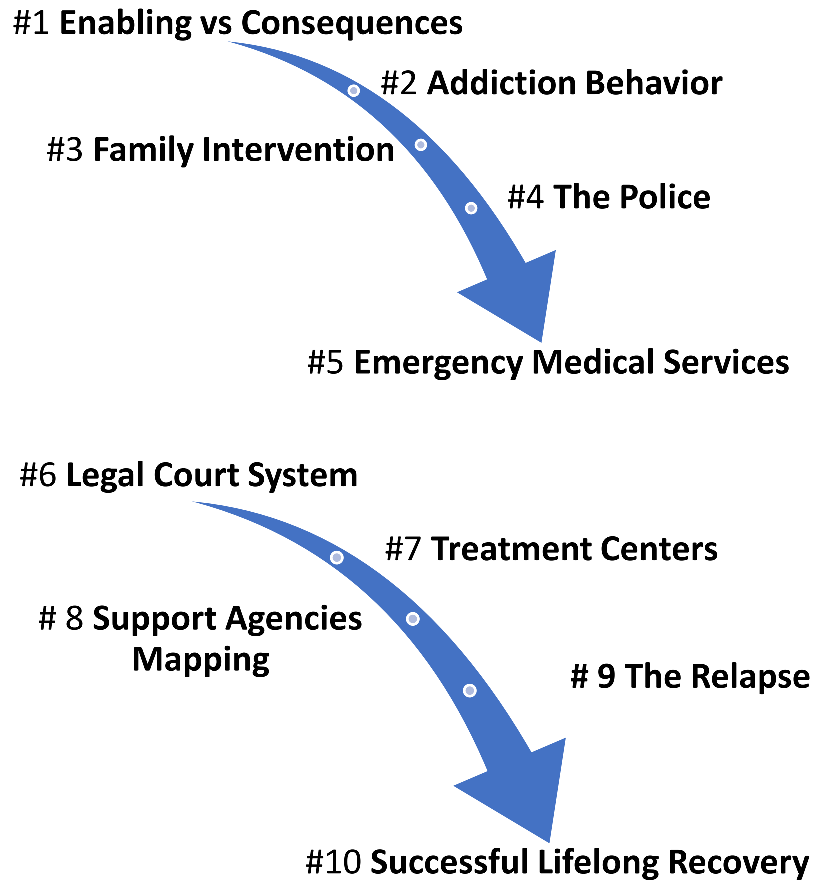
Learning Objectives

1. What is the issue.

2. How can the issue impact the family.

3. What are the options.

Pathfinder: The 12 Key Issues a Family Faces



#11 Bereavement (Learning how to move forward)

#12 **Faith, Spiritual Practices**

What is the issue?

There is more than one type of grief in the bereavement process. Let us look to examine the three most common griefs and learn how to determine the difference more closely.

In most journals there are many topics of bereavement under the heading of Greif. Psychiatrists often are ill prepared to identify complicated grief and grief-related major depression and may not always be trained to identify or provide the most appropriate course of treatment. Both conditions overlap with symptoms found in ordinary, uncomplicated grief, and often are written off as "normal" with the faulty assumption that time, strength of character and the natural support system will heal. While uncomplicated grief may be extremely painful, disruptive, and consuming, it is usually tolerable and self-limited and does not require formal treatment. However, both complicated grief and grief-related major depression can be persistent and gravely disabling, can dramatically interfere with function and quality of life, and may even be life threatening in the absence of treatment; and both usually respond to targeted psychiatric interventions.

This is a journey of time, reflection, and love, for the other and for yourself. You might benefit from creating your own guidebook on how to deal with the loss of your loved one. Go on-line and research what the professionals say about this journey. Meet with a hospice counselor and ask them to guide you. Your local hospice has bereavement counselor that will meet with you at no charge. Join a support group and participate/contribute to the discussions.

How can the issue impact the family?

What is uncomplicated (Normal Grief)

Some investigators have attempted to define discrete stages of grief, such as an initial period of numbness leading to depression and finally to reorganization and recovery. However, most modern grief specialists recognize the variations and fluidity of grief experiences, that differ considerably in intensity and length among cultural groups and from person to person 2, 3. To date, no grief stage theory has been able to account for how people cope with loss, why they experience varying degrees and types of distress at different times, and how or when they adjust to a life without their loved one over time.

The terms bereavement and grief are used inconsistently in the literature to refer to either the state of having lost someone to death, or the response to such a loss. Researchers have suggested that the term bereavement be used to refer to the fact of the loss; the term grief should then be used to describe the emotional, cognitive, functional, and behavioral responses to the death. Also, grief is often used more broadly to refer to the response to other kinds of loss; people grieve the loss of their youth, of opportunities, and of functional abilities.

Mourning is also sometimes used interchangeably with bereavement and grief, usually referring more specifically to the behavioral manifestations of grief, which are influenced by social and cultural rituals, such as funerals, visitations, or other customs.

Complicated grief, sometimes referred to as unresolved or traumatic grief, is the current designation for a syndrome of prolonged and intense grief that is associated with substantial impairment in work, health, and social functioning.

What constitutes “normal” grief? There is no simple answer. Grief is different for every person and every loss, and it can be damaging to judge or label a person’s grief, especially during early bereavement.

However, a clinician needs to make a judgment about whether a person’s grief is progressing adaptively to make categorical decisions about whether to intervene.

A clinician who does not understand the range of grief symptoms is at risk for intervening in a normal process and possibly derailing it. At the same time, knowledge about the boundaries of uncomplicated, adaptive grief can guard against failure to recognize complicated grief and/or depression occurring in the wake of a loved one’s death. Not all physicians understand these differences.

How long does grief last?

The intensity and duration of grief is highly variable, not only in the same individual over time or after different losses, but also in different people dealing with similar losses. The intensity and duration is determined by multiple forces, including, among others: the individual's preexisting personality, attachment style, genetic makeup and unique vulnerabilities; age and health; spirituality and cultural identity; supports and resources; the number of losses; the nature of the relationship (e.g., interdependent vs. distant, loving vs. ambivalent); the relation (parent vs. child vs. spouse vs. sibling vs. friend, etc.); type of loss (sudden and unanticipated vs. gradual and anticipated, or natural causes vs. suicide, accident or homicide) 4.

First, grief is not a state, but rather a process. **Second**, the grief process typically proceeds in fits and starts, with attention to and from the painful reality of the death. **Third,** the spectrum of emotional, cognitive, social, and behavioral disruptions of grief is broad, ranging from barely noticeable alterations to profound anguish and dysfunction.

Bereavement can be one of the most gut-wrenching and painful experiences an individual ever faces. Shock, anguish, loss, anger, guilt, regret, anxiety, fear, loneliness, unhappiness, depression, intrusive images, depersonalization, and the feeling of being overwhelmed are but a few of the sentient states grieving individuals often describe.

At first, these acute feelings of anguish and despair may seem always present, but soon they evolve into waves or bursts, initially unprovoked, and later brought on by specific reminders of the deceased. Healthy, generally adaptive people likely have not experienced such an emotional roller coaster, and typically find the intense, uncontrollable emotionality of acute grief disconcerting, even shameful or frightening.

Yet, grief is not only about pain. In an uncomplicated grief process, painful experiences are intermingled with positive feelings, such as relief, joy, peace, and happiness that emerge after the loss of an important person. Frequently, these positive feelings elicit negative emotions of disloyalty and guilt in the bereaved. Of note, at least one investigator has found that positive feelings at 6 months following a death are a sign of resilience and associated with good long-term outcomes 7.

Fourth, for most people grief is never fully completed. However, there are two easily distinguishable forms of grief 8. First, the acute grief that occurs in the early aftermath of a death can be intensely painful and is often characterized by behaviors and emotions that would be considered unusual in normal everyday life.

These include:

- intense sadness
- crying
- other unfamiliar emotions
- preoccupation with thoughts and memories of the deceased person
- difficulty concentrating
- relative disinterest in other people and in activities of daily life (apart from their role in mourning the deceased).

This form of grief is distinguished from a later form of grief, integrated or abiding grief, in which the deceased is easily called to mind, often with associated sadness and longing. During the transition from acute to integrated grief, usually beginning within the first few months of the death, the wounds begin to heal, and the bereaved person finds his or her way back to a fulfilling life.

Even though the grief has been integrated, they do not forget the people they lost, relinquish their sadness nor do they stop missing their loved ones. The loss becomes integrated into autobiographical memory and the thoughts and memories of the deceased are no longer preoccupying or disabling.

Unlike acute grief, integrated grief does not persistently preoccupy the mind or disrupt other activities. However, there may be periods when the acute grief reawakens. This can occur around the time of significant events, such as holidays, birthdays, anniversaries, another loss, or a particularly stressful time.

Fifth, grief is not only about separation from the person who died, but about finding new and meaningful ways of continuing the relationship with the deceased 9, 10. Faced with the dilemma of balancing inner and outer realities, the bereaved gradually learn to accept the loved one back into their lives as deceased.

What occurs for survivors is the transformation of a relationship that had heretofore operated on several levels of actual, symbolic, internalized, and imagined relatedness to one in which the actual (living and breathing) relationship has been lost.

However, other forms of the relationship remain, and continue to evolve and change. Thus, it is not unusual for bereaved individuals to dream of their deceased loved ones, to half look for them in crowds, to sense their presence, feel them watching out for or protecting them, to rehearse discussions or "speak" to them.

Auditory or visual hallucinations of the deceased person are often seen during acute grief. Sometimes people maintain a sense of connection through objects such as clothing, writings, favorite possessions, and rings, which may be kept indefinitely. Some people continue a relationship with the deceased through living legacies, such as identification phenomena, carrying out the deceased's mission, memorial donations, or seeing them live on in others through genetic endowments. For others, periodically visiting the grave or lighting candles may help keep memories alive. Bereaved individuals may take some comfort in learning that the relationship does not need to be totally severed, but that it is perfectly acceptable and even normal for the relationship to endure indefinitely.

There is no evidence that uncomplicated grief requires formal treatment or professional intervention 11. For most bereaved individuals, the arduous journey through grief will ultimately culminate in an acceptable level of adjustment to a life without their loved one. Thus, most bereaved individuals do fine without treatment. They should have access to empathic support and information that validates that their response is typical after a loss. When support, reassurance, and information generally provided by family, friends, and, sometimes, clergy is not available or sufficient, mutual support groups can help fill the gap. Support groups can be particularly helpful after traumatic losses, such as the death of a child, a death after suicide 12 or deaths from other "unnatural" causes 13.

Complicated Grief

Complicated grief, a syndrome that occurs in about 10% of bereaved people, results from the failure to transition from acute to integrated grief. As a result, acute grief is prolonged, perhaps indefinitely.

Symptoms include:

- Separation distress (recurrent pangs of painful emotions,
- Intense yearning and longing for the deceased,
- Preoccupation with thoughts of the loved one) and traumatic distress (sense of disbelief regarding the death, anger, and bitterness,
- Distressing, intrusive thoughts related to the death,
- Pronounced avoidance of reminders of the painful loss) 10.

Characteristically, individuals experiencing complicated grief have difficulty accepting the death, and the intense separation and traumatic distress may last well beyond six months 1, 4.

Bereaved individuals with complicated grief find themselves in a repetitive loop of intense yearning and longing that becomes the major focus of their lives, albeit accompanied by inevitable sadness, frustration, and anxiety.

Complicated grievers may perceive their grief as frightening, shameful, and strange. They may believe that their life is over and that the intense pain they constantly endure will never cease. Alternatively, there are grievers who do not want the grief to end, as they feel it is all that is left of the relationship with their loved one.

Sometimes, people think that, by enjoying their life, they are betraying their lost loved one. Maladaptive behaviors consist of over-involvement in activities related to the deceased, on the one hand, and excessive avoidance on the other. Preoccupation with the deceased may include daydreaming, sitting at the cemetery, or rearranging belongings. At the same time, the bereaved person may avoid activities and situations that remind them that the loved one is gone, or of the good times they spent with the deceased. Frequently, people with complicated grief feel estranged from others, including people that used to be close.

An assessment is available:

Complicated grief can be reliably identified using the Inventory of Complicated Grief (ICG, 14). It is indicated by a score ≥ 30 on the ICG at least six months after the death. It is associated with significant distress, impairment, and negative health consequences 14, 15.

A targeted intervention, complicated grief treatment (CGT), has demonstrated significantly better outcomes than standard psychotherapy in treating this syndrome 21.

CGT combines cognitive behavioral techniques with aspects of interpersonal psychotherapy and motivational interviewing. The treatment includes a dual focus on coming to terms with the loss and on finding a pathway to restoration. It includes a structured exercise focused on repeatedly revisiting the time of the death as well as gradual re-engagement in activities and situations that have been avoided.

Grief Related Major Depression

Many clinicians are confused by the relationship between grief and depression and find clinical depression difficult to diagnosis in the context of bereavement. Bereavement is a major stressor and has been found to present in major depression, resulting in a diagnostic quandary that may have profound clinical implications 24, 33.

Although there are overlapping symptoms, grief can be distinguished from a full depressive episode. Most bereaved individuals experience intense sadness, but only a minority meets criteria for major depression.

The principal source of confusion is the common occurrence of low mood, sadness, and social withdrawal in both bereavement and major depression. However, there are also clear differences between the two states.

Grief is a complex experience in which positive emotions are experienced alongside negative ones. As time passes, the intense, sad emotions that typically come in waves are spread further apart. Typically, these waves of grief are stimulus bound, correlated to internal and external reminders of the deceased.

Furthermore, grief is a fluctuating state with individual variability, in which cognitive and behavioral adjustments are progressively made until the bereaved can hold the deceased in a comfortable place in his or her memory and a satisfying life can be resumed. In contrast, major depression tends to be more pervasive and is characterized by significant difficulty in experiencing self-validating and positive feelings.

Major depression is composed of a recognizable and stable cluster of debilitating symptoms, accompanied by a protracted, enduring low mood. It tends to be persistent and associated with poor work and social functioning, pathological immunological function, and other neurobiological changes, unless treated. This is as true of major depression after the death of a loved one as in non-bereaved individuals with major depression 34, 38. Moreover, untreated major depression after bereavement carries the extra burden of prolonging the pain and suffering associated with grief.

When a major depressive syndrome occurs soon after the death of a loved one, according to the ICD-10, it should be classified as major depression. The key to successful treatment is the recognition that bereavement related major depression is like other, non-bereavement related major depression.

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Grief and bereavement: what psychiatrists need to know
SIDNEY ZISOOK1 and KATHERINE SHEAR

VIDEO ONE:

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Search Title: When to Treat Grief and Bereavement

TEDx Talks
Sidney Zisook, MD, Phd, describes the circumstances when bereaved patients may benefit from treatment.
Duration: 5:08 min