INVITED ARTICLE

MANAGEMENT OF GRIEF

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ABSTRACT

This article classifies grief into uncomplicated and complicated grief. A review of the psycho-analytic literature, recent studies on incidence, stages and developmental aspects of normal grief, the phenomenology and psychopathology of complicated grief, and the total management of grief amongst psychiatric patients, is presented.

Complicated grief, classified as delayed, prolonged and distorted grief is described. As there is increased morbidity and mortality , the need for psychiatric intervention is necessary.

The treatment of pathological grief includes grief counselling, brief dynamic psychotherapy, group psychotherapy, and family work. In addition to psychotherapy, for mental illness accompanying grief, biological treatment such as drugs should not be avoided.

Therapeutic work with bereaved patients include the empathic approach, active listening, encouragement of verbal expression of affect, giving permission to grieve, and maintenance of therapeutic neutrality. Adequate attention must be given to analysis of counter transference and case supervision of the student therapist.

Keywords: *grief, complicated/ uncomplicated, psychopathology, management*

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INTRODUCTION

The capacity to mourn is an important milestone in personality development. Failure to mourn can lead to difficulties in formation of intimate relations. Grief is a painful experience and the wish to deny it is universal. In undergraduate and graduate medical training, insufficient curriculum time is spent on the teaching of grief and its management. This article examines the developmental and clinical aspects of grief.

Early understanding about loss crystallised upon Freud's discovery of psychoanalysis. Freud's contribution has been summarised by Pollock[1]. Further knowledge on the subject include the work of Spitz[2] on 'Anaclitic Depression', Klien[3] on 'Depressive Position' and Object Loss, Deutch[4] on 'absence of grief', Bowlby[5] on 'attachement and loss', Volkan[6] on 'linking objects', Mawson[7] on "Guided Mourning', and the influential work of Pollock[8]. Loss experience can lead to pathology and illness but it can also contribute to creativity. Gustav Mahler[9], the musical genius, is one good example, whose music reflects his unresolved grief from multiple losses.

Weiseman and Myers[10], found a life-time rate of uncomplicated grief from death, of 10.4%. Singapore's figures are likely to be less because of our young population. Rynearson[11] found that 15% of all bereaved develop intense, enduring pathological grief.

Grief can be divided into uncomplicated and complicated grief. Those experiencing uncomplicated grief may consult healers, pastors, priests, or counsellors, whereas in complicated grief, medical or psychiatric intervention will be necessary. Health workers do suffer from 'occupational grief', especially those working in Oncology, Hospices, Neonatal Paediatrics, Psychiatry, and Social Work. Professionals repeatedly exposed to death of their clients or patients through illness or suicide may deny the loss and suffer from decreased work efficiency, emotional detachment and stress.

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DEFINING GRIEF

Current understanding does not permit a precise definition of grief. Freud[12] described grief as a profoundly painful feeling, associated with cessation of interest, loss of capacity to love, inhibition of activity, and emotional pain arising from actual loss. Clinicians will define grief as the emotional pain that accompanies actual or psychic loss. Psychic loss includes injury to self-esteem, non-material loss, loss of abstractions or developmental losses.

DSM 3(R)[13] has defined uncomplicated grief but recent work (Zisooks et al)[14] indicate that the condition may not be easily distinguished from major depression. The literature is also vague about how uncomplicated grief evolves into major depression.

Post-traumatic stress disorder (PTSD) can occur in the bereaved who have experienced sudden unexpected death of a loved one[15]. In the author's outpatient clinic, a 30-year-old, married Chinese male insurance agent presented with phobic and panic anxiety appearing some months after the sudden death of his father who died of a heart attack. The patient had witnessed the unsuccessful resuscitation of his father at the waiting room of the A & E Unit of a general hospital. Despite treatment for his grief and anxiety, he did not improve until PTSD was recognised.

OBJECT LOSS : DEVELOPMENTAL ASPECTS

Pine[16] has reviewed the literature on object loss in normal development. Unknown to many people, growing up involves some degree of mourning, divided into the three stages of life. In childhood, during the separation-individuation phase, ie the period when the child begins to experience separation anxiety, the emotions of 'grief' become expressed transiently. This is also the period when the child begins to bond with the mother, from the sixth month to the eighteenth month. Separation from mother is essential for the child to individuate. In early childhood, other loss experiences take place when siblings are born which result in loss of parental attention as more time is spent with the new born or when leaving home, going to school,

turnover of teachers, or attending overnight camps. During the latency years, age 6 to 11, the child undergoes less experience with mourning.

Adolescence is a period of intense mourning. This is the phase when the youngster learns to give up his childish habits and behaviour, becoming less dependent on his parents, and turning to peers. Friendship is volatile, and grief sets in when relationships turn sour. Sexual awakening occurs and personality matures. The adolescent will have to 'mourn' the loss of his previous personality. Further distancing from his parents takes place while he forms his peer group. He has to eventually 'mourn' the loosening bonds with his parents, in order to achieve healthy interdependent relationships. Death of parents or siblings during this period can be very painful, associated with intense guilt.

In adulthood, the ageing process leads to loss of omnipotence and one realises that death is not too far away. Our bodies become susceptible to disease and we have to 'mourn' the loss of health. Children leaving home (empty nest), and loss of close relatives take place. Therefore late adulthood must remind us to prepare for our own death.

Object loss during childhood, adolescence and adulthood is seldom scrutinised developmentally unless patients enter psychotherapy.

UNCOMPLICATED GRIEF

Lindeman[17] has delineated the stages of normal grief. A simplified classification of the stages of normal grief will now be outlined, bearing in mind that there is considerable overlap between stages.

Shock

This stage is characterised by numbness of emotions. There is inability to feel the impact of the death and a state of emotional detachment develops. During this stage, the bereaved may have difficulties in making decisions and may carry on with normal duties as if death never occurred. The stage of shock may last from a few hours to a few weeks.

Searching

During this stage the adult bereaved does a mental search for the deceased, becoming obsessed with thoughts of the deceased, while children may do a physical search and check behind doors etc. The adult may make imaginary conversations with the deceased or visit places where the deceased may have frequented. The deceased is idealised. "He is my perfect husband". There may be feelings of anger, guilt, resentment, jealousy or self-pity. The guilty persons may feel: "I could have done more". There may be anger against God or the medical profession. A woman in grief in the searching stage, is illustrated in the example below.

She is searching for her son and moves restlessly around the house, looking in places in which she thinks he might be found and thinking constantly about him. When she hears a creak on the stairs she immediately thinks that it is John: "John, is that you?"

Sadness

At this stage the person freely expresses his sadness and loss becomes a reality. The person feels vulnerable and lonely and may lose interest in housework, living, personal appearance, making frequent visits to the doctor, complaining of physical symptoms. Asians are more likely to somatise grief.

Stability

In this stage the bereaved returns to his normal stable state. He will improve his personal appearance, plan a holiday, take interest in other people's needs, socialise, develop hobbies, and generally become more enthusiastic. When this happens, he has come to terms with the loss, but the grief is never over.

COMPLICATED GRIEF

Complicated grief requires medical and psychiatric intervention because of increased morbidity and risk of suicide. The general practitioner (GP) must be able to identify the condition and consider psychiatric referrals. Complicated grief manifests in 3 forms: (1) delayed grief, (2) prolonged grief, (3) distorted grief.

Delayed Grief

This is characterised by denial of grief, lack of emotion, and a prolonged period of numbness. In the normal person this period of numbness extends for not more than a few weeks. The grief is repressed, and the person diverts his attention into work or other distraction. A second death may trigger off previous unresolved grief. In such cases it may be clinically difficult to ascertain which object the grief is targeted at - present or the past loss.

Prolonged Grief

When grief lasts more than six months, it becomes prolonged, and may continue for many years. The survivor finds it hard to accept the loss, wishing that the partner is alive. Idealisation of the lost person becomes evident and unpleasant aspects of the relationship is repressed. Underlying guilt may be another cause for inability to complete grief work. Prolonged grief may be perceived as a form of punishment - guilt is transformed as a wish for punishment. The wish for punishment may be disguised in the form of somatic symptoms eg epigastric pain.

Physical pain becomes the penalty for having wronged the deceased. All these phenomena are based on unconscious defense mechanisms. Psychotherapeutic exploration of defenses will allow expression of forbidden feelings within a safe, therapeutic environment. Once these repressed feelings are allowed expression, normal grieving will resume. Similarly, repressed anger against the deceased prevents resolution of grief.

Distorted Grief

The common symptoms of distorted grief are excessive preoccupation with thoughts of the deceased and feelings of disabling sadness. Sadness can lead on to depression and its accompanying symptoms and even suicidal behaviour. Sadness is usually accompanied by tearfulness but sometimes by an inability to cry. The bereaved may attempt to avoid the pain by becoming overactive in work, extending working hours, or taking on more responsibilities. Identification symptoms may develop eg. If the deceased died of a heart attack, the bereaved may complain of chest pain. Excessive hostility towards doctors, nurses, and hospitals may lead to complaint letters, law suits etc, usually as a result of projected anger. Anger towards the deceased is displaced towards treaters.

Anxiety attacks and phobic avoidance of places frequented by the deceased may occur. Somatisation or specific somatic illnesses such as asthma, migraine, tension headache, and peptic ulcers can be associated with bereavement. This is especially so with Asian patients who tend to suppress feelings and are to prone somatisation. The symptoms of distorted grief are outlined in Table I.

The evaluation of complicated grief requires a free floating style of interviewing familiar to the psychotherapist. Medical line of questioning must be avoided. A full psychiatric enquiry about each symptom should be carefully obtained without being overly intrusive.

Table I - Symptoms of Distorted Grief

1. Preoccupation with thoughts of the deceased.
2. Sense of presence of the deceased.
3. Excessive tearfulness or inability to cry.
4. Over-activity, blocking off the loss.
5. Acquisition of symptoms of the deceased.
6. Alteration of relationships with relatives/friends.
7. Hostility against specific persons.
8. Depression leading to suicidal behaviour.
9. Excessive anger.
10. Excessive guilt.
11. Over-idealisation of deceased.
12. Phobic avoidance of places, things or people associated with the deceased.
13. Panic attacks.
14. Anniversary reactions.
15. Somatisation.
16. Over-frequent visits to the grave.
17. Attempts to replace loss (takes new partner, becomes pregnant.)
18. Mummification.
19. Nightmares and pseudo-hallucinations.

Diagnosis of complicated grief

The diagnosis of complicated grief is based on mental state examination, including evaluation of the phenomenology and dynamic psychopathology specific to the particular patient. There are no physical findings or positive test results. As grief is a psychological state, its evaluation must begin in the context of a therapeutic environment. As complicated grief seldom presents as an entity by itself, it may accompany depression, stress, neurosis, manic depressive psychosis, or schizophrenia.

A careful assessment for mental illness is mandatory. The general principles of diagnosis of complicated grief will now be described.

When the patient spontaneously reports that he has lost someone, the diagnostician should enquire about symptoms of grief according to Table I. Loss can occur either through death or separation eg divorce. If the patient does not report about losses but complains of physical or psychiatric symptoms, then it would be necessary to check for details of recent or previous beravement. Those presenting with psychiatric illness will eventually reveal their grief if reminded. Psychiatric evaluation includes elucidating the history, and mental state, circumstances of the loss, and the impact of the loss upon the person's life.

Diagnostic evaluation of loss should focus on:

(a) loss of meaningful relationships eg broken marriages or failure of courtship,
(b) real loss by death,
(c) illness in patient or his relatives,
(d) loss of job, blindness, deformity etc,
(e) abortion and/or stillbirth,
(f) birth of handicapped child,
(g) developmental losses.

The reaction to meaningful loss varies with each individual and depends on such factors as early life experiences, the relationship with the deceased (either dependent or conflicted), the nature of the loss, opportunity to prepare for the loss, if any, and extent of social support.

Local patients may somatise grief in the form of physical symptoms or psychosomatic illnesses. Such patients may not be able to consciously link their symptoms with the grief experience. Common symptoms include chest pain, headache, peptic ulcers, or asthma. A grieving patient suffering from peptic ulcers needs antacids and grief therapy. A biopsychosocial approach is recommended for these cases.

Psychotherapeutic assessment should follow psychiatric assessment. Greenson[18] (1992) has outlined the steps involved.

Treatment aspects

The treatment of complicated grief includes brief psychotherapy (either grief counselling or brief dynamic psychotherapy) or long term psychotherapy. If a single focus can be identified such as oedipal or loss issues, brief therapy is indicated. However, there are practitioners who use brief psychotherapy for multiple foci. Those with preexisting personality disturbances, suffering from complicated grief, may do better with long term psychotherapy. Short-term group-psychotherapy has recently been found to be useful in grief management (Piper, McCallum, and Azim)[19].

The general principles of grief counselling has been outlined by Crenshaw[20]. Grief counselling can be done by mental health workers, counsellors, social workers, or psychiatric nurses, under supervision by a trained psychotherapist. The general principles of grief counselling includes the therapist's willingness to listen intently, his patience, and his presence. Confidentiality, privacy, and a generous supply of tissue paper must be available. The therapist must be willing to share the pain of grief expressed by the patient. Both must realise that unbearable pain will finally be resolved. The wish to avoid the pain of grief is universal and the patient must be gently confronted with understanding and empathy. Termination issues must be dealt with as in any psychotherapy. The principles of grief counselling are outlined in Table II.

Table II - Principles of Grief Counselling

1. Helper must come to terms with his own unresolved grief, if any, and anxiety about death.
2. Work in the context of the family.
3. Respect religion, culture of the bereaved.
4. Empathise, but don't over-identify.
5. Be able to detach.
6. Maintain therapeutic neutrality.
7. Create conditions to allow verbal expression of grief.
8. Allow the bereaved to tell their story, and share memories.
9. Give permission not to grieve if therapy becomes too painful.
10. Listen to feelings behind the spoken words.
11. Help the bereaved to develop new interests, activities.

The technique of brief psychotherapy has been outlined by Mann[21](1973), Davanloo[22] (1979), and Sifneos[23] (1979). Davanloo offered 5 to 15 sessions of brief therapy. He did an initial assessment regarding suitability in the following aspects:

(a) patient's quality of human relationships,
(b) affective functioning of the ego,
(c) patient's psychological mindedness,
(d) response to interpretation,
(e) intelligence,
(f) the ego's defensive capacity.

Mann's approach includes a fixed time of 12 sessions and identifying the central issue. The central issue reflects a theme that links the presenting symptoms with childhood conflicts.

The primary function of mourning is to prevent mental ill-health and enable the bereaved to withdraw their emotions

from the lost object and form new attachments. The psychotherapist must assist the patient in achieving this goal. Grief therapy does evoke counter-transference feelings, which, if unrecognised, may affect the therapist's ability to empathise with his patient. No therapist should embark on grief therapy without working on his own personal losses, if any.

As bereavement affects all family members, family work is essential for some cases, especially in the Asian extended family. Bloch[24] has described a family systems approach in the management of unresolved grief.

Psychopharmacology does have a place in the management of complicated grief if there are underlying psychiatric illnesses. Drug therapy should always be combined with psychotherapy.

The value of grief therapy for uncomplicated grief in preventive mental health is unclear. Further understanding of cross-cultural aspects of grief is also necessary.

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