
Grief

Normal

Complicated

Traumatic

Linda J. Schupp, Ph.D.

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ABOUT THE AUTHOR



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On a personal note, Linda is no stranger to the impact of grief. She has suffered the loss of her mother, father, two husbands, and eighteen-year-old son, all in traumatic, unexpected ways. Her personal and professional experiences brings depth, understanding, and practical application to the expanding field of grief.

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GRIEF IS

Like an ominous towering giant, whose uplifted hand darkens the heavens, blocking the light and the sun's warming rays.

Like a champion prize fighter, who knocks me down again and again, then dances lightheartedly around me to make certain I don't arise.

Like an insidious disease that infiltrates every cell of my body, soaking up and sapping my strength, and vitality.

Like a tidal wave that stealthily walks towards me, crashing, crushing, drowning and destroying everything in its pathway.

Like a tornado that deafens and swallows me up in its powerful whirling mouth, then spits me out in a desolate undesirable place.

Like a locomotive speeding down life's track who toots its eerie untimely warning, then flattens me like an unresisting pancake.

Like an engulfing impenetrable fog which makes my movement and functioning impossible.

Like blinders on a horse which restrict and narrow my vision, causing me to continuously focus on my ever present loss.

Like a tormentor who tightly restrains my hands and feet in bands of steel, refusing to allow any movement or freedom.

Like a disguised thief who suddenly pounces on me, gags and binds me, rendering me helpless as he steals my loved ones.

Linda J. Schupp
January 1, 2003

Preface



People are often curious as the motivation for writing a book on grief. Is this a professional interest or a personal one? I would have to answer “Yes” on both accounts. My dedication to this field is more than a passing fancy. The experience of grief is not dry, dusty textbook theory for me. I have personally felt the intensity of its pain in the laboratory of life.

I have grieved the deaths of my mother, father, two husbands and my 18 year old son, all who died in either shocking or expected ways.

My mother was walking along the sidewalk in downtown Miami, Florida when an out-of-control car spiraled down a parking lot ramp, entered the street, hit my mother and hurled her through a storefront window. She lingered unconscious for five days, then died.

My father died unexpectedly in a nursing home from a medical mistake which caused heart failure. Despite his pitiful pleas to stop the procedure, his cries went unheard, and his heart stopped instead.

My teenage husband went to sleep at the wheel of his car, it hit an embankment on the side of the road, and folded like an accordion. Though there was not a broken bone in his body, his liver was crushed, and he died several hours after the accident.

Later in life, I suffered the loss of another husband through suicide. When I returned home from work, I heard an engine running in the garage. I opened the door and found my husband, alive but unconscious, from carbon monoxide poisoning. The Flight for Life took him to the hospital, but he couldn’t be resuscitated.

Though these deaths were painful and shocking, my most severe psychological wounding was the death of my son, Cliff. When he was twelve years old, he was diagnosed with a synovial sarcoma

which required the total amputation of his right arm. My son's illness persisted over a six year time frame and we tried many cancer treatments; some helped temporarily, others not at all. Finally the cancer took his life, and this loss was the most difficult and traumatic for me.

Although the six years of suffering and the ultimate death of my son, Cliff, was overwhelmingly devastating, that experience set me on a path for further destruction. A secondary loss was already in place and beginning to erupt. My faith was temporarily shattered, and I no longer understood the God I had loved and worshiped since my youth. Studies have shown that people of any faith survive tragedies better than the non-faith community. Unfortunately, I was the exception to that rule.

Many friends and loved ones sincerely wanted to comfort us, but words weren't easy, and they were frequently stunned by the enormity of our grief. Not knowing what to say, yet wanting to soothe our pain, they employed "*religious pain killers*," which arrived in the form of clichés. I still vividly remember the painful days that followed the amputation of my son's right arm. We were bombarded with clichés such as, "This is God's will" or "God won't give you more than you can bear." Cliff and I tried in vain to squeeze a drop or two of comfort from such sayings but they only deepened our pain.

Because my well-intentioned comforters kept inflicting wounds, I pulled away from them, and the pencil became my friend. Journaling, writing, and poetry served as therapy for me. My personal pain propelled me into re-entering college and studying psychology, but in that academic environment grief had not been given its rightful place. Today a myriad of research and books are available for college students, interested observers, or victims of grief.

Have I returned to normal after experiencing all these losses? Absolutely not, to return to normal implies that I am the same person I was before I encountered these events. A person is forever altered by traumatic grief, and we must choose what we will do with those experiences. Much healing has occurred in my life by choosing "*creative good*" or as some have said "*finding meaning in the grief*." Grief has carved a vacuum within me that has now been filled with compassion for my fellow sojourners. If I can lighten their load, shorten the grief journey, help them avoid certain pitfalls, or provide them with sustenance on the way, then my mission has been completed.

Introduction



The scientific study of grief is a relatively new field, with its early roots surfacing in the publication of Freud's 1917/1957 paper titled "Mourning and Melancholia." Though Freud wrote in 1917, there was little recognition or interest in the subject of grief until Lindemann published his study "Symptomatology and Management of Acute Grief" in 1944. Lindemann counseled with the bereaved who sought his help after the Coconut Grove fire in Boston, Massachusetts. He worked at the Massachusetts General Hospital and examined the normal and abnormal reactions experienced by those grieving individuals. Adler, who worked simultaneously with bereaved survivors of the fire in the emergency room of the Boston City Hospital, appears to be the first individual to recognize the effects of trauma on grieving. In her opinion, it wasn't just the death and loss of a loved one, but the horrific circumstances of the death. She viewed the trauma itself as the most difficult aspect. Her paper "Neuropsychiatric complications in victims of Boston's Coconut Grove disaster" began the research on traumatic distress.

Current work is underway with bereavement specialists and traumatologists working together uniting the two fields of study. Based on its early beginnings, grief has broadened its foundations and become multidisciplinary. Researchers from many disciplines are now contributing to our understanding and treatment of grief.

Although the study of grief is a comparatively new occurrence, the emotion of grief has been a universally felt phenomenon since the beginning of time. Every human being while traveling life's pathway will encounter losses, and at that time grief will become their companion for a portion of the journey. Even though grief is an uninvited and unwelcome companion, it can be persistent, pervasive, and sometimes overpowering with its presence.

The uniqueness of grief is found in its 100% predictability of invasiveness. All people, if they live long enough, will experience the emotion of grief. No one will escape its clutches; we will all succumb to its grip from time to time. Everyday people lose loved ones, health, finances, abilities, identity, status, a lifestyle, pets, mobility, marriage, confidence, dreams, homes, faith, love, dignity, beliefs, meaning in life, appearance, youth and material possessions to name a few.

Since grief is a condition that all will experience, it behooves those of us in the helping professions to prepare ourselves, regardless of the diversity of our occupations. Grief crosses the borders of all disciplines, titles, and positions. Medical professionals, physicians, and nurses may focus primarily on bodily health, but when cancer, strokes, and heart attacks occur, these physiological problems pave the way for the entrance of grief, both in patients and their families. Social workers may strive to cure the ills of society, but an honest evaluation of those ills reveals that they are heavily layered with grief. Psychologists, psychiatrists, psychotherapists and other mental health professionals may diagnose and treat mental and emotional disorders; however, a closer look may disclose that some of these disorders are intricately intertwined with grief. Hospice physicians and nurses may ease the physical pain and discomfort of terminal illness, but they must also soothe the emotional suffering of the dying and their families. Clergy may concentrate on the relationship between God and people; however, tremendous distortions of God and questions of faith arise because of the overwhelming effects of grief. If grief is not properly handled, it can separate the person from their God.

Are those of us in the helping professions adequately prepared to competently and confidently treat the one condition that will ultimately strike all people? And what about the severe psychological wounding that results from tragedies such as September 11, 2001, the Columbine shootings, or the Oklahoma City bombing?

This book serves as a reminder of the importance of incorporating grief techniques, treatments, and strategies into our particular professions. It also offers new research and a fresh perspective regarding modern techniques and treatment. We are on the threshold of many changes in the field of grief. The term, traumatic grief, may become a diagnostic entity in the next Diagnostic and Statistical Manual of Mental Disorders. If the proposed criteria is accepted, it would expel this most serious type of grief out of the realm of normalcy into a category of a mental disorder.

Regardless of diagnostic terms and categories, the many faces and forms of grief will always be with us. Since there is no vaccination to prevent grief, the helping professions and other concerned persons must stand ready to assist the multitude of clients and patients that the years may bring. I applaud you for your courage and concern in meeting that challenge!

The Nature of Grief



DEFINITIONS

What is grief?

Bereavement professionals, thanatologists, and traumatologists refer to grief as a word that is connected either to an emotion or to a process. The following definitions provide an explanation for grief as an emotion. Later we will describe grief as a process.

An intense emotional state associated with the loss of someone (or something) with whom (or which) one has had a deep bond. Not used as a synonym for depression.

The Penguin Dictionary of Psychology
Arthur S. Reber, 1995

An emotional attitude or a complex emotion, more or less synonymous with sorrow as generally used, but usually implying greater intensity and more specific reference.

A Dictionary of Psychology
James Drever, 1977

Deep mental anguish as that arising from bereavement, a source of deep mental anguish.

American Heritage Dictionary
Houghton Mifflin Co., 1996

2 *The Nature of Grief*

Intense emotional suffering caused by loss, disaster, etc., acute sorrow, deep sadness.

Webster's New World Dictionary
David B. Guralnik, 1970

Building upon the foundation of previous definitions, the existing boundaries of the complex emotion of grief can be expanded to allow room for an accompanying subset of emotions. Grief can change form and appearance, manifesting itself as another emotion. It masquerades in a myriad of emotions such as fear, guilt, anxiety, anger, irritability, and confusion.

The renowned author, C. S. Lewis clearly expressed that the emotion of grief disguised itself and felt like a different emotion.

No one ever told me that grief felt so like fear. I am not afraid, but the sensation is like being afraid. The same fluttering in the stomach, the same restlessness, the yawning. I keep on swallowing.

A Grief Observed
C. S. Lewis, 1961

Because of this chameleon effect, the following definition may be useful in comprehending the parameters and pervasiveness of grief. It can also assist in explaining the complexity of grief to clients who need to understand what they are experiencing.

Grief is an intense set of emotional reactions in response to a real, imagined, or anticipated loss.

Is There Life After Loss?
Linda J. Schupp, 1992

Some clinicians attempt to distinguish between an emotion and a feeling. They indicate that an emotion is defined as a intensely experienced state, which because of the intensity is visible to an observer. Feeling, on the other hand, refers to experiences, sensing, or having a conscious process.

Feelings may be less intense and, therefore, unobservable. Since clients use them interchangeably, and there is only a fine line of distinction, the difference between the two may be only a terminological heuristic.

All of the composite of grief feelings are a natural reaction to the loss we experience. Robert Neimeyer (1998), a grief theorist and researcher, indicates that every feeling has a function or a purpose.

THE FEELING AND ITS FUNCTION

Denial serves as emotional anesthesia and as a defense mechanism so the survivor isn't totally overwhelmed by the loss. It allows the person to gradually comprehend the loss, which makes it more bearable.

Anger/hostility acts as a self defense emotion, a protective one that demands that the world be predictable and operate according to our expectations.

Guilt explores our culpability and considers our effectiveness in the world. It is a self appraisal that wonders if we are competent and how we let the loss occur.

Anxiety awakens an awareness of a person's inability to control events. The person may feel he or she should have been able to prevent or at least predict the occurrence of the loss.

Depression causes the survivor to withdraw from outside stimulation for a while to allow the grieving person to turn inward and reflect on what has happened.

Fear works as an alarm system that warns survivors of major changes in their understanding and assumptions regarding themselves and others.

THE THREE TYPES OF GRIEF

Real—a recognizable event, existing or happening as a fact. **Example:** death, car accident, tragedy.

Imagined—a picture, pretense, assumption or fantasy of what might have been. **Example:** the normal potential of a physically or mentally deformed child, the monetary investment payoff, the promised but undelivered career promotion.

Anticipated—looking ahead, predicting, expecting or preparing oneself for an impending loss. **Example:** terminal illness, divorce, loved ones who are missing in action.

4 🐉 The Nature of Grief

Although most research and clinical interventions have focused on the loss of a loved one, the significance and importance of any type of real, imagined, or anticipated loss is person specific and all encompassing.

Common Losses

Loved Ones	Animal companions
Marriage	Amputation of body part
Career	Potential of self or others
Home	Image
Health	Safety
Appearance	Security
Mobility	Finances
Status	Material Possessions

MODELS OF GRIEF

There are numerous models that theorize the experiences of the bereaved as they move through the grief process. Some of the more popular models are briefly explained.

The Four Tasks of Mourning J. William Worden, 1991

Task I:	To accept the reality of the loss.
Task II:	To work through the pain of grief.
Task III:	To adjust to an environment in which the deceased is missing.
Task IV:	To emotionally relocate the deceased and move on with life.

Note: Worden's research dealt primarily with widows and widowers, so his work focused on "*real, imagined, and anticipatory*" grief.

Stages of Grief Elizabeth Kubler Ross, 1969

D—Denial	Rejection or refusal to accept the truth. Also known as shock.
-----------------	--

- A—Anger** Physical expression of hostility directed toward people and God.
- B—Bargaining** An agreement between conscious mind and soul involving a negotiation for more time to live.
- D—Depression** Reactive grief over a specific loss and preparatory loss over their coming death.
- A—Acceptance** An approval of existing conditions, a receptivity to things that can't be changed.
-

Note: Ross worked predominantly with terminally ill patients and her model reflected their psychological journey. This emphasis leaned heavily on the component of “anticipated” grief.

Six “R” Processes of Mourning Therese Rando

1. Recognize the loss.
 2. React to the separation.
 3. Recollect and re-experience the deceased and the relationship.
 4. Relinquish old attachments to the deceased and the old assumptive world.
 5. Readjust to move adaptively into the new world without forgetting the old.
 6. Reinvest.
-

Note: Rando used her model with various populations and dealt with “*real, imagined, and anticipated*” grief.

The Process of Mourning John Bowlby, 1961

- Preoccupation**—thoughts are focused on deceased person. Searching and protest take place.
- Disorganization**—survivor feels the pain of the experience, suffers from turmoil and despair.

Reorganization—normal functioning and behavior are restored.

Note: Bowlby's focus as indicated in his model was "real" grief resulting from the death of a significant person.

THE GRIEF JOURNEY FOR SURVIVORS OF LOSS

Linda J. Schupp, 1992

SHOCK

A loss occurs, news of a terminal illness arrives, or tragedy strikes and the first reaction may be shock. It is frequently accompanied by denial, or a non-reality state which acts as an emotional anesthesia to temporarily numb the senses. It also serves as a shock absorber which enables the survivor to gradually comprehend the loss.

Anger may also be a part of this initial shock process. Anger is a normal defense emotion and may be used to protect oneself or others from the intensity of the pain. Anger serves another purpose throughout the grieving process; when people experience a feeling of helplessness, they may choose to mask it by expressing the more dominant powerful emotion of ANGER. Anger momentarily provides epinephrine which energizes the person while sadness renders a person weak. Gradually survivors recognize that they must accept this loss or trauma as real and then the shock is over and suffering begins.

SUFFERING

After a few days or weeks, depending on the severity of the loss, a person enters the suffering phase and begins to acutely feel the pain. During the early phase of suffering, most of the energy is absorbed by intense emotions and "*mole hills have become mountains.*" As time progresses (Worden, 1991), many adjustments are taking place; perhaps new tasks must be performed, additional roles absorbed, and unfamiliar skills required, all of which saps strength and endurance. The griever will gradually feel better, but may experience "pockets of grief" for a long time. Healing is a gradual upward climb with peaks and valleys. Many grief theorists are questioning

and re-evaluating the usefulness of timetables. There are just too many variables to make an accurate assessment.

SURVIVAL

A person knows he or she has survived and is becoming emotionally stable when the loss or tragedy no longer absorbs all the daily thoughts and energy. A degree of energy is now available to be reinvested in life. For people who have experienced a minor loss, they recognize within a few weeks or months that some healing has occurred. For others with significant life losses, they may be aware of a small amount of healing, but it is a gradual process that could take many years.

Survivors often need signposts to recognize that they are moving successfully through the grief journey. The *energy shift question*, enables survivors to measure their own degree of healing. “*How much time and energy do I have available for the present or for the future?*” Immediately after a substantial loss, approximately 85–95% of time and energy may be locked into the grieving process with only 5–15% available for the present. As healing continues, the percentages will gradually shift with less time invested in the grief process and more time available for the present. The “*energy shift*” can be an excellent tool to demonstrate that they are making progress. It is also an indicator for a therapist to determine if the client is moving through the process appropriately, or if they are stuck and perhaps the grief has become complicated.

STABILITY

Stability is the final state of emotional homeostasis. It occurs when the bereaved has completed the grief work and is reinvesting the time and energy into experiencing life. The loved one or the lost object may always be viewed with sadness, but it doesn’t hold the survivor in its power as it did at the onset. The survivor has adapted to the loss and can experience satisfaction and pleasure in life and relationships.

Note: This model is applicable for “*real, imagined, and anticipated*” grief for most types of loss

Regardless of the model adopted, most theorists believe that if the survivor doesn't complete or move through the process, then the grief becomes complicated.

THE PSYCHOPHYSIOLOGICAL AND IMMUNOLOGICAL IMPACT OF GRIEF

Much current research indicates there is a relationship between physiological processes and psychological experience, hence the term “*psychophysiological*.” Colin Murray Parkes in the third edition (1998) of his book, *Bereavement* makes a compelling case for this connection. He cites numerous studies that tie mortality to grief. It has long been recognized that widows and widowers have a higher mortality rate than their married counterparts. One study by Young, Benjamin and Wallis (1963) found that mortality rates peaked for widowers during the first year of bereavement. About 40% of the group studied died during the first 6 months of bereavement. Other studies have had similar findings over the years. Stroebe, *et al.*, (1993) reviewed 15 longitudinal studies on widows and widowers and stated that

The bereaved are indeed at higher risk of dying than are non-bereaved persons. This seems to apply not only to the widowed but also for other bereaved relatives. Highest risk occurs in the weeks and months closest to loss, and men appear to be more vulnerable than women.

There have also been indications that link grief to heart disease. In 1835 Benjamin Rush, a physician who signed the Declaration of Independence, wrote “*Dissection of persons who have died of grief, show congestion in, and inflammation of the heart, with rupture of its auricles and ventricles.*” Parkes (1998) explains that a ruptured heart is not a frequent occurrence but it is usually caused by coronary thrombosis. Perhaps this distinguished physician knew something significant that we today are only beginning to realize. It gives us food for thought and further research.

Parkes (1998) also attributes increased mortality after bereavement to “*cirrhosis of the liver, infectious diseases, accidents, and suicides.*” Jones and Goldblatt (1987) and Mellstrom, *et al.*, (1982) also report excesses for accidents. It is possible that newly bereaved people find it difficult to concentrate while driving, and some may deliberately take risks, while others may consume too much alcohol.

Kapno, *et al.*, (1987) showed a ten-fold increase in suicides among women during the first week of bereavement. The same study revealed a sixty-six-fold increase in men.

Osterweis, *et al.*, (1984) believes that suicide, cirrhosis, and cardiac arrest are the 3 principle causes of grief-connected death.

All three conditions have clinical antecedents (depression, alcoholism, and cardiovascular disease) that can be detected before or very shortly after bereavement, thus identifying three high risk groups for whom early intervention might be useful.

Parkes (1998) further indicated that current research shows that heart disease is the most frequent cause of death in relationship to bereavement. His following question makes sense in light of that fact.

Is there a medical way of preventing cardiac deaths after bereavement? Well, there may be. The main way in which the emotions influence the heart is via the vagus nerve. If we could block or damp down that influence in people with known heart disease who suffer a bereavement then we might be able to protect their coronary arteries from possible damage. The use of a beta-blocking drug such as Propranolol as a preventive measure would do just that. No research has yet been undertaken to test this theory but the medication is widely used and, with proper medical supervision, quite safe.

Parkes (1998) further discussed a cancer link and bereavement. Some excellent studies linking grief with cancer in women have been conducted by psychiatrists, Schmale and Iker (1966) at the Strong Memorial Hospital in Rochester, Minnesota. These psychiatrists believed and proved that helplessness and hopelessness which may accompany loss could cause a physical illness. Women who were suspected of having cancer of the cervix were interviewed about recent losses in life. When such evidence was present, it was predicted that she would have cancer. This psychiatrist was accurate in 71% of the cases.

Additional studies cited by Parkes (1998) have given us information regarding the body's "*immune response system*" and its relationship to infections, cancer and more serious diseases. Our immune system is complicated and it determines whether we can resist the infections, disease, or cancer cells that attack us. We possess 2 types of lymphocytes which reside in our blood, T-cells and B

cells. Schleifer (1983) discovered that both types were suppressed in 15 widowers during the first 2 months after the death of their wives. Recent studies prove that grief can impair the T-cells, also known as “natural killer” cells, and grief causes increases in the T-helper cells. We do know that bereavement has an effect on our health.

Much more study needs to be conducted but we certainly have a good beginning of a base of knowledge relating bereavement to death and illness.

NORMAL GRIEF

Grief is considered normal when it has a known cause and no correlation with self esteem. Other designations for these phenomena are uncomplicated grief, uncomplicated bereavement and acute grief.

Normal Reactions

Physical

Headaches
 Nausea
 Appetite disturbances
 Shortness of breath
 Heart palpitations
 Chest pain
 Loss of motor skills
 Dizziness
 Insomnia
 Fatigue
 Choking sensation
 Muscle weakness
 Dry mouth
 Empty or fluttering
 sensation in stomach

Emotional

Sorrow
 Fear
 Anxiety
 Guilt
 Anger
 Relief
 Numbness
 Release
 Helplessness
 Listlessness
 Loneliness
 Longing

Cognitive

Memory problems
 Inability to concentrate
 Problems with decision
 making
 Confusion
 Auditory or visual
 hallucinations
 Sensing the deceased

Behavioral

Wearing clothing of deceased
 Crying
 Keeping room of deceased intact
 Carrying picture or object of
 deceased
 Absentmindedness
 Distancing from people
 Loss of interest in regular events

Intrusive or obsessive thoughts	Dreams
Disbelief	Avoiding painful reminders
Lack of sequential processing	Frequent sighing
Non-reality	Intolerance to noise

COMPLICATED GRIEF

Complicated grief is a disruption in the normal grief process which prohibits healthy closure and healing for the affected person. It manifests itself as a response or reaction which may be prolonged, delayed, distorted, absent, concomitant, excessive, or unresolved/layered. Studies indicate that 14–30% of grieving people will develop complicated grief.

Aaron Lazare (1979), a psychiatrist at the Massachusetts General Hospital Mental Health Clinic, estimates that 10–15% of their clients have an unresolved grief issue beneath their presenting psychological condition.

Zisook S. and DeVaud, R.A. (1985) found that 77% of patients in a California psychiatric facility had unresolved grief, per the patients' own statements. John Bowlby (1980) stated

Clinical experience and a reading of the evidence leaves little doubt of the truth of the main proposition—that much psychiatric illness is an expression of pathological mourning—or that such illness includes many cases of anxiety state, depressive illness, and hysteria, and also more than one kind of character disorder.

Lindemann (1944), a pioneer in complicated grief who worked with survivors of the Coconut Grove fire in Boston, lists nine signs of abnormality. He referred to these abnormalities as “*distorted reactions.*”

- (1) Overactivity without a sense of loss.
- (2) The acquisition of symptoms belonging to the last illness of the deceased, presenting as conversion (hysterical) or hypochondriacal complaints.
- (3) A recognized medical disease, such as ulcerative colitis, rheumatoid arthritis, or asthma
- (4) Alteration in relationships to friends and relatives, with progressive social isolation.

- (5) Furious hostility against specific persons, resembling a truly paranoid reaction.
- (6) Such suppression of hostility that affectivity and conduct resemble a schizophrenic picture, with masklike appearance, formal, stilted, robotlike movement, and no emotional expressiveness.
- (7) Lasting loss of patterns of social interactions, with absence of decisiveness and initiative.
- (8) Behavior that is socially and economically destructive, such as giving away belongings, making foolish business deals, or performing other self-punitive actions with no realization of internal feelings of guilt.
- (9) Overt agitated depression.

Common Factors That Complicate Grief

An uncertain death or loss such as those who were missing in action

Holding on to false hopes

Concomitant losses

Unexpressed hostility

Narcissistic relationship

Self blame for abuse issues

Overly dependent relationship

History of depressive illness

Personality factors

Unresolved previous losses

Child abuse or childhood trauma

Insecure childhood attachments

Self-concept roles

Social problems

Prolonged duration

Delayed and insufficient responses

Excessive and disabling reactions

Repressed emotion or absence of emotion

Death of a child

Sudden unexpected death or loss

Death following a lingering illness

Ambivalent relationship with deceased

Belief that loss was avoidable

Note: When interviewing a client, these factors may serve as a predictor of potential complications. It would be advisable to use them as a checklist for part of your intake interview.

TYPES OF COMPLICATED GRIEF

Prolonged grief, also known as chronic grief, is easy to diagnose because of its lengthy existence. Clients often recognize that they are stuck somewhere in their grief journey and the end is not in sight. Since the grief does not subside and remains persistently severe, they may seek therapeutic assistance. Osterweis, *et al.*, (1984) states “*Not only is there no movement but there is a sense that the person will not permit any movement. It is the felt intensity of anger, self blame or depression that makes the reaction pathologic.*”

Absent grief, also known as masked, inhibited, and repressed grief, occurs when there is no overt expression of grief and the loss definitely warrants it. Perhaps an intimate relationship with a wife has ended through death or divorce, and the husband shows no symptoms of grief for weeks or months. It is clear that he is demonstrating a complicated reaction.

Distorted grief is also known as exaggerated grief. This is a rare occurrence, and usually manifests in individuals that have an underlying pathology. Perhaps there have been previous psychotic episodes or other diagnoses such as borderline or narcissistic personality disorder, or schizophrenia. This individual usually exhibits a bizarre behavior such as a young mother dressing the family cat in her deceased baby’s clothes.

Delayed grief is the manifestation of absent grief which characterized itself by its late arrival. It is then accompanied with intense emotions. Although numbness is common in the first weeks after bereavement, persons with delayed grief don’t even recognize it. Nearly all people suffering delayed grief develop depression.

Excessive grief hits with such intense emotions and frightening symptoms that the bereaved is overwhelmed. Although they are not psychotic, they may appear traumatized, out of control, and need a great deal of attention. They may be suicidal and require immediate hospitalization. Medication and stabilization must occur before the grief journey can begin.

Unresolved or layered grief attempts to grieve a present loss while there are layers of unresolved losses beneath it. One symptom that may be prevalent is an overreaction to the present loss, where the current grief doesn't warrant it.

Concomitant grief happens when there are several significant losses that occur simultaneously or in close succession. Multiple or simultaneous griefs usually should be viewed as trauma. In successive grief, the survivors cannot complete one period of mourning before another loss has overtaken them.

TRAUMATIC GRIEF

According to Selby Jacobs (1999), a leader in the field, a complete and precise definition for traumatic grief is still forthcoming. A group of experts in the fields of grief and trauma, organized by theorist and researcher Holly Prigerson and colleagues, met several years ago and discussed the need for a disorder which they called traumatic grief. Jacobs (1999) states that the choice of the name, Traumatic Grief, occurred as a result of data review and a consensus of the following group: Prigerson, Maciejewski, Piekonis, Wortman, Williams, Widiger, Davidson, Frank, Kupfer, Zisook, in press; Prigerson & Jacobs (2001). Many in that group had been referring to Traumatic Grief as complicated grief, and they didn't like the negative connotations of pathologic, morbid, neurotic, or unresolved grief. They felt that Traumatic Grief clearly defined the boundaries and focused on the two central elements, that of separation anxiety and traumatic distress, (Raphael and Martinek, 1997). Prigerson, *et al.*, developed a consensus proposed criteria for Traumatic Grief, which may become part of the next Diagnostic and Statistical Manual of Mental Disorders. Please see Chapter Two, "Assessment," page 22, for Prigerson's proposed criteria.

Lindemann (1944), a pioneer in the field, described the intense pangs of grief that was experienced by the survivors of the Coconut Grove fire; however, Adler (1943) was the first researcher to recognize the horror and trauma experienced by the bereaved survivors, which she diagnosed as anxiety neuroses, similar to Post-traumatic Stress Disorders. The diagnosis of Traumatic Grief probably would have been an accurate one for many of those people had there been such a classification at that time. Adler felt the trauma was the most salient feature of the survivors' problems. Horowitz (1976) fur-

thered Adler's concept that a bereavement disorder could have its roots in the traumatic aspects of a death.

Many experts have seen a need for a categorization of "*pathologic grief*" even though the name was not well liked. Raphael (1997), a well known leader in both bereavement and trauma, has summarized the distinctions between both fields. In grief, the survivor focuses on the deceased loved one, searches for reminders and is involved in separation distress over the deceased person. The focus in a traumatized individual is on the horror or violence surrounding the death, and they try to avoid any reminders of it. This survivor is hyper-vigilant, feels threatened, and is constantly on alert for a similar threat. Thus, with those fields each defining their unique criteria, they are working towards an integration of thanatology and trauma.

In the past, many clinicians saw grief and depression as being closely related, and if grief became pathological, it then left the realm of a normal diagnosis and became a mental disorder. Clayton (1990), as well as many others, shared this opinion. Jacobs (1999) clarifies that while it is true that there is a high risk of grief becoming depression, there is also a high risk for acute bereavement to manifest itself as an anxiety disorder or Post-traumatic Stress Disorder.

Jacobs (1999), in his book titled *Traumatic Grief: Diagnosis, Treatment, and Prevention*, summarizes:

Traumatic Grief is a disorder that occurs after the death of a significant other. Symptoms of separation distress are the core of the disorder and amalgamate with bereavement specific symptoms of being devastated and traumatized by death. For diagnosis, the symptoms must be marked and persistent and last at least 2 months. The symptomatic disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning. The use of "traumatic" in the name of the disorder does not refer to etiology but rather describes the phenomenology. Thus, the disorder may occur not only after deaths that are objectively violent and horrific but also in individuals who are highly vulnerable, after deaths that are not conspicuously traumatic. The nidus of the disorder for an individual is a traumatic separation. The disorder is one of a class of disorders, including Post-traumatic Stress Disorder and Acute Stress Disorder that occur after an event in a person's life which opens a period of risk for the disorder. Traumatic Grief may prove to be an adult form of Separation Anxiety Disorder in

adults and studies of Traumatic Grief as a new nosologic entity are necessary to establish this relationship.”¹

Jacobs (1999) uses attachment theory as the basis for Traumatic Grief “because of its objective, behavioral, personal, developmental and cognitive strengths.” He places it in the framework of a broad medical model, which “emphasizes the clinical complications of bereavement as disease states (or disorders).”

Bowlby (1977) defined attachment behavior as “any form of behavior that results in a person attaining or retaining proximity to some other differentiated and preferred individual who is usually conceived as stronger or wiser.” Bowlby (1980) explained that the expression of grief is an attempt to remain attached to the deceased person and to protect the loved one.

When separated from this important figure, humans experience separation anxiety as part of what we define as grief. Jacobs (1999) posed the question as to why we grieve after a death? The obvious answer is because the attachment bonds are broken. However, there is also another reason. In normal, complicated or traumatic grief, changes occur within the brain itself.

Jacobs (1999) elucidates regarding the neurobiology of grief affiliation citing numerous studies of evidence.

Posatron Emission Tomography scans now produce images of those regions of the human brain activated by test induced feelings of loss. . . . these studies identify diffuse limbic and prefrontal areas as the loci of these emotions.

Jacobs (1999) compares the similarities and contrasts the differences between Prigerson’s consensus group criteria for traumatic grief and another group’s criteria. Horowitz, Wilner & Alvarez (1979) developed The Impact of Events Scale which assessed traumatic phenomena. Horowitz, *et al.*, (1997) introduced criteria for a Complicated Grief Disorder that provides an additional set of published criteria. Horowitz also restricted his research and criteria to bereaved individuals. Horowitz, *et al.*, and Jacobs both agree and emphasize the interference or impairment in functioning for the bereaved. Both sets of criteria focused on severe symptoms of separation distress as well as avoidance being a symptom. They also included feelings of emptiness, loneliness, and loss of interest in usual pursuits.

¹ Copyright 1999 from *Traumatic Grief: Diagnosis, Prevention, and Treatment* by Selby Jacobs. Reproduced by permission of Routledge, Inc., part of the Taylor & Francis Group.

Horowitz and Prigerson's consensus criteria differed on duration of symptoms. Regarding timetables, Horowitz and Prigerson's criteria differed on duration of symptoms. Horowitz used one month duration at least 14 months after the death. Prigerson recommended two months duration without being defined in time relationship to the death. There were other differences in the sets of criteria. Horowitz included sleep disturbance, Prigerson did not. Prigerson's consensus criteria included the following additional criteria:

1. Detachment and absence of emotional responsiveness
2. Difficulty acknowledging the death (disbelief)
3. Sense of futility
4. Difficulty imagining a fulfilling life
5. Feeling part of oneself has died
6. Harmful symptoms or behavior related to the deceased
7. A shattered world view

Horowitz didn't have these items or any similar ones in his criteria, so there is no comparative data.

Horowitz and Prigerson's consensus group hope to reconcile the differences and have one single set of diagnostic criteria for Traumatic Grief. Prigerson's *et al.* criteria uses the outline of the DSM-IV, although the criteria is not complete and final. Different algorithms need to be tested for several years. This disorder is being introduced while waiting for additional data and studies.

As stated before, the person suffering from Traumatic Grief must have experienced the death of a significant individual in order to qualify for this particular diagnosis. Jacobs (1999) explains that this restriction does not diminish the importance of other losses, but they are not included at the present time. A divorce, a loss of a limb, loss of home or health do not qualify. The Traumatic Grief disorder may occur as a result of a horrific, violent, sudden or unexpected death, but it does not need those events to render the diagnosis. Horowitz, Marmar, and Weiss, (1984); Horowitz, *et al.*, (1997) indicate that Traumatic Grief could occur with any death that is personally devastating. The devastation is related to the relationship with the deceased and other personal factors as opposed to the violent death. They believe in most cases, however, the combination of environmental and personal factors will contribute to the creation of this disorder.

Rando (1994) indicates that there are 6 factors which contribute to a traumatic death.

Suddenness and lack of anticipation; violence, mutilation, and distraction; preventability and/or randomness; loss of a child; multiple death; and the survivors personal encounter with death secondary to either a significant threat to survival or a massive and/or shocking confrontation with the death and mutilation of others.

Until such time that a proposed criteria becomes a part of the Diagnostic and Statistical Manual of Mental Disorders, each clinician will have to use his or her own judgment as to how to label various grief problems. Since Horowitz and Prigerson's consensus criterion both agree that the death of a significant person is the entrance point to the diagnosis, it may be helpful to currently use Prigerson's Traumatic Grief criteria for any deaths that warrant it. It will be easy to follow because it closely resembles the DSM criteria.

Other losses can be placed in the individual categories such as absent, excessive, distorted, unresolved/layered, concomitant, multiple and prolonged. Not all grief is death-related and yet it can be complicated; therefore, other categories of complicated grief need to have a place in a counselor's diagnostic vocabulary.

Although complicated grief may not occur in the following examples, these individuals would certainly place in the high risk population. How would we categorize a mother who was involved in a car accident which permanently crippled her 2 year old baby girl? What about this little one as she develops and struggles with life? What diagnosis would be used for the parents of a child that is burned beyond recognition, yet lives? What effects would the disfigurement have on the child? How about the parents of the 250,000 children who are born physically and/or mentally handicapped each year, requiring constant care with no hope of attaining normalcy? How would we diagnose the husband who is beaten and maimed and must spend the rest of his life in a wheelchair? And what about the devastating effects on his wife? What about the husband whose wife must succumb to multiple amputations of body parts due to diabetes? And what effect would the loss of body parts have on her life? What about the lonely widow who is legally blind and spends her days in seclusion and darkness? How would we diagnose the husband who watches his wife mentally disintegrate because of the dreaded disease of Alzheimer's? A *living death* can be as devastating as an actual death, and may be more complicated. Perhaps in time the definition of traumatic grief will be expanded to include other griefs, but until then, the consensus group of experts has limited the diagnosis to death-related losses.

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