Grief and Mourning
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Learning Objectives
• Define grief and mourning and understand how they are interrelated.
• Examine theories and research related to grief.
• Identify the bio-psychosocial impact of grief and mourning.
• Formulate interventions for various stages of grief and mourning.
• Determine appropriate use of medications in patients who are grieving and mourning.

Why Talk About Grief?
• “While life expectancy in the US grows, the mortality rate is still the same. One out of one will die.”
Definitions

- **Bereavement:** state of having suffered a loss.
  - Period after a loss during which Grief is experienced and Mourning occurs.
  - Comes from same Latin root word as “to have been robbed...” i.e. to have experienced loss.
- **Loss:** Change that includes being without someone or something;
  - Physical (person, car, house, breast)
  - Psychosocial (divorce, illness, ob, dream, hope).

Definitions

- **Grief:**
  - Multi-faceted reaction to loss
  - Emotional, physical, cognitive, behavioral, social, and philosophical.
  - Universal, yet unique.
- **Mourning:**
  - Outward expression of loss and grief
  - Action to the reaction
  - Influenced by cultural customs, rituals, and society’s rules for coping with loss.

Grief and Mourning
Why We Grieve & Mourn

• We Grieve because love doesn't end with death.
• We Mourn because grief is painful.
• Grief and mourning are the price we pay for love.

Common and Unique

• Each death is unique.
• Each person’s experience is his or hers alone.
• Each grief experience is unlike any other.

Grief & Loss Theory
Grief Theory: Work

- Freud: “Grief Work”
- Process of breaking ties that bind survivor to deceased.
- Involves 3 elements:
  - Freeing the bereaved from bondage to the deceased
  - Readjustment to new life circumstances without deceased
  - Building of new relationships
- Requires acknowledging and expressing painful emotion
- Failure to engage in or complete grief work leads to:
  - Complicated grief
  - Increased risk of mental and physical illness
  - Compromised recovery

Freud & Shapiro, 2001

Grief Theory: Stages

- Kubler-Ross landmark work: Anticipatory Grief
  - 5 stages people experience when faced with:
    - Terminal illness grief management
    - Reality of impending death or catastrophic loss
  - Stages include: denial, anger, bargaining, depression and acceptance
  - Revolutionized care of terminally ill and thinking about loss.
  - Stages don't capture complexity and diversity of the grieving experience
  - Don't address physical, psychological, social or spiritual needs experienced by the bereaved
  - Not research based

Downe-Wamboldt & Tonyn, 1997

Grief Theory: Phases

- Parkes: Numbness, Yearning, Disorganization, Reorganization
- Sanders: Shock, Awareness of loss, Conservation withdrawal, Healing and Renewal
- Bowlby (1950-60s): Shock/Numbness, Yearning and Searching, Despair/Disorganization and Reorganization and Recovery
### Grief Theory: Directions

- **Bonanno:**
  - First to contradict work of Fraud and Kubler-Ross
  - Research showed it is possible to measure grief
  - Compelling finding:
    - Resilience most common pattern
    - Natural resilience is main component of grief and trauma
    - Delayed grief reactions rare
    - Laughter and smiling is healthy and protective response
  - Qualitatively distinct paths through grief

**Bonanno, 2006**

### Grief Theory: Directions

- **Four Trajectories:**
  - Resilience - ability to maintain normal functioning
  - Recovery - normal functioning temporarily gives way to some level to some psychopathology but recover in months
  - Chronic dysfunction – prolonged suffering and dysfunction
  - Delayed grief or trauma – grief not delayed but trauma can be delayed

**Bonanno 2004**

### Grief Theory: Meaning Making

- **Neimeyer:**
  - Meaning making is central feature of grieving”
  - Process of reconstructing world of meaning challenged by loss.
  - Can be:
    - Positive: loss consistent with worldview, thus able to “make sense,” “find meaning” and heal.
    - Negative: death unfair, unjust or random leads to complicated grieving

Grief Theory: Identities

- Berger assigns identities:
  - Nomads: Grief unresolved and person doesn’t understand how loss affected their lives.
  - Memorialists: Commit identity to preserving memory of lost loved one
  - Normalizers: Place identity into re-creating sense of family and community.
  - Activists: Focuses on helping others who experience similar issues.
  - Seekers: Create meaning in by adopting religious, philosophical, or spiritual beliefs.

Berger, 2009

Grief Theory: Reconciliation

- Wolfelt, a child therapist:
  - Acknowledge the reality of the death
  - Embrace the pain of the loss
  - Remember the person who died
  - Develop a new self-identity
  - Search for meaning
  - Receive on-going support from others

Wolfelt

Grief Theory: Phases

- Avoidance Phase
  - Recognize the Loss
- Confrontation Phase
  - React to the Separation
    - Recollect and re-experience the deceased and the relationship
    - Relinquish the old attachments to the deceased and the old assumptive world
- Accommodation Phase
  - Readjust to move adaptively into the new world without forgetting the old
  - Reinvest

Rando, 1993
Grief Theory: Processes

• Therese Rando: “Six R’s”:
  – **Recognize**: experience loss and understand that it happened
  – **React**: react emotionally to loss
  – **Recollect and Re-Experience** deceased: Memories and rituals
  – **Relinquish**: Put loss behind, accept new world, “no turning back.”
  – **Readjust**: Return to daily life (here loss starts to feel less acute and sharp)
  – **Reinvest**: re-enter world, form new relationships (here accept changes that have occurred and move past them)

Grief Theory: Tasks

• Worden: 4 Tasks of mourning
  – Accept the reality of the loss
  – Work through the pain of grief
  – Adjust to life without the lost loved one
  – Find an enduring connections with the lost loved one while embarking on a new life.

Gender Differences

• Women: More emotion focused- want to talk
  – Intuitive and affective
  – Socialized to display emotion so more likely to grieve more overtly and longer than men
  – Openly express feelings
  – Seek out others to process their feelings
  – Grow more after the loss
  – Protective factor for women
Gender Differences

- Men: More rationally and problem solving focused - task oriented
  - Physical and cognitive
  - May want to grieve privately
  - Prefer to be alone more
  - Divert themselves with activities or hobbies

Cultural Differences

- Little research on cultural approaches to grief
- Values, beliefs, expressions, and rituals towards death and loss are culture bound
- Things to consider
  - Family concepts
  - Religious beliefs
  - Attitudes toward the body
  - Funeral practices
  - Attitudes: death, bereavement, grief

Myths: Grief and Mourning

- Myths
  - Messages society or culture relay
  - Expectations of peers or culture
  - Shapes expectations bereaved place on themselves
  - If faulty, set guilt and failure in motion
Myth

• It takes 3-5 months to get over grief.

• Truth: “Grief and Mourning takes as long as it takes!”

Bereavement Study

• George A. Bonanno examined 1,500 elderly married individuals several years.
  – 205 subjects
  – Tracked several years
  – Tracked at 6 and 18 months after loss of spouse
  – 50% experienced no significant depression or distress before or after the death
  – Some felt sad for a short time
  – 8% depressed before loss and stayed depressed

Study Findings

• Study findings
  • Common grief or recovery (11%)
  • Stable low distress or resilience (46%)
  • Depression followed by improvement (10%)
    – Depressed at the death
    – Many improved after death
    – Unhappy marriage/relationship - death brought relief from depression
  • Chronic grief (16%) – no improvement
  • Chronic depression (8%).

Bonanno 2004
Grief: A Whole-person Experience

Biological  Psychological  Social  Spiritual

Grieving Brain

- Brain imaging studies show increased activity along a broad network of neurons that link to
  - Mood
  - Memory
  - Perception
  - Conceptualization
  - Regulations of physiological systems
    - Heart and digestive system

Grieving Brain

- fMRI study of grief validates uniqueness and subjective quality
- Brains of 8 women showed:
  - Grief is mediated by impairments in neural network
  - Leads to dysfunction
    - Affect processing
    - Mentalizing
    - Memory retrieval
    - Autonomic regulation.

Cook, 2013
Gundel, et al., 2003
Psychological Effects

• Mentalizing: “refers to spontaneous sense of self and others in terms of desires, needs, feelings, reasons, beliefs, etc.”
• Mentalizing is conscious activity
  – Helps us “make meaning”
  – Understand reaction of others
  – Make sense of own behavior
  – Make sense of social world and our place in it.

Psychological Effects

• “Am I crazy?”
• Confusion: “What is real?”
• Difficulty concentrating
• Short attention span
• Difficulty learning new material
• Short term memory loss
• Difficulty making decisions
• “Nothing seems real”

Psychological Effects

• Common Emotions:
  – Sad
  – Lost
  – Angry
  – Irritable
  – Guilty
  – Sensitive
  – Disbelief
  – Helplessness
  – Numbness
  – Yearning
  – Shock
  – Confusion
  – Anxious
  – Regretful
  – Fearful
  – Lonely
  – Relieved
  – Satisfied
  – ‘Spaced out’
  – Disorganized
Psychological Effects

- Common behaviors:
  - Absent minded
  - Social withdrawal
  - Dreams of deceased
  - Avoid reminders of deceased
  - Sighing
  - Restless over activity
  - Crying
  - Carrying and/or treasuring objects as reminders of the deceased

Worden, 2008

Social Effects

- “People treat me differently”
- Social circle may change
- Support systems may change
- Family relationships may change
- People will say hurtful things
- Social withdrawal if grieving is complicated

Myths

- “Grieving and being upset means that you do not believe in God or trust your religion.”

- Truth: “Faith gives meaning to grief and loss.”
Spiritual

- 90% of Americans believe in God or a universal spirit
- Death is a life stressor that leads to question faith and existence of a higher power
- Yet, working through crisis in faith is a necessary step in grief and mourning

Wilkum & MacGeorge, 2010

Spiritual

- If death is sudden, traumatic, or unexpected:
  - Question "Why" reverberates
  - Ask "Where was God?"
  - "If God loves me, how could this happen?"
  - "Prayers weren't answered..."
- Truth: Knowing "Why" will not change the grief.

Wilkum & MacGeorge, 2010

Religious Coping Styles

- Three religious coping styles:
  - Self-directing - individual freedom and responsible for coping with own problems
  - Deferring - individual defers to higher being for intervention and/or insight into problem
  - Collaboration - shared responsibility with God
- Research showed:
  - Comforting messages representing God as one who helps one cope perceived as sensitive and helpful
  - Self-directing messages affirming God's presence but personal responsibility to cope perceived as least sensitive

Wilkum & MacGeorge, 2010
Biological Effects

• Grief experienced on an emotional level
• Stress of emotions can
  – Worsen preexisting physical illness
  – Exacerbate an existing illness
  – Set stage for new physical problems

Physical Manifestations

• Physical sensations:
  – Hollowness in stomach
  – Tightness in chest
  – Tightness in throat
  – Breathlessness
  – Overly sensitive to noise
  – Muscle weakness
  – Lack of energy
  – Appetite disturbance
  – Dry mouth
  – Sleep disturbance
  – Compromised immune response

Healthy Grieving

• No absolute normal
• “Normal” is almost anything that is not harmful to self, property or others
Myth
• “You will get over it.”
• Truth: “You will get through it.”

Year 1: Year of Losses
• Whole first year is one loss after another
  – Secondary losses very painful
• Beware of special occasions and holidays all year
• Uncomplicated mourning is normally 2-3 years
• Complicated mourning may be a 5-7 year process.
  • Grief continues for a lifetime through major life milestones.

Myths
• “Grieving means letting go of the person who died.”
  • Truth: We never fully detach from those who have died.
• Studies show about half of bereaved experience sense presence of deceased.
  Daton & Manwitz, 1987
Myths

• Moving on with your life means you’re forgetting the one you lost.

• Truth: Moving on means keeping loved one close in memories.

Complicated Grieving

• Term used by Rando and others to describe grief that does not follow “normal course” or process to a successful completion.
• Bonanno’s study indicated approximately 25% have chronic grief or MDD
• Depression improved in most but 16% experienced chronic grieving

Other Terms: Complicated Grief

• Dysfunctional grief
• Conflicted grief
• Unresolved grief
• Prolonged grief disorder
Causes Complicated Grieving

- Delayed Grief
- Unexpected Death
- Multiple Losses (Chronic grief)
- Unfinished Grief
- Grief Not Validated By Others
- Unanswered Questions

Risk Factors

- Multiple losses
- Severe trauma
- Violent death
- Axis 2 traits
- Concurrent mental illness
- Isolation
- Physical illness
- Life Skill Deficits
- Parents who lose children
- Poor support system
- High level of dependency
- Lack of “meaning making”
- Guilt
- Parents who lose children
- Poor support system
- High level of dependency
- Misusing prescribed drugs
- Doing risky or dangerous things
- Abuse or violence directed toward someone else

Complicated Grief Symptoms

- No progress through grief over time
- Inability to “connect” with others
- Choosing to isolate
- Habitual unhealthy or self-destructive behavior
- Alcohol or illegal drug misuse
- Misusing prescribed drugs
- Doing risky or dangerous things
- Abuse or violence directed toward someone else
Severe or Acute Grief

“Loss is forever, but acute grief is not, a distinction that frequently gets blurred.”
Ruth D. Konigsberg
• 8-10% become severe and prolonged
• Marked by MDD

Other Terms: Severe Grief

• Pathological mourning
• Chronic Mourning
• Persistent grief (bereavement)

Severe Grief Risk Factors

• History of Depression
• Presence of Depression
• Suicide survivor
• Dependent relationship
• History of abuse
• Substance abuse/dependence
• Unsatisfactory “meaning making”
Severe Grief Symptoms

- Severe disruption in function
- Loss of touch with reality
- Hallucinations
- Deep clinical depression
- Substance abuse
- Preoccupation with suicide or plans
- Disrupted family and social relationships
- Increase in stress-related illnesses (compromised immune function, hypertension, cardiac problems, cancer)
- Increased use of healthcare services

Bereavement: DSM-IV-TR

- Bereavement is exclusion in MDD criteria
  - May present with characteristic MDD symptoms
  - Not MDD with 2 weeks persistent symptoms if bereaved unless, suicidal, psychotic or severely impaired
  - Bereaved individual typically regards the depressed mood as ‘normal’.
- Bereavement coding:
  - V62.82 focus of clinical attention, “reaction to the death of a loved one”

DSM-V Diagnosis

- Bereavement exclusion removed
- Other Specified Trauma-and-Stressor-Related Disorder-Persistent complex bereavement disorder” (309.89)
  - Symptoms characteristic of trauma-and-stressor-related disorder
  - Cause significant distress or impairment in social, occupational or other important areas of function
  - Do not meet the full criteria for disorders in the trauma-and stressor-related disorders
  - Can identify the stressor and why it doesn’t meet any specific criteria for
Bereavement: Future Dx Criteria

- Conditions for Further Study as research emerges
  - Called “Persistent Complex Bereavement Disorder”
  - Persistent, prolonged, and abnormal grief
- Involves persistence of symptoms for at least 12 months and characterized by:
  - Longing
  - Yearning for the deceased
  - Intense sorrow and pain
  - Preoccupation with the deceased

ICD-10

- ICD-10 Clinical Descriptions and Diagnostic Guidelines: “normal bereavement reactions, appropriate to the culture of the individual concerned and not usually exceeding 6 months in duration”
- Should not be coded in the chapter on mental disorders.
- Code:
  - “Factors influencing health status and contacts with health services.”
  - Z63.4 is a billable ICD-10-CM code (Disruption due death or disappearance of a loved one.)

Grief versus MDD

- “The capacity to be consoled is a consequential distinction between grief and depression.” Kay Jamison
MDD versus Bereavement

- Data suggests:
  - Bereavement-related depression no different
  - Equally genetically influenced
  - More likely with personal and family Hx of MDD
  - Similar personality characteristics
  - Similar patterns of comorbidity
  - Likely to be chronic and/or recurrent
  - Equally responds to antidepressant medication

<table>
<thead>
<tr>
<th>Major Depressive Disorder</th>
<th>Bereavement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings experienced most of the day, every day</td>
<td>Emotional pain experienced in “waves”</td>
</tr>
<tr>
<td>Markedly diminished interest/pleasure in all/almost all activities.</td>
<td>Remains interested in life and those around them.</td>
</tr>
<tr>
<td>Significant weight loss or weight gain.</td>
<td>May or may not be present</td>
</tr>
<tr>
<td>Insomnia or hypersomnia</td>
<td>May have some sleep disturbance, esp. in early stages</td>
</tr>
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MDD versus Bereavement

<table>
<thead>
<tr>
<th>Major Depressive Disorder</th>
<th>Bereavement</th>
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</thead>
<tbody>
<tr>
<td>Psychomotor agitation or retardation</td>
<td>May be present early on</td>
</tr>
<tr>
<td>Fatigue or loss of energy</td>
<td>Usually present early on</td>
</tr>
<tr>
<td>Feelings of worthlessness</td>
<td>Self esteem remains intact</td>
</tr>
<tr>
<td>Excessive/inappropriate guilt</td>
<td>Guilt about actions taken or not (Regret)</td>
</tr>
<tr>
<td>Diminished concentration; indecisive</td>
<td>May be present in early stages</td>
</tr>
<tr>
<td>Recurrent thoughts of death; wish to die</td>
<td>Feels would be better off dead/should have died</td>
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</tbody>
</table>
Other comparisons

<table>
<thead>
<tr>
<th>Major Depressive Disorder</th>
<th>Bereavement</th>
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</thead>
<tbody>
<tr>
<td>Persistent sadness</td>
<td>Mixture of sadness with more pleasant emotions</td>
</tr>
<tr>
<td>Mood and ideation almost constantly negative</td>
<td>Feelings mixed with positive memories</td>
</tr>
<tr>
<td>Little to no optimism about the future</td>
<td>Maintains hope that things will get better</td>
</tr>
<tr>
<td>Not usually triggered by the death of a loved one</td>
<td>Can be triggered by loss of a loved one</td>
</tr>
<tr>
<td>Guilt about things unrelated to death</td>
<td>Guilt about actions taken or not taken (more regret than guilt)</td>
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</tbody>
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Key Distinctions

• MDD manifests as:
  – Excessive guilt
  – Preoccupation with feelings of worthlessness
  – Psychomotor retardation
  – Marked functional impairment
  – Suicidal thoughts
  – Hallucinatory experiences

Intervention Uncomplicated

• Evidence in Normal Grieving:
  – Routine intervention for bereavement not empirically supported and may interfere with the natural mourning process
  – Outreach strategies are not advised
  – Carefully evaluate requests for intervention to insure that patient understands grief and mourning process

Schut and Stroebe, 2005
Intervention Complicated

- Evidence in Complicated Grieving
  - Intervention should be considered in complicated forms of grief
  - Effective for those at high risk for complications
  - Effective for those already experiencing complications

Schut and Stroebe, 2005

Model for Helping

<table>
<thead>
<tr>
<th>Grief Phase</th>
<th>Mourning Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance</td>
<td>No tasks, just surviving</td>
</tr>
<tr>
<td></td>
<td>Intellectual knowledge of loss only</td>
</tr>
<tr>
<td>Confrontation</td>
<td>Accept the reality of the loss</td>
</tr>
<tr>
<td></td>
<td>Work through the pain of grief</td>
</tr>
<tr>
<td>Accommodation</td>
<td>Adjust to life without loved one</td>
</tr>
<tr>
<td></td>
<td>Find enduring connections with lost</td>
</tr>
<tr>
<td></td>
<td>loved one in memories/activities</td>
</tr>
<tr>
<td></td>
<td>Embark on new life</td>
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How to Help

- Worden: Seven determining factors critical to understanding patient’s experience
  - Who was the person that died
  - Nature and strength of the attachment to the deceased
  - How the person died (physical proximity, level of violence or trauma)
  - Historical antecedent
  - Personality variables (attachment style)
  - Social mediators
  - Concurrent stressors (both risk and protective)
Care for the Mourning

- Companioning
  - Honor the mourner
  - Listen with the heart
  - Be curious about their experience
  - Learn from the mourner
  - Walk alongside
  - Be still
  - Be present in pain
  - Respect the disorder and confusion of the mourner
  - Remember, you can’t find their way!

Helpful Advice

- Encourage:
  - Mourning: inwardly experience and outwardly express the reality of loss
  - Mourner to tolerate the pain and care for self (Grief does get better.)
  - Converting the relationship with the lost person from presence to memory
  - Exploration of new self-identity based on life without the person who died
  - New roles and exploration of personal strengths
  - “Meaning making” Encourage development of enduring support system while healing takes place in the months and years ahead.

Practical Suggestions

- Expect to move in and out of different feelings
- Give attention to your own needs
- Take a “break” from the pain
- Give yourself permission to smile or even laugh
- Take as long as it takes to grieve.
- Don’t let others tell you how to grieve.
- Don’t do things until you...
Medical Intervention

- Thoughts of death
  - (Not uncommon for survivor to think he/she would be better off dead or should have died with the loved one)
- Morbid preoccupation with worthlessness
- Significant psychomotor retardation (in bed for days)
- Prolonged and serious functional impairment
- Hallucinations/psychosis (Survivors may think they hear or see loved one but recognize was not real)

Treatment Options

- Support Groups
- Grief therapy (individual or group)
- Psychotherapy
- Medications

Treatment: Support Group

- Effective and useful treatment
  - Meet other people with similar concerns
  - Understand more about self and life’s challenges
  - Reduces feeling of isolation
  - Opportunity to give to others
  - Learn practical tips to cope with common situations
  - Helps keep expectations realistic
  - Group support to prepare for the future

Vernon, 2002 & Stroebe et al., 2008
Treatment: Psychotherapy

- Grief Therapy (esp. if death is traumatic)
- Therapeutic writing to express and explore stories of loss (journaling and assignments)
  - Psychotherapy (supportive, CBT, family)
- Bibliotherapy
- Psycho-educational programs

(Rando, 1993 & Wagner, et al., 2006)

Medications

- Antidepressants: Improved depression but not grief
  - Some evidence for escitalopram with Dx of MDD (Hensley, 2009)
  - Buproprion SR (Zisook et al., 2001)
  - Paroxetine (Zygmont et al., 1998)
- Benzodiazepines
  - No evidence outside Dx of anxiety (Hensley, 2009)
- Sedatives
  - Helpful to support restorative sleep if sleep hygiene fails

Grief Support Programs

- GriefShare: www.griefshare.com
  - Find local groups adults, teens and children
- Compassionate friends: Loss of Child
  http://www.compassionatefriends.org/home.aspx
- Bereaved Parents: Loss of child or sibling
  http://www.bereavedparentsusa.org
- Missing Grace Foundation: pregnancy or infant loss.
  http://www.missinggrace.org
SC Highway Fatalities

- South Carolina Highway Patrol: Families of Highway Fatalities. FHF is comprised of three components:
  - Highway Safety Speakers’ Bureau
  - Safety Ambassadors
  - Peer Team: Generate a condolence card to new fatality families
  - Fatality Memorial Web site: www.schp.org/inmemoryof

Online Support for Grief

- Griefnet: http://www.griefnet.org
  - Children's site: http://kidsaid.com
- Facebook widows site

Grief Counseling

- Joy in the Mourning: Center for Life’s Losses
  www.joyinthemourning.com
  Located in Lexington SC
South Carolina Resource Lists

- [http://www.mushealth.com/pastoralcare/bereavement.htm](http://www.mushealth.com/pastoralcare/bereavement.htm)

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