Treatment of complicated mourning

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GENERIC GUIDELINES FOR TREATMENT

It is presumed that caregivers providing treatment for complicated mourning are well versed and clinically adept in the skills required in mental health intervention in general, as well as in techniques for facilitation of uncomplicated mourning. The reader is referred to Rando (1984) for a more comprehensive discussion of specific techniques. In addition to these skills and techniques, a number of generic guidelines for treatment of complicated mourning exist. These guidelines, listed in Table 8.2 and detailed in the following pages, are mandated throughout all phases of treatment with each mourner and should be incorporated into the caregiver's own clinical perspective. All are intended to be employed toward the general goal of enabling the mourner to successfully complete the six "R" processes of mourning.

Table 8.2 Generic Guidelines for Treatment of Complicated Mourning

1. Orient the mourner to treatment.

2. Provide the mourner with explicit permission-indeed, a prescription-to mourn.

3. Support the mourner in coping with the mourning processes.

4. Promote social support of the mourner.

5. Maintain a family systems perspective in dealing with the mourner

6. Ensure that the mourner has appropriate medical evaluation, medication, and treatment when symptoms warrant.

7. Do not necessarily accept what is on the surface; probe for underlying issues and impaired "R" processes.

8. Work with the mourner to recognize, actualize, and accept the reality of the death.

9. Normalize and legitimize appropriate affects, cognitions, wishes, fears, behaviors, experience, and symptoms.

10. Assist the mourner in identifying, labeling, differentiating, and tracing affective experiences and their component parts.

11. Appreciate and enable the working through process.

12. Acknowledge that repetition is an inherent part of treatment, but ensure that repetition takes place in the service of working through.

13. Once affective experiences are identified, labeled, differentiated, and traced, enable the mourner to feel, accept, examine, give some form of expression to, and work through all of the feelings aroused by the loss.

14. Design and tailor treatment to address general and specific issues identified for the individual mourner.

15. Determine the symbolic meanings of persons, objects, experiences, and events to the mourner.

16. Identify, interpret, explore, and work through resistances to the mourning processes.

17. Identify any unfinished business with the deceased and discover or create appropriate ways to facilitate closure.

18. Help the mourner identify, label, differentiate, actualize, mourn, and accommodate secondary losses resulting from the death.

19. Recognize and respond to the importance of security afforded by the caregiver's availability to the mourner.

20. Recognize the dynamics of complicated mourning and adhere to the five "Ps" in work with the mourner.

21. When a normal, expectable emotion is absent, determine why and address the omission.

Orient the mourner to treatment

When taking an individual experiencing complicated mourning into treatment, it is helpful to provide an overall perspective along with information about what to expect, what the "rules" are, and how the process tends to go. Misinformation about mourning is rampant, and the mourner certainly has already had problems in processing the loss and most probably is ambivalent in some areas about achieving a successful outcome. For these reasons, it is essential that the caregiver familiarize the mourner with that treatment.

Throughout the orientation, the caregiver should present the mourner with a clear rationale for and description of therapy. The mourner should be able to feel that the caregiver knows what will happen and why-that everything has a purpose, even though the mourner might not be able to comprehend it at the time. This is especially important because of the natural tendency for the mourner to resist treatment in order to maintain a relationship with the deceased and to avoid the necessary pain of coming to grips with the loss and its implications. These feelings, coupled with lack of a sense of purpose, can promote a flight from therapy. Proper orientation can also clarify confusion about mourning in general and correct any misinformation the mourner might have in particular. To the extent that the mourner has faith in the caregivers, this will engender predictability, control, order, security, and confidence-things typically in short supply in this situation.

To achieve these goals, the orientation should focus on the following areas.

The caregiver's perspective on complicated mourning. The caregiver's perspective on complicated mourning provides (a) the bulk of the rationale for the interventions and processes the mourner will be experiencing in treatment; (b) a brief overview of treatment goals; (c) assurance that treatment can be beneficial; and (d) the framework within which the caregiver presents normative information about grief and mourning, along with specific facts to debunk the various myths, stereotypes, and misconceptions about grief and mourning that impede the individual's healthy experience of both.

> Example: I believe that people often develop complicated mourning for two reasons: They are afraid they will lose their connection to their loved one if they mourn the death too well, and they are frightened that they will be unable to cope with the pain of the loss if they really face it. Both things are very scary, and understandably so. The ultimate purpose of treatment, as I see it, is to find special ways to maintain a connection with _____but to make sure these are ways that won't bring you additional problems, as you are having now. We need to work together to find out how to do this and how to help you learn to live without _____'s being here as before. This means we will need to look very slowly at what the loss means to you and all the feelings it brings up in you. Most people think this is a simple process, but it really isn't. It's doable, but it takes work.

This sort of presentation gives the mourner an indication of what will occur and why. It also disabuses the Common myth that mourning should not require very much work. Note the explicit and implicit empathic statements made in this context. These are important because the mourner is often quite fearful and needs reassurance that the caregiver recognizes her perspective.

The mourner also will need to receive information about grief and mourning. This information can be provided in a conversational, specific fashion. One need not lecture or present this information didactically but can interweave it as appropriate into the conversation.

> Example: You are absolutely correct-many people do not understand your unique problems in this particular

situation. Unfortunately, most folks think that all losses are the same. They fail to recognize that bereavement is determined by who and what the person lost, how the loved one died, and by the type of individual the person is, among many other things: Because no loss is ever exactly the same as another, mourning will be as individual and as different among people as are their fingerprints. Certainly, there are commonalities, but even these are experienced in idiosyncratic ways.

Information about the design and rules of this particular type of treatment. Information about the design and rules of treatment gives the mourner structure and a reason for undergoing this often painful process. Factual knowledge informs the mourner about what to expect, providing her with a sense of predictability, control, and participation.

Example: At this point I think it would be helpful for us to meet on a weekly basis. During these early meetings I will be asking you to tell me all about _____. I will be interested in what _____ was like, how you met, how you got along, what you did, and so forth. This is important for us to do because it helps me understand who the person was you are mourning and what your relationship was like so I can be most helpful to you. It will also give you opportunities to recall these things as well, which is a process you need to engage in right now.

Obviously; this type of example would not be appropriate for someone doing a different type of intervention (e.g., emotional flooding) or for certain mourners for whom such instructions would be contraindicated (e.g., a chronic mourner, who may require assistance in ceasing rumination about the deceased-although, in the beginning of that treatment, this is information that must be garnered even if the process is later to be attenuated). As for all the examples discussed here, the caregiver will have to tailor the message to the specific treatment and individual involved.

In any type of therapy, it is important to be specific about the rules to which the mourner must adhere. These must be clarified in order to en- sure that the mourner understands what the caregiver expects and will tolerate and to provide the mourner with information she needs to make the decision whether or not to enter treatment. For this reason, clinical pragmatics such as the following must be addressed: length of sessions, fees and other financial obligations, limits of confidentiality, cancellation policies, emergency services, office policies, and the caregiver's clinical rules for treatment. The latter will vary according to the caregiver and the caregiver's philosophical orientation (e.g., eliciting free association, prohibiting physical aggression in the office, completing homework or maintaining a journal, asking the mourner to question the caregiver if necessary or giving the mourner responsibility for saying she disagrees with something).

Instructing the mourner about these rules should not be done in a cold, mechanical manner, as if reading a list of "Do’s and Dont's:” It must be done gently and with the stated purpose of providing the mourner with the information necessary for her to decide whether treatment with this particular caregiver is what she thinks she would like to attempt at this time. Laying the details out for the mourner's consideration shows respect, conveys that there is a structure in place (often very comforting to the mourner), and indicates that she has choices and is not helpless. This last aspect provides further ammunition to work against generalization of the powerlessness that may have occurred at the time of the loved one's death.

Predictions about resistances to, the course of, and the pitfalls of treatment. In orienting the mourner to treatment, the caregiver may carefully-and in a manner so as not to establish a self-fulfilling prophecy or frighten the mourner-offer some predictions about resistances to, the course of, and the pitfalls of treatment. The purpose in gently pointing out these resistances right away is to avoid having the mourner act them out and prematurely drop out of treatment. If done properly, providing this information also illustrates that the caregiver has listened and ob- served carefully and already is aware of potential problems. Although this generally tends to make the mourner feel more secure, depending upon the particular dynamics, it can make her feel more anxious. (If so, this problem should be addressed directly at the time.) It also demonstrates that issues will be handled in a straightforward manner and indicates that the caregiver appreciates the ambivalence with which the mourner approaches treatment. Finally, it provides a mechanism for discussing how the caregiver and mourner together can handle future resistances and defenses that may arise and for letting the mourner know what to expect.

Example: In telling me about how you responded to previous deaths you said that whenever you became very sad you would literally run away from the situation. How should we, handle it if that comes up here? Do you think we could make an agreement that if you feel as though you want to run out of my office when we are talking about you could tell me as soon as you notice it? Then perhaps I can help you find a more effective way to cope with your sadness. If I notice that you look as if you want to bolt, I'll point that out to you, OK? It's understandable not to like to be so sad-you'd have to be a masochist to be unmoved-but maybe we can find better ways for you to cope with it.

Resistances will occur throughout all aspects of treatment, and issues of timing, interpretation, working through, and so forth should be dealt, with as dictated by the caregiver's theoretical or philosophical orientation. Even if anticipated, problems still may occur, but at least the door has been opened to discussing them. After resistances or defenses have been discussed, the mourner will more likely understand them as such. Having had these resistances pointed out also can help the mourner prepare for them and not be frightened or disheartened by them. As in all types of treatment, however, the caregiver must remain nonjudgmental and must never predict outcomes in such a fashion as to set the mourner up for acting them out.

Predictions other than those pertinent to the mourner's resistances or defenses can be made early in the treatment of complicated mourning. For instance, the caregiver can convey that the Course of treatment is usually a "Two steps forward, one step back" process and that the work it entails most probably (although not necessarily) will make the mourner feel somewhat worse before she feels better. This forewarning is designed to work against premature termination, but it must not be overemphasized or it may frighten the mourner away. A medical analogy often is quite useful.

Example: Sometimes it will be a little difficult as we talk about things that can bring up some pain. However, you need to know that it is pain in the service of healing. If you avoid it, you will never reap the benefits of working it through. To stop treatment is like stopping the physician in the middle of cleaning out an infected wound. If you stop then, the wound will only stay open and become more infected, and your pain will continue unabated-maybe even get worse. If you can tolerate the cleansing, then the wound will be able to heal afterwards. When you feel the pain, let's talk about it. That is one way pain can be reduced as you are undergoing this uncomfortable process. Finding ways to tolerate the pain so you can remain in treatment can help you get to the point where it does not hurt as much anymore and you can begin to heal.

Predictions can help prepare the mourner, place the mourning process in context, and eliminate unnecessary fear when certain events take place. An example of predicting a potential pitfall would be the caregiver's noting the tendency of some individuals to want to terminate treatment after an initial reduction in symptoms. The caregiver should warn the mourner about the inadvisability of terminating before treatment is completed. Any other predictions that may be made (e.g., about the occurrence of anniversary reactions or the possibility of treatment's causing family conflict) should be handled in a fashion to suggest to the mourner that certain things may occur.

Example: In a few weeks it is the anniversary of _____'s death. Sometimes, not always, people find that they

get a little more symptomatic at these times because they are reminded consciously or unconsciously of what happened about the time of death. That mayor may not happen to you.

When concerns are worded this way, the mourner is not forced to act out any self-fulfilling prophecy. Generally, predictions should be kept to a minimum and used only when it is in the mourner's best interests to be forewarned as opposed to discovering the reality herself. Obviously, caregivers must refrain from using predictions to impress mourners with their own knowledge.

Empowerment of the mourner through explicit provision of a number of aspects of control. It is important for the caregiver to orchestrate the empowerment of the mourner by providing a number of aspects of control. Empowering individuals in therapy is a critical goal for most types of treatment. In complicated mourning, where the mourner may feel-and is- victimized by the loss, empowerment is crucial. The mourner may be given explicit control of such issues as timing, content, pacing, depth, and so forth. In the frequent situation where resistance is high because of the fear of being overwhelmed by affect, empowerment is particularly necessary and fruitful. If mourners feel they have control, over time they will be more open to exploring dangerous or painful areas. Such control decreases the sense of helplessness, lack of control, and fear of being overwhelmed that the mourner often feels in the face of coping with the loss. It challenges passivity.

Example: As we deal with _____'s death here, you can go as I fast or as slow as you desire. You set the pace, and I will follow your lead. Some things may be comfortable to talk about, even pleasant. Some may be a little more uncomfortable. All I ask is that if things are difficult, you tell me. I will not force you to deal with anything you do not want to deal with- I could not even if I wanted to-but we can talk about how to make these things less difficult. We'll take it slow and easy as I we look at this whole situation in little, tiny pieces, one at a time, until we've got the entire picture. Rome wasn't built in a day, and mourning doesn't happen all at once.

Explicit recognition of the mourner's pain and distress, as well as communication of the conviction that the mourner ultimately will be able to cope with the loss more effectively than at present. The caregiver must be sure to convey two important messages to the mourner early on in treatment. First, there must be an explicit recognition of the mourner's pain and distress. If the mourner fails to feel that the caregiver recognizes her pain and distress, not only will comfort be lacking, the necessary experience of empathy also will be absent. Needless to say, a feeling of empathy from the caregiver is a prerequisite if the mourner is to continue on in this exquisitely painful work. Of course, empathy must be conveyed in such a fashion as to communicate understanding and support, not to support avoidance of pain.

Second, the caregiver must communicate the conviction that the mourner ultimately will be able to cope with the loss relatively more effectively than at present. Hope is a necessary ingredient in getting through any adversity, and the mourning process is no exception. By sending the message that the work eventually will enable the mourner to cope with the loss more effectively, the caregiver essentially provides hope that at some point things will be better. Of course, one cannot promise a cure and certainly should not communicate the conviction that things will be better if one does not genuinely hold it. However, one can offer realistic hope for the future that still recognizes the currently intense experience of mourning and the permanent changes that come from major loss.

The hopes of each mourner will differ: One may hope for a decrease in pain, another may aspire to an eventual reunion with the deceased in an afterlife, and yet a third may hold onto the hope that in the future life will regain some meaning. The point is not for the caregiver to predict what will happen if the mourner pays attention to the work of mourning, but rather to assert that in the future the agony and anguish can be less than they are at the current time. This need not be set forth explicitly but may be communicated by implication. For instance, saying, "It must seem as if there's no light at the end of the tunnel" suggests that there is one, but the mourner just cannot get a sense of it yet.

Example: I recognize that this is an excruciatingly painful time for you. Your loss brings many agonizing feelings and seemingly insurmountable tasks in learning to live without _____'s presence in your life as before. It won't

always be this difficult -you will learn to cope with _____'s death and the pain it brings little by little over time- but for right now it probably does seem almost impossible, even though it isn't.

Enlistment of the mourner's commitment to treatment. The enlistment of the mourner's commitment to treatment is an often overlooked but important ingredient in therapy, both in the beg inning and throughout the entire process. By definition, a commitment has the mourner "own" her involvement in the treatment and specifies that involvement, and the choice it inherently includes, as a required element of change.

Enlisting commitment entails the caregiver's directly asking the mourner whether she is willing to give treatment a chance to help her learn to live with her loss. The caregiver makes it clear that the mourner has the pivotal role in the therapy and helps her to see that, although she may have had no control or choice about the loss, she has both control and choice over how she will respond to it over the long term. This view pertains not so much to the acute period of grief, in which the mourner has been subjected to psychological, behavioral, social, and physical effects in all realms of life; rather, it pertains to the perspective or attitude she will assume thereafter.

Example: I believe that with some hard work you can get to the point where you are in less pain and better able to tolerate living your life without _____'s presence. Are you willing to make the commitment to give this type of treatment a chance to help you get there? You are the only one who can determine whether it does. I can help you, but you are the one who must make the decision.

Provide the mourner with explicit permission- indeed, a prescription-to mourn

Most people experiencing uncomplicated as well as complicated mourning require both permission and encouragement (verbal and nonverbal) to mourn because of the traditionally unacceptable thoughts and feelings that become aroused and the personal and social discomfort such an experience brings. For many mourners experiencing difficulties, there is less need for permission and encouragement than for actual prescription. They often require an authority figure to inform them that they need to mourn and to mourn all aspects of the deceased person and the mutual relationship- even the "unacceptable" parts such as the deceased's negative qualities. They frequently require this direction in order to overcome their own resistances, which interfere with complete mourning, as well as to legitimize their struggle to free themselves from pain. As noted before, many mourners may view relinquishing their pain as severing all ties with the deceased. In this case, the professional prescription to mourn can help reduce guilt about doing so.

Support the mourner in coping with the mourning processes

Helping the mourner cope as best as possible with the vicissitudes of the mourning processes entails providing appropriate information and support. As in any other human situation, understanding makes the circumstances more tolerable. Therefore, normative psychoeducational information about mourning is very important. However, as is the case for normalization and legitimization, caregivers often fail to appreciate the therapeutic value and significance of providing psychoeducational material. This cognitive information is critically important in a number of ways.

1. It corrects misinformation held by the mourner and debunks myths establishing unrealistic expectations for mourning that, when unmet, eventuate in feelings such as guilt and failure. In this regard, it helps prevent further complications in mourning.

2. It provides a framework to help the mourner feel less over- whelmed, out of control, and helpless.

3. It offers specific data that promote healthy mourning (e.g., recognition that mourning reactions are unique to each person and will be experienced in many if not all realms of life, comprehension of appropriate expectations for time and course).

4. It normalizes and legitimizes aspects of mourning the individual erroneously may have interpreted as indicating negative things about himself (e.g., pathology, deficiency, worthlessness, that he is going crazy).

In addition to providing information, the caregiver can support the mourner in other ways by using interventions such as the following.

1. Instructing the mourner in how to "dose" himself (i.e., direct attention toward and then away from disturbing stimuli before they become intolerable) and control the pace of mourning by structuring respites

2. Helping the mourner discover ways to replenish himself following the severe emotional, social, physical, intellectual, and spiritual depletion resulting from the loss (e.g., rest, nutrition, social support, physical activity/sports, religion, philosophy, literature, media)

3. Encouraging physical activity or exercise to release pent-up emotion

4. Acknowledging pragmatic Concerns and referring the mourner to the Proper resources for assistance in these areas

5. Promoting appropriate support from others

6. Working with the mourner to maintain the proper balance between experiencing pain and other unpleasant affects and maintaining sufficient defenses to avoid being overwhelmed

7. Assisting the mourner to maintain good physical health and avoid or keep to a minimum Use of drugs, sedatives, alcohol, caffeine, nicotine, and other self-medication

8. Helping the mourner develop the proper perspective on what accommodating the loss will mean

Promote social support of the mourner

A perceived failure in the area of social support is a high-risk factor for complicated mourning (see chapter 10). Sometimes the failure is global (i.e., there is no support at all for the mourner); sometimes it is specific (i.e., there is no support for certain aspects of mourning, such as the expression of anger or guilt, or a certain person does not offer a particular type of support). Consequently, the caregiver must do whatever possible to enable the mourner to receive the support that is lacking. This may involve teaching the mourner to be more assertive and effective in securing from the support system precisely what is needed. In other cases, it may mean meeting with family or other social system members to provide psychoeducational information about mourning, help them address their reasons for lack of support, and/or furnish them information on its importance in the mourning process. Depending on the caregiver's theoretical bent, some treatment may be provided in collateral visits in order to deal with the system dynamics interfering with appropriate support for the mourner. In cases of disenfranchised grief (Doka, 1989)-grief that is not socially acknowledged, validated, or supported-it may mean identifying alternate sources of support if a support system is unavailable or cannot or will not provide what is necessary. In instances where support is notably absent, the caregiver may work to help the mourner establish some type of network or system that can provide support (e.g., a self-help group). It is well recognized that connecting mourners with others who have sustained similar experiences is an important therapeutic contribution (see the previous section in this chapter concerning the efficacy of self-help and other groups).

Maintain a family systems perspective in dealing with the mourner

Regardless of whether the caregiver's philosophical or theoretical discipline or clinical practice includes family systems, it is important to remember that the family will influence the mourner and vice versa. Family members can potentiate reactions and conflicts among themselves that positively or negatively affect the mourner. The Caregiver must take into account this multiplier effect (Rando, 1984) in families and also must be prepared to weigh the needs of a particular family member against the needs of another or against the needs of the family as a whole. Personal differences in mourning styles, idiosyncratic courses of bereavement, non-identical needs, and the loss of different relationships despite the death of the same person all can complicate the individual family member's coping, the family's reorganization process, and the system's dynamics and ability to survive the loss. Closeness among family members can bring support but also can make them likely to displace blame, anger, and other hostile feelings onto one another; avoid communication for fear of upsetting one another; or place irrational demands on one another. The caregiver can promote support for the family but must be prepared to work with the mourner alone if this fails. Provision of information about the impact of mourning on families, the appropriate and inappropriate assumption of roles that influence adaptation, family reorganization after a death, the necessity for fair compromise, and so forth can help the individual cope with her own mourning within the context of the family system.

Ensure that the mourner has appropriate medical evaluation, medication, and treatment when symptoms warrant

Given the association between complicated mourning and Physical morbidity, the mourner must receive appropriate medical evaluation, medication, and treatment when necessary. Theoretical issues relating to this topic are discussed here; specific clinical management issues relating to medication for depression and anxiety are provided in chapter 5.

For the caregiver to exclude attention to somatic symptoms in favor of psychosocial ones is to incompletely address the mourner's needs. Unless medically trained, the Caregiver should never assume that physical symptomatology is merely a somatic manifestation of either uncomplicated or complicated mourning. This may well be the case, but the Caregiver must make sure organic reasons are ruled out by a physician before commencing treatment.

The need for medical consultation is especially keen with regard to medication. In the past, physicians too readily prescribed too much medication for too many mourners with too little justification. Usually, antianxiety agents

were prescribed to quell the symptoms of distress manifested in acute grief. Because the effect was often to retard the individual's experience of mourning, it was common to hear mourners later on express only the vaguest recollection of postdeath rituals and complain that, when they did come out of their drugged state, others expected them not to manifest acute distress. Their anguished cries, their wailing, their protest-all were silenced by drugs. Crucial opportunities to mourn were lost. For many of these individuals, complicated mourning was thus midwifed by benzodiazepines or anxiolytics. Later in the acute grief process, the drugs prescribed for many were antidepressants or sedatives. Sometimes, sedatives might be dispensed immediately after the death to help the mourner sleep.

Out of this overuse of medication grew a reactionary position condemning the use of any medication for grieving people. However, this extremist position meant that many of those who legitimately required medication were denied it. Notwithstanding the fact that in the past- and even currently-medication has been inappropriately prescribed, some mourners do require it. Failure to recognize and respond to this reality is every bit as harmful as forcing medication.

It is not the nonmedical caregiver's role to determine whether or not medication is actually needed, but rather to determine whether or not a consultation should be requested. In doing so, the caregiver should take great pains to find a psychiatrist or physician who is knowledgeable about psychotropic medication and comfortable with and interested in working with bereaved individuals. Unfortunately, too many psychiatrists and physicians are unfamiliar with uncomplicated reactions to loss and, as a result, misdiagnose and misprescribe. Many are actually frightened by mourners.

Both the caregiver and the physician who will consider prescribing medication must be aware of several important issues. First, as observed by Maddison and Raphael (1972), they must recognize the dynamic implications of psychopharmacotherapy for the bereaved. Specifically, these implications concern an unspoken message to stop expressing distress; a substitute object for the oral needs that are heightened by the loss of the loved one; suppression of anger and guilt, which can tip the balance of normal ambivalence to its pathological extreme and cause complications; and, in cases where the physician had cared for the deceased, a need to prescribe medication for the bereaved that may be motivated by the physician's desire to assuage guilt over the death, to give now what he or she could not give then, and to reaffirm his or her own potency. Maddison and Raphael also caution against pharmacotherapy that works to inhibit mourning.

Notwithstanding these caveats, the majority of those writing about the use of medication in bereavement draw the conclusion that, although studies are currently insufficient to provide conclusive data, medication probably should be considered when symptomatology is severe. The question then becomes what constitutes severe symptomatology.

Barton (1977b) believes that judicious amounts of tranquilizers and sleeping medications may be indicated during the early phase of un- complicated grief but should be used only when medication would facilitate the mourner's reorganization, assist with overall coping, and intervene in disturbances of such important functions as sleep. He warns that medication should not be used in any fashion that would suppress the normal grief process and advises of the possibility of habituation to the medications as a means of forestalling the pain of grief. Like Maddison and Raphael (1972), he urges caregivers to be aware of the implicit communication in the prescription of drugs that the mourner's feeling state should not be present. This communication works against the legitimization of expression of feelings and acceptance of grief as a normal process. In some situations of complicated grief, Barton notes that psychiatric hospitalization or the use of medication in conjunction with psychotherapeutic efforts must be employed.

In the treatment of pathological grief, Parkes (1985) asserts that medication can have a place in conjunction with psychotherapy for those who are unable to communicate or are a serious suicide risk. Nevertheless, he voices the concern that medication is often misused to suppress grief and can become a means of self-destruction. He suggests that drugs of low toxicity are preferred, with brief hospitalizations as necessary.

Following extensive reviews of the literature, two separate investigating teams have concluded that, in instances of significant symptomatology or when symptoms meet criteria for mental disorders, medication can be beneficial. However, both groups urge great care in its prescription. Specifically, Stroebe and Stroebe (1987) identify the use of medication as a form of emotional control in the early part of grief as "dysfunctional:' and Osterweis et aI. (1984) stress that medication be prescribed for the bereaved with caution because of an absence of data about its usefulness and impact. Both teams note that, notwithstanding the view that interference with the grief process can result, use of psychotropic medication is wide- spread in bereavement. When medication is required, both teams suggest using the smallest effective dosage.

More positive views of medication, still stressing the care that must be exercised, appear in the writings of Sidney Zisook and his colleagues (e.g., Zisook et al., 1990), who observe:

> Although some might argue that the use of psychotropic medications during bereavement is maladaptive, in that these substances prevent the bereaved from "getting in touch with their true feelings" and thereby block the resolution of grief, this position has not been validated by empirical data. Alternatively, these medications may be an effective tool in helping the bereaved individual cope with the overwhelming stress of widowhood, particularly initially, so that resolution might occur. (p. 325)

All of this still leaves the caregiver with a number of clinical issues to struggle with when considering medication for a bereaved person. Clearly, when symptoms are extreme, health or life is endangered, coping and functioning are unacceptably low, or mourning has evolved into a diagnosable mental disorder, the decision to use medication is more clear cut. Although issues of dynamic implications, dosage, and duration must be considered even in these scenarios, the more difficult cases by far are those in which the line between uncomplicated and complicated grief and mourning is less distinct. The following recommendations, which take into ac- count both clinical experience and review of the literature, will be helpful in determining whether a medication consultation or prescription of medication is necessary. These recommendations presuppose the caregiver's understanding of what constitutes uncomplicated and complicated responses at a given point and for a given loss and knowledge of the appropriate use of various medications under different bereavement scenarios.

1. A thorough and accurate assessment must be made of the mourner and the factors surrounding the loss. Use of the GAMSII is encouraged (see chapter 6 and the appendix).

2. Mourners with preexisting psychological, psychophysiological, or physical disorders typically require continued attention to and medication for these disorders.

3. Mourners with post-traumatic stress symptoms usually require medication to address post-traumatic elements sufficiently such that mourning then can be accessed.

4. Grief and mourning can turn into a diagnosable mental disorder requiring medication (e.g., depression, anxiety disorder, adjustment disorder, brief reactive psychosis). Whenever this evolution occurs and diagnostic criteria are met, medication appropriate for that disorder is warranted. However, acute grief can account for many of the symptoms also typical of these disorders. Therefore, before medication is prescribed, caregivers must distinguish acute grief symptoms from mental disorder and be aware of which symptoms of uncomplicated acute grief can benefit from medication even before solidifying into these disorders. (See chapter 5 for more on recognized mental disorders.)

5. If the individual does not have the ability to mourn properly because coping is overwhelmed, functioning is compromised, or symptomatology endangers health and/or life, it makes sense to do what is necessary to facilitate mourning. For example, even if in the absence of one of the aforementioned mental conditions the mourner experiences significant sleep deprivation, a mild sedative may be in order.

6. If the mourner evidences symptoms inconsistent with grief and mourning or that simply are not consonant with the caregiver's own internal norms, it may be wise to request a medical consultation.

7. If and when medications are prescribed, the caregiver must work with the mourner to ensure that they are used therapeutically and that they do not adversely interact with other drugs the mourner may be taking either by prescription or through self-medication. Both prescription and nonprescription use of drugs increases dramatically following bereavement. Nonprescription drugs used for self-medication may include illicit drugs as well as drugs whose use is socially, sanctioned (e.g., alcohol, caffeine, nicotine, over-the-counter preparations).

8. The caregiver must remain alert for suicide (and, on occasion, homicide) potential in mourners receiving medication and must act according to usual and customary professional standards in evaluating and intervening in situations where threat to self or others exists.

9. The caregiver must appreciate and, where necessary, explicitly correct any messages implied by medication prescription that grief or mourning should be suppressed.

10. If suppression or interference with grief or mourning is suspected, the caregiver must reevaluate the drug used, dosage, and accompanying need for additional psychotherapeutic intervention. Consideration must be given to discontinuing the medication if reevaluation warrants.

11. The caregiver must use all medication as an adjunct to treatment or normal support, not as a replacement for it. Prescription must be time-limited, targeted to specific symptoms, and employ the lowest possible effective dosage to promote the mourner's coping and restorative processes.

Over time, the caregiver will develop internal norms about medication and mourning. When these have been established, they can be quite helpful in determining the need for a medication evaluation. Needless to say, whenever any significant doubt exists, the caregiver should err in the direction of requesting an evaluation.

Do not necessarily accept what is on the surface; probe for underlying issues and impaired "R" processes

The caregiver treating complicated mourning must look for hidden issues, latent needs, obscured reactions, and underlying dynamics. What is apparent on the surface milt serve the function of camouflaging or defending against what is underneath (e.g., superficial guilt may cover deep- seated helplessness). Ultimately, treatment must be directed toward the underlying issues, and the caregiver must intervene to enable the mourner to relinquish the superficial and address the more pivotal concerns beneath. As with resistances, this must be done gently and without strip- ping the mourner prematurely of needed defenses. In the same vein, in ascertaining which "R" processes have been impaired, the caregiver must not focus exclusively on the material presented superficially. In all cases, the caregiver must appreciate that there are manifest and latent levels to any mourner's response and must not exclude examination of either.

Work with the mourner to recognize, actualize, and accept the reality of the death

The ability to believe cognitively or to internalize affectively that the loved one is truly dead and to comprehend all of the implications of this is frequently hampered in complicated mourning. The caregiver's interventions must be geared toward helping the mourner come to grips with this reality. Many mourners superficially accept the loss but hold expectations to the contrary (e.g., the mourner "knows" his mother is dead but on some level continues to wait for her return). This situation is to be differentiated from the normal lag time that exists in uncomplicated mourning between intellectual and emotional acceptance of the death. In this latter circumstance, repeated confrontation with the deceased's absence and frustration of the mourner's wishes to be reunited with the loved one eventually teach the mourner that the loved one is irretrievably gone.

In complicated mourning, intellectual acknowledgment may be missing, disbelief may have the upper hand, and the mourner's own issues may prevent him from being able to allow himself to perceive the loss and its implications. Because intellectual acceptance is missing, it follows that affective acceptance will be absent as well. The caregiver's job is to work through resistances to the intellectual, and ultimately the affective, acceptance of this loss in order that mourning can progress. Anything that concretizes the loss for the mourner helps actualize it. The caregiver may encourage actualization of the loss by promoting actions such as the following. (All save the last also serve as evocative techniques to elicit the mourner's thoughts and expressions of grief.)

1. Talking about the deceased, the loss, and its meanings and implications

2. Recounting the circumstances of the death

3. Reviewing the relationship and reminiscing about its meanings and memories

4. Bringing into the session and interacting with tangible reminders and various memorabilia, such as photographs, special possessions, or, in some cases, linking objects (Volkan, 1m, 1981)

5. Identifying secondary losses accompanying and engendered by the death

6. Discussing the frustrating inability to gratify needs relating to the deceased

7. Finishing unfinished business with the deceased

8. Reality testing the loved one's absence and the mourner's expectations related to it

9. Confronting denial, resistances, and defenses

10. Visiting the cemetery or viewing other sources of confirmation of the death (e.g., death certificate, insurance payment voucher)

11. Using and making sure the mourner uses past tense verbs when discussing the deceased (except as involves the development of an appropriate new relationship)

12. Examining the altered assumptive and external worlds and the need for the mourner to change in regard to them and his identity

13. Assisting in the development of a healthy new relationship with the deceased that acknowledges the reality of the death and its implications and coincides with the mourner's going forth adaptively in the new world

Normalize and legitimize appropriate affects, cognitions, wishes, fears, behaviors, experiences, and symptoms

Normalizing and legitimizing the mourning process offer the mourner support, reassurance, and control. Doing so can eliminate additional stress and anxiety resulting from inappropriate self-evaluations based on erroneous interpretations about the mourning experience and general misinformation about grief and mourning. Normalizing and legitimizing minimize the mourner's concerns about going crazy and put things in a meaningful context, which in turn increases the ability to tolerate and cope. In addition, they tend to encourage further expression and release, which is so important in mourning. As is the case for providing psycho- educational information about mourning, normalization and legitimization are sometimes viewed by caregivers as unsophisticated techniques. However, they are critically important therapeutic interventions.

Assist the mourner in identifying, labeling, differentiating, and tracing affective experiences and their component parts

Complicated mourning often brings a confusing, undifferentiated mass of painful stimuli under which the mourner must labor. To the extent that components of this undifferentiated mass can be identified, named, distinguished from one another, traced back to original sources, and dealt with individually, the mourner will be better able to cope and experience a sense of control. It is vastly more difficult and discouraging to confront a vague, diffuse, oppressive accumulation of pain than it is to contend with specific components and then address their sources individually (e.g., anger at the loss, frustration at not being able to reach out and touch the deceased, fear of making it alone, or sadness at unfinished business). When a person identifies and names something, it becomes more manageable; when its source is identified, it becomes more grounded. Even if such awareness does not obviate

problem solving, it helps give a sense of cognitive control and establish a direction for action. At the very least, it makes the experience more understandable and tolerable, thus decreasing emotional press upon the mourner. This type of differentiation also allows each feeling to be fully experienced and diminishes intellectual and affective confusion.

Appreciate and enable the working through process

One of the most important tenets of treatment in complicated mourning involves the need to work through its various aspects. Working through combines the three analytic techniques of confrontation, clarification, and interpretation (Karasu, 1989) and is an inherent objective of mourning. It involves repetition and continual elaboration or demonstration of the same defensive or instinctual behaviors in differing contexts, the goal being to make insight more effective and bring about significant and lasting changes. It entails overcoming resistances, expanding and modifying prior interpretations, identifying basic themes, or highlighting central issues to lead eventually to the inclusion in the conscious personality of previously warded-off components (Moore & Fine, 1990).

The repetition required in this working through process must be respected by the caregiver. It cannot be eliminated:

> The individual mental or emotional experiences. . . are, of course, part of the person's pattern of reacting and thinking, but they are interlocked with one another in multiple ways. Interpretive dissolution and understanding of some specific piece of dissociated material, therefore, can produce only a certain degree of actual change. The extent to which any single piece of awareness and understanding affects a patient's many other known or dissociated interpersonal experiences, which are mutually interlocked with the first one and through them with his general patterns of reacting and thinking, will deter- mine the extent of real change.
>
> As a result, any understanding, any new piece of aware- ness which has been gained by interpretive clarification, has to be reconquered and tested time and again in new connections and contacts with other interlocking experiences, which mayor may not have to be subsequently approached interpretively in their own right. That is the process to which psycho- analysts refer when speaking of the necessity of repeatedly "working through" the emotional experiences for the dynamics and contents of which awareness and understanding have been achieved, and when they speak of "working through" the elements which operated in the process of establishing this awareness and this understanding. (Fromm-Reichman, 1950, p. 141)

Caregivers need not espouse Fromm-Reichman's psychoanalytic perspective to appreciate her views on the working through process. Indeed, by other names this idea is also present in a majority of the other theoretical orientations. It is a pivotal concept inherently involved in the repetition compulsion principle (Freud, 1920/1955a) that underlies the generic processes of psychological adaptation to psychosocial change (e.g., psychosocial transitions and assumptive world changes, identified by Parkes, 1988) and trauma (e.g., the stress response syndrome, identified by Horowitz, 1986a), each of which is present to some degree in most bereavement reactions. Certainly, problems exist for which the working through process sustains less emphasis. In mourning, however, because of the extent of the readaptations of self that must occur, the complex interrelationships among the various parties involved, and the relative intractability of investment in loved objects, repetition and working through are a major portion of the experience. It is no coincidence that working through as a general process in psychotherapy has been compared with the work of mourning (Rando, 1925) and perceived as a process of mourning (Livingston, 1971).

It must be noted that simple recollection or intellectualized treatment of memories is insufficient. There also must be emotional catharsis and a review and reintegration of relevant past and present thoughts and beliefs, culminating in a revision of the assumptive world. Work must take place repeatedly over time and must clarify, interpret, and work through the present loss's links with earlier deprivations; fears of overwhelming, disintegrating emotions; and concerns about facing the future without the loved one (Raphael, 1986). In working with children traumatized by the Chowchilla school bus kidnapping, Terr (1979) observed that it was only when the children's traumatic dreams and play were interpreted- promoting both abreaction and understanding-that release occurred. Similarly, Pennebaker and Beall (1986) found that writing about the facts of a traumatic event and not the associated emotions was not upsetting but also did not lead to the same benefits as when emotions were addressed. Review of the literature on coming to

terms with major negative life events suggests that cognitions and emotions are equally essential and that the working through process involves a dynamic interplay between them (Tait & Silver, 1989).

All "R" processes must be worked through, but several rely particularly upon this process for Success. The "R" process of recollecting and reexperiencing the deceased and the relationship is ideally suited to working through, as are the four subprocesses associated with readjusting to move adaptively into the new world without forgetting the old (i.e., revising the assumptive world, developing a new relationship with the deceased, adopting new ways of being in the world, and forming a new identity).

Acknowledge that repetition is an inherent part of treatment, but ensure that repetition takes place in the service of working through

Repetition in order to master the loss-comprehend it, get new perspectives on it, achieve closure, work it through, and identify and express the feelings and thoughts to which it gives rise-is valuable and should be supported by the caregiver. Indeed, if a caregiver is not comfortable with repetition, he or she should focus on a different type of work, for repetition is an inherent part of the mourning process. Repetition should not be supported and encouraged, however, when it constitutes a resistance, a form of complicated mourning serving as a complex defense against therapeutically dealing with the death and moving forward (i.e., chronic mourning), a denial of the loss or some of its aspects, or an indication of being "stuck" in the mourning processes.

Once affective experiences are identified, labeled, differentiated, and traced, enable the mourner to feel, accept, examine, give some form of expression to, and work through all of the feelings aroused by the loss

It is not unusual for those experiencing complicated mourning to deny, inhibit, or distort some of their feelings after the loss of a loved one. The ultimate goal is for the mourner to feel, accept, examine, give some form of expression to, and work through each of these feelings. This is some- times known as "processing the emotions:' The mourner must deal with the entire spectrum of affect generated by the loss: feelings that are positive and negative, those with which the mourner is comfortable and those that make her uncomfortable, those that are socially validated, and those expected to be suppressed. If a feeling exists, it must be addressed in mourning. Failure to process applicable emotions as specifically noted here leaves mourning incomplete.

Design and tailor treatment to address general and specific issues identified for the individual mourner

Very simply, treatment of the mourner experiencing complications should take into account the general strategies and techniques to promote successful completion of the six "R" processes of mourning and address the two attempts of complicated mourning (i.e., to deny, repress or avoid aspects of the loss, its pain, and the full realization of its implications; to hold on to and avoid relinquishing the lost loved one). Treatment should also include specific interventions to address the mourner's idiosyncratic situation (e.g., high-risk factors, type of death, specific impediments to mourning). Designing and tailoring the treatment package in this fashion presupposes accurate and in-depth assessment.

Determine the symbolic meanings of persons, objects, experiences, and events to the mourner

Throughout the treatment process, the caregiver must work to under- stand the idiosyncratic experience of the mourner in order to know how best to intervene. This means the caregiver must continually process the meanings, symbolism, and significance the mourner attributes to specific persons, objects, experiences, and events. The fact that what may be true and required in one mourner's treatment may not be so for another is not unique to complicated mourning. It should be assumed for all types of problems and for all types of intervention. However, in complicated mourning the caregiver may be especially prone to attributions about the mourner-attributions that mayor may not be accurate.

The most effective way of ensuring accuracy is to ask the mourner to clarify meaning (e.g., the meaning of displaying the deceased's photo, of engaging in a particular identification behavior, of admitting to previous feelings

of rage). In all situations, the caregiver must be confident that his or her understanding of the meaning, symbolism, and significance attributed to a person, object, experience, or event accurately reflects that sustained by the mourner. If this is not the case, the caregiver is not operating within the phenomenological world of the mourner, and serious problems -or at least diminished therapeutic value-can ensue. For example, one caregiver made a serious blunder by failing to appreciate that the death of a deceased child's dog constituted for a particular bereaved parent an end of the connection to her son. The mourner's feeling of disconnectedness precipitated a suicide attempt.

Identify; interpret, explore, and work through resistances to the mourning processes

Like peeling an onion, the caregiver must gently remove layer after layer of resistance to the requisite processes of mourning. This is a crucial part of treatment, not something to be rushed through to get to the "underlying issues:' Indeed, in complicated mourning, the resistances and defenses employed are the underlying issues and the therapeutic targets. Resistance can be seen in any thought, feeling, behavior, impulse, conflict, attitude, value, belief, issue, or conditioned response that contributes to complication in one or more of the six "R" processes of mourning.

It is ill-advised to assail defenses in an effort to force the individual to mourn. This strategy will only engender stronger resistance or overwhelm and/or traumatize the mourner and possibly lead to decompensation. Defenses and resistances are there for a purpose and must be respected, interpreted, and treated carefully. The caregiver gently works them through with the mourner so that he no longer needs them and can let them go. The mourner is never stripped of them, but rather permits him- self to relinquish them. In brief, one never leaves the mourner without appropriate recourse to defense. Even in aggressive attacks upon mourning, such as those seen in some of the behavioral therapies, the caregiver accounts for and deals with resistances. For example, in Ramsay's (1979) controversial use of emotional flooding, discussed in some detail in chapter 7, the caregiver takes great pains to respect defenses and build in safeguards against the mourner's becoming overwhelmed.

Identify any unfinished business with the deceased and discover or create appropriate ways to facilitate closure

Unfinished business is anxiety provoking, presses upon the mourner for completion or closure, and tends to be acted out through the repetition compulsion. It can contribute to detrimental behaviors and relationships and can create significant pathology in all realms. For this reason, the care- giver must work to assure that the mourner in some fashion expresses all appreciations and positive feelings and thoughts, all resentments and negative feelings and thoughts, and all regrets and feelings and thoughts associated with the wish that things had been different. The caregiver may ask the mourner specifically what needs to be said or done to come to peace with the deceased and may create opportunities to achieve this closure. To the extent that the caregiver can assist the mourner in achieving closure with the deceased, there will be no unfinished business to prompt acting out, fewer complications of the "R" processes of mourning, fewer unrecognized secondary losses, and less emotional baggage from the past to interfere with current functioning.

Help the mourner identify, label, differentiate, actualize, mourn, and accommodate secondary losses resulting from the death

Just like the initial loss, secondary losses, whether physical or psycho- social, must be addressed. In this regard, secondary refers to consequence or time of occurrence, not degree of importance. Often secondary losses, especially psychosocial ones, fail to be legitimized as losses requiring grief work and are eclipsed by the more immediately visible death of the loved one. Nevertheless, such losses may be enormously significant. They can be even more problematic than the primary loss in terms of lack of social validation, support, or the mourner's preparation for them.

It is important to reiterate that secondary losses pertain not only to something once possessed but now lost (e.g., loss of a home because of financial problems, status because of widow hood, or security after a murder), but also to the loss of future plans or hopes (e.g., loss of the retirement to have been spent together, the opportunity to

make amends with an ex-spouse, or a parent's presence at the marriage of a child). Secondary losses proliferate the more the mourner was tied to the deceased; the stronger the mourner's attachment to the deceased; the more numerous and central the roles the deceased played were in the life of the mourner; the more meanings that relationship embodied; the more behavior, inter- action, and reinforcement patterns involved the deceased; the more integrated that person was in the assumptive world of the mourner; and the more investment, needs, feelings, thoughts, memories, hopes, wishes, fantasies, dreams, assumptions, expectations, and beliefs the mourner had relating to the deceased. Each loss requires its own mourning, despite the fact that often a number of such losses occur together. In fact, the total bereavement experience represents the accumulated sum of all of the grief and mourning for all of the losses engendered by the death. As is the case for feelings following the initial loss, feelings about each secondary loss must be processed, and ultimately each secondary loss must be mourned to the extent necessary. This is an area in which treatment is generally found lacking for individuals experiencing both uncomplicated and complicated mourning.

Recognize and respond to the importance of security afforded by the caregiver's availability to the mourner

Precisely because of dynamics contributing to complicated mourning (e.g., the mourner's insecurity without the deceased, avoidance of acknowledging aspects of the loss and its implications, fear of painful affects), the mourner typically will require assurance of the caregiver's psychological and physical availability. This does not mean that the caregiver must be available 24 hours a day; however, it does mean that the caregiver recognize that the treatment is stressful, attempts to be as supportive as possible in helping the mourner undergo It gainfully, and will be as responsive as is therapeutically advisable when the mourner requires assistance.

Acting on the recognition of these needs does not mean that the caregiver never challenges, confronts, or nudges; it means rather that such actions are always undertaken in concert with the five "Ps": presence, permission, patience, predictability, and perseverance. These qualities are essential for successful work with this population.

Recognize the dynamics of complicated mourning and adhere to the five "Ps" in work with the mourner

Mourners experiencing difficulties are typically insecure, anxious, and phobic about acknowledging the loss, its implications, and/or the painful affects it brings. Therefore, the caregiver needs to ensure that all interventions are characterized by the five "Ps:' Presence refers to the care- giver's commitment to be there for the mourner through the struggle with thoughts, feelings, and memories that may have frightened others away. Permission describes the attitude of the caregiver, which is open, interested, nonjudgmental, and nonprohibitive as regards the mourner's sharing of information, feelings, memories, and so forth. It does not mean that no boundaries or rules exist in the treatment, but it does mean that the mourner will not have to fear censorship or rejection if she expresses anger or other difficult emotions. Patience refers to the caregiver's attitude in putting into practice the recognition that the treatment process is painful, difficult, and often quite slow. The caregiver will act accordingly and be tolerant and imperturbable. If confrontations or limit setting are necessary for the good of the mourner (e.g., a chronic mourner may need to have a limit placed on how many times she can repeat the same story), they are accomplished without excitement or punitive attitude. Predictability means that the caregiver has demonstrated dependability, consistency, and trustworthiness and that the mourner has the security of knowing that the caregiver will act in a fashion consistent with those attributes. Perseverance is the quality of enduring through a treatment that can be long, painful, and frustrating at times. It implies the caregiver's commitment to see the treatment through to the end and not abandon the mourner.

When a normal, expectable emotion is absent, determine why and address the omission

In all of the forms of complicated mourning, by definition one or more aspects of healthy mourning are missing. The caregiver's responsibility is to rectify this situation-for instance, to help the mourner acknowledge the death, deal with the negative aspects of the relationship with the deceased, revise the assumptive world, and in short complete whatever "R" processes are incomplete. This principle also applies on a smaller scale: When the mourner describes a situation in which a normally expected emotion is lacking or minimized, the caregiver can rightfully

wonder about this. For example, in the case of a bereaved parent who admits only to sadness at a police officer's "blaming the victim' after a drunk driving crash, the caregiver might note, '1 wonder what other types of feelings you might have had when the officer said your daughter should have known better than to be crossing the street at that time of night:' Depending upon the response, the caregiver can query why the normal response of anger was missing. This can lead to a discussion of reasons for denial and other defenses.

Of course, a danger exists in this type of questioning that the caregiver will insist upon the mourner's unconsciously having had emotions he never did have. Such absences may not necessarily be a consequence of a defense but may result from some aspect of personality or upbringing. For this reason, the caregiver always needs to pose hypotheses and statements in a fashion that is not global or absolute: "Most people would be somewhat disturbed about a comment like that" is preferable to anyone would be angry on hearing that statement:

Sometimes the caregiver can assist a mourner to own affect by presenting the same situation as if it had happened to someone else and inquiring about the mourner's reactions to it. Thus, in the situation described, the caregiver might ask, 'What do you think you would feel if some police officer blamed your best friend's daughter for being on the street instead of the drunk driver who hit her?" Frequently, distancing a situation in this way enables the caregiver to circumvent personal restrictions or perfectionist standards the mourner might apply to himself but not necessarily to anyone else. Sometimes the same effect can be achieved by the caregiver's minimizing the situation to dramatize to the mourner precisely what he may be doing and to make a point (e.g., "I see. It was nothing. Just the funeral of your best friend:'). This always must be done with care to avoid being perceived as mockery instead of illustration by understatement.