CME

Grief counseling

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SUMMARY

Patients grieve the loss of loved ones, jobs, marriages, or even functioning. They seek comfort, understanding, respect, and especially hope. The "work of grief" progresses through stages. Mixed with the sadness can be feelings of anger, fear, and guilt. Psychotherapy can relieve self-destructive anger and guilt, advance the recovery phase, and stimulate psychological strength and personality growth.

RÉSUMÉ

Les patients pleurent la perte des êtres chers, d'un emploi, la rupture d'un mariage et la perte de leur autonomie fonctionnelle. Ils recherchent du soutien, de la compréhension, du respect et surtout de l'espoir. Le cheminement à travers ce processus de deuil comporte plusieurs stades. La tristesse peut s'accompagner de sentiments de colère, de crainte et de culpabilité. La psychothérapie peut atténuer la colère et la culpabilité autodestructrices en accélérant le stade de récupération et en stimulant le pouvoir psychologique et la croissance de la personnalité.

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LOSS IS SO MUCH A PART OF BEING human that we tend to underestimate the impact of grief on the health of our patients. Increases in morbidity in terms of physical and mental health problems and greater health care use as well as increases in mortality have been substantiated.[1] Increased use of sedatives, tranquilizers, alcohol, and medications has been demonstrated among those who are grieving the death of a husband or wife.[2]

Holmes and Rahe[3] developed the Social Readjustment Rating Scale showing that people are more likely to become ill after a loss. Patients commonly grieve the loss of loved ones, such as parents, spouses, children, and siblings, and also the loss of jobs, marriages, or even functioning (loss of body part or use). Frequently the grieving process is a normal adjustment to the realities of daily living rather than a pathological state. People come to physicians looking for a wise sage, a human being who has experience dealing with the tragedies of life. They look for an empathetic, nonjudgmental, supportive listener whom they can trust. They often turn to physicians first.

It is sometimes difficult to find psychiatrists, social workers, or psychologists who have the time to counsel people who need help. This is especially true in rural areas. As a result, much of the responsibility falls on primary care physicians. Often physical complaints and medical conditions make the emotional problems more complicated to treat. Family practitioners are in an excellent position to integrate the psychological with the physical (taking into consideration the spiritual) to provide "holistic care."[4] This article attempts to heighten physicians' awareness of the grieving process and indicate how we can intervene.

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Acute phase

Patients in the acute phase of grief are seeking comfort, understanding, respect, and especially hope. They do not need to be judged, told what to do, or told to keep a "stiff upper lip." They need to be allowed to cry and express in words their feelings of loss. An appointment right after a loss enables a physician to assess the effect the death has on the patient's life and decide what appropriate action can be taken.

It is helpful in the acute stage to be a creative listener. Dr Carl Rogers in his book, *Client Centred Therapy*,[5] describes a technique of simply playing back to patients the essence of what they said, reflecting content and affect. Patients get the experience of being listened to and of hearing feedback from another person replaying their words and feelings. Rogers postulated "empathy," "unconditional regard," and "genuineness" as necessary conditions for psychotherapy.

People who are suddenly bereaved could require more support and counseling than those who have known their loved ones are dying. They need to be given the opportunity to talk through the death, to have repeated opportunities to share feelings and make real the events of the death, to work through the unfinished feelings about the deceased (especially the feelings of chaos and insecurity stimulated by unanticipated loss), and to learn how not to overreact to the insecurity and fear that remains after this type of death.[6] Emergency departments, coronary care units, and intensive care units should provide help for the bereaved. Early counseling can reduce morbidity among high-risk groups.[7]

Anticipatory grief

Anticipatory grief encompasses the processes of mourning, coping, interaction, planning, and psychosocial reorganization that are stimulated by awareness of the impending death of a loved one and recognition of the associated losses that have already occurred; of the ongoing losses of progressive debilitation, increasing dependence, continual uncertainty, decreasing control; and of the losses yet to come. Physicians can help patients with the delicate balance of simultaneously holding onto, letting go of, and drawing closer to the dying person.[8] Certain people are more at risk of having problems because of highly ambivalent or dependent relationships.

Unresolved grief

Sigmund Freud described a clear difference between grief and melancholia. In grief the mourner comes to terms with a permanent detachment from the much loved person:

> [The] work of grief is a progression through stages of anger, painful dejection, loss of interest in the outside world, inhibition of activity and the temporary interruption of the capacity to love. Melancholia results when the normal process is not completed.[9]

Often patients will offer other symptoms as a way of getting a foot in the door. They sometimes believe it is inappropriate to discuss psychosocial issues with their physicians. Sometimes their own denial is so strong that they themselves have blocked their true feelings, and the sadness comes out inadvertently in the course of an appointment for something else.

Easing the transition

Bob, a 70-year-old retired man, came to the office with his wife, Gwen, during the last several months of her life while she was dying of cancer. Gwen had done all the bookkeeping, banking, paying of bills, housekeeping, and cooking. They had no children, so Bob was extremely dependent on Gwen for not only emotional support but also total support.

In a way, the grief started before her death as she became more and more disabled. We were able to talk about how Bob was taking on more responsibility. Slowly over time he learned more and more about household affairs. During this type of chronic illness, death and dying can be talked about, and certain issues and fears can be expressed and discussed while the dying patient is still alive. This makes the transition easier. Attention was also focused on Bob during Gwen's last days.

As soon as Gwen died, I booked an appointment with Bob that same week. I saw him weekly for 3 weeks, if only for short appointments. At each session practical matters like lawyers, wills, and the future – as well as sad and lonely feelings – were discussed. Even after a year, he still visited once every few months. He cried each time he came in, and we talked about Gwen and his grief.

A patient comes in with a headache or bronchitis and, in the midst of a 15-minute appointment, starts to cry. There is too little time available to deal with the complex issues. It is helpful to attempt to manage the acute situation and then arrange for a follow-up appointment in a psychotherapy slot for a half-hour or full hour. It is important to establish that there is no danger of homicide or suicide and even see the patient for another short appointment next day if a longer session cannot be arranged quickly.

It is not unusual for patients to visit years later with unfinished, unresolved issues concerning a death from the past. Usually the grieving process lasts somewhere from 6 months to 2 years. But there are differences between cultural backgrounds. All people, depending on their cultures, belief systems, and personalities, will find their own ways to resolve the loss.

If, after a reasonable period, the person is still not over the death of a loved one, it is worthwhile to look for other factors preventing resolution. Mixed in with the sadness can be feelings of anger, fear, and guilt. None of us likes to admit anger at a dead person, so these emotions are often disguised or repressed and prolong the period of grief or show up in other ways.[10] Sometimes the patient is clinically depressed and needs antidepressant medication.

Techniques of interventions

A technique originally developed by Jacob Moreno and later adapted by Dr Fritz Perls in Gestalt therapy involves psychodrama or the patient's acting out a dialogue with the deceased.[11] The patient plays both roles by actually changing chairs and talking back and forth to the imagined person with the aim of contacting old feelings and linking them up to thoughts. The focus can be on expressing the loss, anger, fears, and resentment. Eventually working toward forgiveness of the deceased is helpful.

This technique has been used to deal with the loss of children, grief about abortions, and even miscarriages. The patient plays the part of herself and the unborn child.

Relieving anger and guilt

A 22-year-old medical student had a history of sharp chest pain under his left breast lasting for minutes, often associated with light-headedness and precipitated by exertion. This had been going on for many months, and he was worried because his father had died from a myocardial infarction. A full examination, electrocardiography, and blood assessment found no organic cause for his chest pain.

I simply stated that perhaps there was a relationship between his father's death and his chest pain. He identified strongly with his father. Sometimes the loss and missing someone is so great that we keep them around with physical or emotional symptoms, as a way of staying connected. His father had died in front of him, and he felt guilty that he could not save his father's life. He also was angry that his father "abandoned him" by dying. Unresolved anger often needs to be dealt with for resolution to be possible. After our discussion the student felt relieved and had no further symptoms at follow up 10 years later.

Achieving forgiveness

Often patients feel guilty at somehow causing another person's death. Geraldine was always arguing with her mother. On the day of her mother's death, they had a serious fight shortly before the mother died. Twenty years later Geraldine still felt responsible for her mother's death. She was depressed and unable to enjoy life.

In therapy the events that preceded the death were reviewed and reframed. It was clear that the mother really loved Geraldine and wanted the best for her daughter. Geraldine meant no harm to come to her mother even though she had been angry. She acted out having a conversation with her deceased mother and through this believed that her mother did not hold a grudge. Geraldine was able to forgive herself and her mother for what had been said and done. A heavy burden of guilt and unresolved resentment was lifted.

Sometimes patients feel unresolved because they never actually got a chance to say goodbye and see the person die. Deaths often occur in hospitals, with family and friends absent. Having them act out a conversation with the deceased and actually saying goodbye, even though totally artificial, can dramatically help to resolve unfinished feelings. This type of intervention can also be done using hypnosis.

The biggest problem faced by parents of a stillborn child is the failure of families, friends, and physicians to recognize that their grief has arisen from the death of a real person.[12] Always make a point of talking about grief after abortions, miscarriages, and deaths from sudden infant death syndrome. It is not uncommon to find parents even years later with unfinished sad feelings about the loss of their unborn child. Because recovering from the death of a child is perhaps the most difficult, suggest patients get involved in self-help community support groups to help reduce the psychological damage to themselves and remaining siblings.

The death of a parent is one of the most stressful occurrences for a child to endure. A reported 61% of bereaved children have suicidal thoughts and plans.[13] Children can experience developmental disturbances, psychiatric disorders, disturbed ego development, and physical complaints. Intervention with this group can prevent future psychiatric disturbance.

Because children tend to communicate nonverbally, drawings that allow children to express their feelings freely and their concerns without the pressures and risks of miscommunicating are an important tool for physicians. Physicians can ask children to draw a picture of the family and then ask them to talk about the picture. If serious concerns are raised, referral to professionals experienced in dealing with bereavement among children can be sought. Physicians can provide surviving parents and children with books and movies, which can stimulate further discussion in terms the child can understand.[14]

Instead of death being seen as part of life, deaths can be seen as somehow a mistake or deficiency. Even physicians can have feelings of guilt if they see any death as a failure on their part. If only they had done this or that or responded differently, the person might still be living. As physicians we must learn from our mistakes and be able to share our grief with our patients and their families.[15]

Counseling that focuses on the grief reaction can help to advance the recovery phase and stimulate new psychological strength and personality growth. Mourning is important, but when the mourning takes over, affects functioning, and is excessively prolonged, then intervention is necessary. Psychotherapy can focus on the resentment and anger suppressed or turned back on the self as well as help resolve self-destructive guilt.

Someone to watch over me

Mary, a 37-year-old secretary, had a 2-month history of insomnia. Further inquiry revealed she was having bad dreams and was afraid to fall asleep. Mary's mother died in her country of origin and Mary did not receive notice that her mother was even ill until after she was dead. Mary felt guilty at not being there with her mother. When she saw her mother in her dreams, she got scared and kept waking up. We established that Mary had a good relationship with her mother and they loved each other very much.

Mary was asked to consider the possibility that her mother was not angry and came in the dream to express her love and tell her that she would watch over and guide her when she needed support. There should be no reason for Mary to feel guilty about not being with her mother. We established that Mary's mother only wanted the best for Mary and would not want her to suffer because of her death. Mary was able to imagine talking to her mother and settling the unresolved feelings.

When Mary visited 2 weeks later, she was having no more insomnia and was sleeping comfortably through the night. She felt that her mother was with her as a spirit guide and she could depend on her watching over her when she needed it.

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Involving family members in the therapy can mobilize additional support. Often working on forgiveness and helping patients to express unspoken feelings eases the grief and helps patients to heal. ■

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