NATIONAL CENTER FOR PTSD
FactSheet

Managing Grief after Disaster

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The recent terrorist disasters left many people suddenly bereaved of spouses, children, parents, close friends, and coworkers. In the immediate aftermath, some have been numb or unable to accept the loss. Many have felt shocked, lost, anxious, depressed, and physically unwell as a result of this loss. For many, the pain has been intense and unrelenting. In the acute aftermath of the violent death of a loved one, a sense of disbelief or intense, uncontrollable emotionality is very frequent. Distressing physical symptoms are also common (Lindeman, 1944; Stroebe & Stroebe, 1993). These emotional and bodily reactions may be very strong and can themselves be traumatizing, especially if they are unfamiliar and unexpected. Such a secondary reaction can further amplify the pain caused by the loss and can be mitigated by information about grief and stress reactions. It is important to realize that intense and unfamiliar emotionality is entirely normal and does not necessarily have implications for long-term emotional stability or health. The fact that a popular Internet book site lists 2,776 titles on the topic attests to the fact that grief is both common and difficult. In ordinary, peaceful times millions of people die every year, each leaving friends and family bereaved. Many experience numbness or intense pain in the immediate aftermath. For most, this initial reaction subsides with time, and the bereaved person finds a way to again engage fully in life. However, studies show bereaved individuals, in general, are at risk for longer term mental and physical health problems. It is a good idea to provide ongoing support, monitor the outcome of grief, and know that professional intervention can be helpful.

Given the universality of bereavement, there has been relatively little research to characterize its course, develop a nosology for bereavement problems, identify risk factors, or guide treatment. The information provided below draws upon what has been done and upon ongoing work.

The course of bereavement

The course of bereavement has become increasingly better understood since the mid '80s, with the development of several measures that have proven consistent across some populations. These include the Texas Revised Inventory of Grief (Faschinbauer, Zisook & DeVaul, 1987), Core Bereavement Items (Burnett, Middleton, Raphael & Martinek, 1997), Criteria for Complicated Grief Disorder (Horowitz, Siegel, Holen, et al., 1997), and the Inventory of Complicated Grief (Prigerson et al., 1995). Few studies have targeted a full range of ages and circumstances of death and the bereaved. Most of the information

available refers to older people or widows, although selected studies have targeted parents of deceased children, surviving friends and partners of HIV sufferers, parents of children who have died violently, and combat veterans. However, younger individuals, especially men, may be at highest risk for complications, relative to a comparison group of same age and sex (Ball, 1977; Stroebe & Stroebe, 1983).

Research by Stroebe and colleagues (1993) provides a model of the type of study needed. These researchers compared widows and widowers under retirement age to a control group consisting of married couples, interviewing participants 4 to 7 months following their loss and again at 14 months and at two years. The researchers found that widows who participated were more depressed than widows who did not while the reverse was true for widowers. It is important to keep in mind that most studies of bereavement have succeeded in recruiting only about one-third of eligible individuals, so all data need to be viewed in light of the characteristics of the individuals who choose to participate. Given this caveat, studies consistently find bereaved individuals to have higher levels of depressive symptoms than matched controls in the 6-12 months after the death. Most of those with milder levels of depression improve by year 2, while those who are clinically depressed (about 20%) remain depressed. Somatic symptoms are reported by widows and widowers at a rate nearly 10 times the rate reported by members of the control group in the initial 6 months, and these symptoms are still reported 4 times as much at two years.

Less is known about the course of bereavement following violent death, but available studies have consistently found that symptoms and impairment are more prolonged and a sense of resolution less likely (e.g., Murphy, 2000). A recent study of women college students (Green, 2001) found those who experienced a violent loss had symptoms and impairments similar to those who experienced assault. A dissertation study by Pivar documented grief symptoms in 70% of veterans and found that these could be differentiated from symptoms of PTSD and depression. Taken together, this work suggests that sudden violent bereavement is a very intense stressor. While many people will find a way to cope without intervention, skilled professional assistance may be important in decreasing the morbidity and even mortality of those bereaved as a result of disaster. In order to provide such assistance, professionals need to be informed about grief and about treatment strategies that have been developed and tested.

The experience of grief

Grief is the process by which we adjust to the loss of a close relationship. Therefore, grief is an inevitable companion to love and attachment. The lives of those we love are interwoven with our own in thousands of small and large ways. One's immediate family, in particular, contributes to a sense of comfort, security, and happiness and reinforces behavior. Endocrine function can become entrained by cues from another person. When this happens, losing that person requires a period of physiological adjustment. In all cases, loss of a loved one

engenders feelings of loneliness, sadness, and vulnerability. The death of someone close also makes one's own death imaginable, thus evoking fear of dying. When a person experiences the death of someone close, that person is confronted by mortality and undergoes a certain degree of acute separation distress. Sometimes, there is also guilt about being alive when the other person has died, or there is guilt about not being able to save the person or make his or her life or dying easier.

While grief is not the same for every person, there are certain commonalities. During the initial phase, the bereaved person is preoccupied with the deceased, preoccupied with feelings of yearning and longing, and with searching for him or her. While grieving, most people withdraw from the world and turn inward, often reviewing the course of the relationship, including positive and negative thoughts and feelings. People often also review the meaning the relationship had in their lives. Grief entails a host of painful emotions that can sometimes be very strong and persistent. Strong feelings of sadness and loneliness almost always occur following the death of a close friend or family member. Fear and anxiety are also common. Difficult feelings of resentment, anger, and guilt can occur. Experiencing any or all of these emotions following the loss of a friend or family member is perfectly normal.

As the transition to life without a friend or family member progresses, the intensity of grief subsides. The bereaved person accepts the death and begins to take some comfort in positive memories, establishing a permanent sense of connection to the person who died. It becomes possible to reengage in activities and relationships while still having memories of and maintaining a sense of closeness to the deceased. The period over which this adjustment occurs is variable, depending on the circumstances of the death, the characteristics of the bereaved, and the nature of the relationship. In some circumstances, intense grief persists for many months or even years. Intrusive images and disturbing ideas inhibit the healing process, and there is a sense that the death is unacceptable and unfair. For some who have difficulty coping with the death, grief sometimes seems to be all that is left of the relationship. Also, a decrease in the intensity of the grief may feel like a betrayal of the person who died. Some people also have persistent feelings of guilt. When a death is sudden, violent, and untimely, the bereaved will most likely also face other difficulties. The condition in which unmanageably intense and/or persistent grief symptoms occur is called Traumatic Grief. Symptoms of Traumatic Grief are listed in Table 1. Work is underway to establish diagnostic criteria and to develop treatments for this condition. Traumatic Grief may predispose to other psychiatric, medical, and behavioral problems that can complicate bereavement. These are generally treatable conditions and need to be recognized by professionals and by the bereaved individuals themselves.

Complications of bereavement

Bereavement is a risk factor for a range of mental and physical health problems. Among

these are the following:

- Prolonged grief or Traumatic Grief
- Onset or recurrence of Major Depressive Disorder
- Onset or recurrence of Panic Disorder or other anxiety disorders
- Possible increased vulnerability to PTSD
- Alcohol and other substance abuse
- Smoking, poor nutrition, low levels of exercise
- Suicidal ideation
- Onset or worsening of health problems, especially cardiovascular and immunologic dysfunction

Traumatic Grief

Grief will inevitably disrupt mental functioning following the death of a loved one. While it should be emphasized that grief itself is a normal process of adapting emotionally and cognitively to the loss or absence of a loved one, sometimes the intensity of a person's grief may be overwhelming or last longer than is healthy. This may occur for a variety of reasons. The relationship between the deceased and the bereaved might have been very close or complicated; the circumstances of the death may be sudden or traumatic, as in accident, disaster, or illness; or the grieving person may not have good coping skills or the social support that would help the grieving process. In situations like these, it may be helpful to seek professional help or counseling in order to resolve the grief.

When grief goes on longer than is healthy or when it is overwhelming, a diagnosis of Traumatic Grief might be appropriate. It may be helpful to draw an analogy to a physical illness. An illness is not a characteristic of a person; it is a state a person is in at a given time. Many illnesses are very treatable. Another analogy is to an acute injury. People are more or less vulnerable to disability from an injury, but some types of injury are so severe that they always cause impairment. Using such an analogy, it is possible to see that following an accident or disaster or the sudden death of a very close person, it is entirely normal to experience Traumatic Grief, just as it is quite normal to develop tuberculosis upon exposure to a virulent organism, and it is normal to be unable to walk on a broken leg. It is also clear that it is a good idea to diagnose and treat these conditions. No one would tell a person with pneumonia "pull yourself together" or "get on with it" or expect a person with a deep cut or a broken bone to heal him- or herself. Although labels can be hurtful if misused, they can also be helpful. An ill person needs to have a "sick role" and to receive treatment. An ill person benefits from support and assistance from family and friends, as well as from treatment by a trained professional.

Table 1: Symptoms of Traumatic Grief (Prigerson, 1995)

- Preoccupation with the deceased
- Pain in the same area as the deceased
- Memories are upsetting
- Avoid reminders of the death
- Death is unacceptable
- Feeling life is empty
- Longing for the person
- Hear the voice of the person who died
- Drawn to places and things associated with the deceased
- See the person who died
- Anger about the death
- Feel it is unfair to live when this person died
- Disbelief about the death
- Bitter about the death
- Feeling stunned or dazed
- Envious of others
- Difficulty trusting others
- Lonely most of the time
- Difficulty caring about others

Risk factors for complications of bereavement

Risk factors are those aspects of a situation that tend to increase vulnerability to complications and that may slow recovery. Existing studies suggest that risk factors relate to the characteristics of an individual, the nature of the relationship to the deceased, the circumstances of the death, and the social context within which recovery takes place. Some risk factors relate to the larger situation in which the bereaved finds him- or herself, and some risk factors relate to the bereaved individual's specific history and makeup. While both kinds of risk factors raise the distress level of the bereaved person, it is useful for clinicians to be particularly aware of the bereaved's individual situation.

The following risk factors have been identified:

Demographic factors

Socioeconomic status

Lower socioeconomic status is related to a poorer health status in general. Bereavement appears to affect people similarly, regardless of socioeconomic status. Age: Bereavement appears to be somewhat more stressful for younger individuals than it is for older individuals, with the exception of elderly people. The disparity between how older individuals are affected and how elderly people are affected may be because the stress experienced by elderly people

is related to preexisting health problems. Gender: There is some evidence that men, especially widowers, have more bereavement-related health problems than women, especially when dealing specifically with the loss of a spouse. Although both men and women are deeply affected by the loss of close family members and friends, the death of a child may be more difficult for mothers than for fathers. Women may also recognize the effects of bereavement more readily than men, and men and women may cope differently.

Individual characteristics

Overall, individuals who are defined as "neurotic" have been shown to have more health problems. Low internal locus of control is generally associated with more depression. This is not specific for bereavement. On the other hand, high internal locus of control does not act as a buffer for bereavement-related distress. Anecdotal evidence suggests that a belief in life after death may be protective. However, when this was examined in a study, a protective effect was not found (Stroebe & Stroebe, 1987). Guilt or self-blame about the death may contribute to traumatic grief.

Relationship quality

Relationship quality may affect men and women differently when it comes to difficulty with bereavement. A good marriage may be associated with more bereavement-related problems in women, while the opposite may be true for men. In general, data does not support clinical lore that implies that bereavement problems occur because of ambivalence or problems in a relationship. It is very clear that in some instances an especially positive relationship may be associated with very difficult bereavement reactions.

Circumstances of the death

Not surprisingly, sudden death is associated with more symptoms of bereavement difficulty in the first 6 months after the loss. In some studies this difference was not present in later interviews, while in other studies it was. A low score on a measure of internal locus of control signified a greater likelihood for difficulty for younger bereaved spouses. In some studies, there is evidence of continuing distress from the loss for many years following a sudden, violent loss. Experiencing multiple losses or witnessing the death (especially a factor for children who witness a death) has been found to correlate with levels of grief intensity. Feelings of helplessness and powerlessness, survivor guilt, threat to one's own life, confrontation with the massive and shocking deaths and mutilations of others, and a violation of one's assumptive world of safety and meaning are traumatic factors that may impact a person's ability to resolve grief. It is clear that many of those bereaved by the WTC disaster may experience treatable psychiatric difficulties for a long period of time. It is important for professionals to be vigilant about this possibility.

Social context

Both perceived and received social support are related to lower symptoms of depression in the general population, but there does not appear to be a specific relationship between social support and bereavement outcome. However, it is important to note that bereaved individuals often perceive that others lack empathy and that others are hostile about the bereaved's continued symptoms. This perception is likely related to a poorer outcome but has not been specifically studied. In general, however, social support and positive family functioning, along with the opportunity to express grief, may help to mitigate the negative effects of bereavement.

Treatment of bereaved individuals

Grief support groups and grief counseling are widespread and undoubtedly highly variable. Little information is available related to support group and counseling outcome. There is specific controversy regarding the importance of confronting the death (also called "grief work") in the early phase of grief. In one study (Stroebe), investigators developed a measure to assess the extent to which individuals confronted or avoided their loss and used scores on this instrument to predict outcomes at later times. They found that low scores for widows did not influence outcome, but low scores for widowers predicted poorer outcome. There is some evidence that the occurrence of symptoms of major depression in the first month following the death predicts a worse course later, especially for suicidally bereaved individuals (e.g., Jordan, 2001).

It goes without saying that the loss of a close relationship permanently affects the bereaved person. It is not reasonable to think that one can recover from such a loss or resolve the loss. Such a loss is permanent and has permanent effects on the bereaved. Still, it is possible and important that the bereaved person will eventually have comforting memories of the deceased and feel interested in and able to engage in life. Weiss (1993) provides a list of reasonable expectations we can have for the bereaved. A person who has lost someone should eventually have (1) the ability to give energy to everyday life, (2) psychological comfort, or freedom from pain and distress, (3) the ability to experience satisfaction and gratification in life, (4) hopefulness for the future, and (5) the ability to function adequately in a range of social roles. How can a professional assist the bereaved in achieving these goals?

The role of a professional in the early phase of disaster bereavement

There is little data on the effectiveness of early intervention for grief. However, it is clear that early intervention is a good idea following a disaster, provided a skilled, empathic clinician administers the intervention. Although data suggest that even after sudden, violent death, most people eventually grieve successfully, the initial process can take a long time. Many people consider grief to be a personal experience and so do not turn to mental-health professionals for help with grief. However, when a loss is sudden and violent, the intensity of emotions can be frightening and the need for support and outside intervention greater. In

response, the professional needs to engage in a skilled, supportive intervention. Useful components of such an intervention include:

- Providing information about grief and its symptoms, course, and complications
- Evaluating the nature of the individual's distress
- Helping to identify and solve practical problems
- Providing strategies for management of intense feelings
- Helping the person think about the death in a way that leads to emotional resolution

Affect-evoking interventions must be used with care and expert skill and be balanced with containing and soothing strategies. During the early phase of bereavement, it may be very useful to provide information and strategies for thinking about the death. It is best if the professional provides some follow-up and remains available for consultation and support, should this be needed.

Prigerson and Jacobs (2001) provide a list of "do's" and "don'ts" for how physicians might interact with family members following a patient's death. These may also be useful to consider. The authors recommend:

- Direct expression of sympathy
- Acknowledgement that the clinician does not know exactly what the bereaved person is going through
- Talking about the deceased, including saying his or her name
- Eliciting questions about the circumstances of the death
- Asking questions about feelings and about how the death has affected the person

The authors also provide a useful list of cautions about things that are **NOT HELPFUL**, including:

- A casual or passive attitude (e.g., Do not merely say, "Call me if you want to talk," or ask "How are you?")
- Statements that the death is in any way for the best or acceptable (e.g., "He/she is in a better place," or "It's God's will.")
- An assumption that the bereaved is strong and will/should get through this
- Any kind of avoidance of discussion of the death or the person who died

Even given its private nature, variable course, and usual resolution, there are circumstances in which grief can be intense and prolonged, hindering reengagement in daily activities. When this occurs, a focused intervention may be needed. There is wide acknowledgment that bereavement can be prolonged and that it can lead to other mental-health problems, especially depression and anxiety. Therefore, professional intervention may be especially important if the bereaved exhibits the risk factors discussed above.

Treatment strategies for complications of bereavement

Treatment should target the symptoms experienced by the patient. It is now very clear that bereaved individuals who have Major Depressive Disorder (MDD) respond to antidepressant medication and/or psychotherapy similarly to those who are not bereaved. A very interesting recent study suggests that treatment of MDD as early as a month after the death may be extremely helpful and prevent later symptoms. Similarly, for those who meet criteria for PTSD, it makes sense to provide treatment similar to that used with other PTSD patients. However, the most common postbereavement problems center around traumatic grief reactions, and unfortunately, few treatments have been developed or tested for symptoms of Traumatic Grief. Studies of early intervention for grief document some reduction in grief symptoms, with support groups showing efficacy equal to that of active psychotherapy. An early study of a behavioral therapy called "guided mourning" also appeared to have beneficial effects, although grief outcome was not measured. A specific "Traumatic Grief Treatment" (TGT) is currently undergoing randomized controlled testing. In a pilot study, TGT had a large effect size, even taking into consideration individuals who did not complete the full course of the treatment (Shear, 2001). Components of this treatment include:

- Providing information about bereavement and grief to bereaved individuals and their families
- The bereaved describing the deceased and relating the history of the relationship with the deceased
- Relating the story of the death and its aftermath
- Careful assessment of current grief levels, target grief levels, and components of grief (i.e., cognitive, behavioral, and somatic)
- Reviewing the bereaved's personal goals and determining how the bereaved person will know when these goals have been met
- Carefully managed imaginal exposure to the death and related events
- In vivo exposure to situations that are avoided and/or response prevention for situations of preoccupation
- Focusing on positive memories of the deceased

Therapists should undertake imaginal exposure only if they are familiar with this technique and with emotion control techniques. The remainder of the treatment may be of help alone, but it has not been tested. It is also important to evaluate the bereaved person's social support system and encourage engagement with existing supportive people. To date, no treatment has been proven effective in the early stages of bereavement, and there is some indication that for some people formal grief counseling can do more harm than good. In light of this, caution may be indicated.

Guidelines for early treatment in the acute phase of Traumatic Grief include:

- Allowing the bereaved person to talk about the nature and circumstances of their loss according to their own readiness (without probing)
- Educating about the course of bereavement and what to expect
- Assessing for possible troubling symptoms like an unusual intensity of grief reactions or intrusive thoughts
- Encouraging, as much as possible without intruding, the use of social support and the broadening of activities
- Encouraging positive memories and a feeling of connection to the deceased, which may help supplant traumatic memories

Pharmacotherapy may also be helpful for individuals suffering from Traumatic Grief. However, little has been done to test pharmacotherapy. As with depression and PTSD, it appears that serotonin active medications have some beneficial effect (Zygmont, 1998). Given the available information, it is important that clinicians learn to administer the techniques that appear to be efficacious.