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Review Article

Bereavement

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This paper attempts to draw together current knowledge in the field of bereavement, but it will not be possible, in the space available, to give scientific justification for every statement made. However, that can be obtained from the books and review articles to which reference is made; the whole field has been reviewed by Raphael (1983), Osterweiss *et al* (1984) and by Parkes (1972a).

Our knowledge and understanding of grief and its consequences have grown rapidly in recent years, the topic proving to be one of great importance to psychiatry. Most of the life events which have been blamed by Brown & Harris (1978) and by Paykel (1974) for the psychiatric disorders that follow them are in fact losses, and there is good reason to believe that some bereavements endanger mental health (Parkes, 1972a).

Not that every loss is necessarily harmful. Many people come through the stress of bereavement, stronger and more mature than they were beforehand. This is particularly likely to occur following the death of parents in adult life, and explains why some studies of psychiatric symptoms following the death of parents and more remote relatives do not show the increased symptomatology which has been reported following conjugal bereavement or the untimely death of children (Fulton & Owen, 1977).

The fact that bereavements and other losses can lead to good or bad outcomes makes it important for us to understand the intermediate variables that lead up to these different outcomes, and to identify people at special risk, before lasting damage has been done. We can then introduce appropriate services which have been shown to be an effective way of reducing risk (Raphael, 1977; Parkes, 1981).

'Normal' grief

Two major components have been identified as characterising the typical response to bereavement: an acute episodic component (the so-called 'pang of grief'); and, a chronic background disturbance (Worden, 1982).

Pangs of grief

These are episodes of restlessness, angry pining, and anxiety, brought on by any reminder of the loss, and including the autonomic accompaniments of anxiety and fear. They have close parallels in the 'separation anxiety' of young children separated from their mothers, and in the comparable behaviour of other social animals who cry aloud and search restlessly when separated from other members of the same species to whom they are attached (Parkes, 1972a). The fact that the intelligent human adult knows very well that it is useless to cry aloud and to search for a dead person does not remove the impulse to do just that. But it does leave him feeling bewildered and ashamed of such irrational impulses, and may cause him to do all in his power to repress, avoid, or postpone the expression of his grief. Any of the psychological defence mechanisms familiar to psychiatrists can come into operation at such times and can influence the ways in which grief is expressed. Hence the wide range of inter-individual differences which occur (well illustrated in the close-circuit TV film, *The Life that's Left).* Avoidance of grief can be a special problem for men who, more than women, have to present a 'stiff upper lip' and keep their feelings under control.

The chronic background disturbance of grief

This is distinguished by lasting feelings of dejection, loss of any sense of purpose or meaning in life, social withdrawal, difficulty in concentration, impairment of memory and, in many cases, disturbance of appetite, weight and sleep (Clayton *et al*, 1972). Corticosteroid function is disturbed (Hofer *et al*, 1977) and there are changes in the immune response system, reflected in depression of lymphocyte (T-cell) function (Bartrop *et al*, 1977; Schleifer *et al*, 1983). These changes, too, have parallels in the responses of social animals to lasting separation or loss. Hofer suggests that, in the environment of evolution, separations and losses were times of increased vulnerability, when it was necessary to withdraw from challenges and to

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conserve reserves. To this, one must add that bereavement invalidates a host of assumptions about the world. Plans, habits of thought and action, and ways of coping with problems all have to be relearned.

The psychosocial transition of bereavement

It takes time and energy to make 'real', inside the self, the reality which exists outside of it. Throughout this psychosocial transition, the bereaved are unable to rely on their previous view of reality and it is not surprising that they stay close to home, associate only with those they can trust to protect them, and avoid novel or testing situations in which their presumed weakness will be exposed.

In this respect, bereaved people have a lot in common with others who are forced by circumstances to give up one set of assumptions about the world and to develop another. Systematic comparison of reactions to situations as diverse as loss of a limb, loss of a spouse, and loss of a home, have been made from sociological and psychological perspectives by Marris (1974) and by Parkes (1972b). These studies have demonstrated how difficult it is to change basic assumptions: major change is usually resisted, and obsolete assumptions clung to long after they have ceased to make sense. Studies also emphasise the importance of anticipatory guidance in helping people to prepare for changes in their lives, and of post-change guidance for those who have been unprepared for change.

Mourning: the social expression of grief

How a person mourns is determined, to some extent, by the way he is expected to mourn. But the mourner also determines, to some extent, the way others will react to his mourning. Even in non-human species, the physical expressions which are evoked by separation and loss, themselves evoke a social response, inhibiting aggression, alerting others to danger, and evoking social supports. In humans, these social supports include complex rituals and patterns of belief and expectation, which vary from one culture to another. But Rosenblatt *et al* (1976), who compared 80 different anthropological studies, claim that these rituals contain certain common elements and serve basic human needs. Each culture performs certain 'rites of passage' which Van Gennep recognised as the ways by which societies help their members through each of the principal life transitions (adolescence, marriage, birth of a child, death, etc.). These comprise rituals of induction which may uniformly encourage the expression of tears and other features of grief (funerals, marriages, etc.), liminal periods during which those in transition are excused from certain obligations and permitted to withdraw, as well as usually a final ritual, following which they are expected to move into a new set of roles and responsibilities, consonant with their new status.

Western cultures have abandoned many of the rituals which attend these transitions and the belief systems that go with them (Gorer, 1965). Lacking these social supports, some bereaved people adopt roles which ensure that their society will be forced to accord them liminal status: they become sick, or rather they interpret the features of grief as 'symptoms' and seek help from our ritual specialists—the medical profession. Many doctors respond by writing a prescription for the bereaved person. This confirms the 'patient' in his sick role and provides him with the means to suppress some of the physiological manifestations of grief. Since grief is a process of relearning which, however painful it may be, needs to be done, there is some danger (though not conclusive evidence) that actions of this kind only complicate and prolong the process.

Recovery

In the normal course of events the intensity, frequency and duration of the pangs of grief tend to diminish as time passes. This diminution of searching behaviour can be seen as an example of 'extinction by non-reinforcement', and it is accompanied by a concurrent diminution in intensity of the background disturbance. The appetite for food is one of the first appetites to return and, like other appetites, may surge to an unusual degree, so that weight which was lost in the early weeks of bereavement is not only replaced but also increased (Parkes, 1972a). Similarly, surges in sexual feelings may become a problem for the bereaved at a time when social and self-expectations do not permit their expression.

Anniversaries are often times of renewed grieving, but they are also turning-points, after which the bereaved begin to seek a new identity. Because each relationship is different, each grief is different, and it is not possible to adopt a rigid time frame for bereavement. Also, there is no clear end to grief. The bereaved do not forget the past: rather, they gradually discover which assumptions continue to be relevant and enriching in their new life situation and which have to be abandoned. However, the old assumptive world remains in the mind—a network of association into which the bereaved can again be switched by anything which brings the dead person to mind.

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Bereavement and physical health

Evidence for the effects of bereavement on health comes both from prospective studies of bereaved samples and from retrospective studies of sick samples. Some of these are easy to understand, others less so. Among the puzzles requiring solution is the statistical association between bereavement and death from heart disease (the classical 'broken heart'). Although recent studies suggest that not all types of bereavement are equally dangerous to the heart, the evidence for a small but statistically significant increase in the death rate from heart disease during the first year after the death of a wife remains strong. There is also evidence that deaths which occur in places other than home or hospital (e.g. sudden deaths in the street or place of work) are followed by an increased mortality among family members (see Stroebe *et al* (1981–2) for a recent review). In the present state of our knowledge, any explanation for these findings is conjectural. The effects of emotions on the coronary arteries are, of course, well known, and it is not unreasonable to suppose that people with severe heart disease may be vulnerable to the physiological accompaniments of severe grief. For this reason, it is worth considering the prescription of a beta-blocker, such as propranolol, as a means of blocking vagal influences on the heart among newly bereaved people with known coronary disease. But we need to learn much more about the intermediate variables in this chain of causation.

Equally obscure are the links between bereavements and a wide variety of other psychosomatic and somatic disorders. These include certain types of cancer, as well as less serious conditions, such as rheumatism and arthritis, which often take people to their general practitioners following bereavements. Admittedly, 'sick role' behaviour accounts for some of this increase in consultation rates, and it is important to avoid 'medicalising' grief wherever possible. But there still remains substantial evidence for believing that certain bereavements are at least contributory factors in the ailments which follow them. The recent discovery of disturbance in the immune response system *(vide supra)* may explain some of these.

Bereavement and psychiatric disorder

More easily understood are the psychiatric conditions which follow bereavement. Some of these are simply exacerbations of pre-existing tendencies. Thus, it is no surprise to find a heavy drinker becoming an alcoholic after the death of the partner who previously kept his or her drinking within bounds. Nor is it unusual for patients with long-standing neurotic traits to get worse after the death of a loved person. However, the largest proportion of bereaved psychiatric patients are classified as suffering from reactive depression or anxiety, and are found to be suffering from pathological forms of grief. The delineation of these pathological reactions is an important step forward in psychiatric research because it enables us, for the first time, to identify a group of psychiatric disorders with distinctive aetiology as well as clinical characteristics.

Earlier empirical studies tended to lump abnormal forms of grief together as 'pathological grief reactions', and to assume that they resulted from one thing—the repression of grief. Other studies indicated that there are at least two common types of pathological grief—delayed (or avoided) grief and chronic grief. More recently, a longitudinal study (Parkes & Weiss, 1983) enabled a further subdivision into *three common patterns or syndromes.*

The unexpected grief syndrome: This occurs following major losses which are unexpected and untimely; they give rise to a defensive reaction of shock or disbelief, which delays the full emotional reaction but does not prevent moderate to high levels of anxiety from being experienced. Typically, the grieving process is complicated by a persisting sense of the presence of the dead person, feelings of self-reproach, and feelings of continued obligation to the dead which make it hard for the bereaved to make a fresh start.

The ambivalent grief syndrome: This follows the loss of relationships which have been punctuated with quarrels and ambivalence. Here, the immediate reaction is often one of relief; the bereaved see little need to grieve, and overall levels of anxiety are not high. but as time passes, feelings of intense pining and despair emerge and the bereaved begin to grieve more intensely, not only for the lost person, but also more generally, for the loss of hope in marriage itself. These reactions may become prolonged and self-punitive in character. The bereaved may feel compelled to make restitution for their failure, but see no satisfactory way to complete the process of grieving. These two types of reaction seem to account for most of the delayed griefs which are seen in psychiatric settings.

Chronic grief: This is expressed in full from the outset and goes on for an abnormal length of time. It tends to follow the ending of relationships characterised by dependence or clinging, and is associated with intense feelings of helplessness. Surprisingly, it is not always the survivor who was the more 'dependent' member. This suggests that

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symbiotic relationships in which one partner is seen as 'weak' and the other as 'strong' may not be quite what they seem.

These three grief syndromes may occur in pure culture or in any combination; thus, one sometimes comes across bereavements that are unexpected, ambivalent, *and* dependent.

Risk factors

It follows that we are often able to identify people *before* a bereavement who are at special risk and for whom preventive intervention may be needed. The factors which research has shown to contribute to poor outcome are:—I *Type of death* (1) a cause for blame on survivor (Martin *et al,* 1968 & Martin, 1970; Nixon & Pearn, 1977); (2) sudden or unexpected and untimely (Lundin, 1979; Parkes & Weiss, 1983); (3) painful, horrifying or mismanaged (Martin, 1978 & 1970; Nixon & Pearn, 1977; Raphael, 1977). II *Characteristics of the relationship* (1) relationship 'dependent' or 'symbiotic' (Parkes & Weiss, 1983); (2) relationship ambivalent (Parkes & Weiss, 1983); (3) spouse dies (Fulton & Owen, 1977; Parkes, 1972a); (4) child under 20 dies (Fulton & Owen, 1977; Raphael, 1983; (5) parent dies (especially mother) leaving child(ren) aged between 0 and 5 or 10 and 15 (Rutter, 1966; Raphael, 1983); (6) parent dies leaving older unmarried adult (Parkes, unpublished clinical findings). III *Characteristics of survivor* (1) grief-prone personality (expressed in intense clinging and pining) (Parkes & Weiss, 1983); (2) insecure, over-anxious (with low self-esteem) (Parkes, 1972a); (3) previous mental illness (Parkes, 1972a); (4) excessively angry (Parkes & Weiss, 1983); (5) excessively self-reproachful (Parkes & Weiss, 1983); (6) physically disabled or ill (Perlin & Schmidt, 1975); (7) previous unresolved losses (Volkan, 1972); (8) inability to express feelings (particularly with strong 'macho' self-image prohibiting expression of grief). Hence, perhaps, the evidence from some studies that men have more lasting problems after bereavement than women (Cummings, 1969; Berardo, 1970). IV *Social circumstances* (1) family absent or seen as unsupportive (lack of an intimate other) (Clayton *et al,* 1973; Maddison & Walker, 1967; Duke, 1980); (2) detached from traditional cultural and religious support systems (especially if immigrant) (Gorer, 1965); (3) unemployed (or unhappy at work) (Perlin & Schmidt, 1975); (4) with dependent children at home (but this may be a positive factor in the long run) (Brown & Harris, 1978); (5) low socio-economic status (Atchley, 1975; Lowenthal & Berkman, 1967); (6) other losses (Kastenbaum (1969) terms this 'Bereavement overload').

Within each section, factors have been ranked in their approximate order of importance, with major factors at the top of the list. In most instances, a number of factors will be found to contribute to overall risk. About one in three of major bereavements (e.g. death of a spouse) can be expected to lead to problems for which help may be required (Raphael, 1983).

Prevention of pathological reactions

In my opinion, psychiatrists have no direct role to play in prevention, but they can play an important part in setting up and supporting preventive intervention services. Knowledge of individual and group psychodynamics is valuable in running support groups for counsellors and in the selection and training of volunteer counsellors. Well trained psychologists, psychiatric nurses, and social workers can share these roles.

Anticipatory guidance

Although further evaluation is needed, evidence from comparative studies suggests that care given to the family before bereavement can influence subsequent adjustments (see, for instance, Cameron & Parkes' (1983) comparison of families of patients dying under two types of care in Montreal). Accurate information, support for the expression of appropriate anticipatory anxiety, opportunity for continued interaction and communication with the dying person, and a chance to make restitution for any failure or ambivalence in the relationship by contributing to the care of the patient whenever possible—all of these can be expected to help the family as well as to relieve the sufferings of the patient. The undoubted success of hospice care for terminal cancer patients is attributable to the network of care which surrounds the family, as well as to the care of patients themselves. But the implications extend to other causes of death and other types of loss. They include the support of patients and families in intensive care units and many other situations met with in medicine. Some of the best evidence for the value of anticipatory guidance comes from studies of preparation for major surgery, which have demonstrated significant reduction in drug consumption, post-operative anxiety, and psychiatric complications, as well as reductions in the length of stay in hospital (reviewed by Parkes, 1979). The liaison psychiatrist must recognise that if staff are to stay close at such times and give the care that is needed, they too will need support. Staff meetings may start as patient-

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centred case conferences, but the focus can be gently changed to include the patient's family and eventually the feelings of the staff themselves, as mutual trust develops.

Breaking bad news

The announcement of a death or the communication of other disastrous information tests the empathic sensitivity of us all. Such moments will be vividly remembered for the rest of the recipient's life, and they constitute a trauma as real as any surgical operation. Yet there are few medical schools at which the skills of breaking bad news are taught, and some would argue that they cannot be taught at all. Experience in the use of role play and video-taped interviews with simulated patients leads one to conclude that psychiatrists who work in teaching hospitals have the opportunity and the tools to remedy this defect. Attention should also be paid to the setting in which traumatic communications are delivered. A friendly or home-like atmosphere can do much to counteract the frightening impersonality of a hospital ward, emergency department, or mortuary.

Counselling or befriending after bereavement

It is worth making a distinction between counselling and befriending. The latter is the kind of support which is commonly given by friends and neighbours; it requires little or no special training and is probably needed by most bereaved people. It is likely to arise spontaneously in many communities or to be organised as a part of 'good neighbour' or similar schemes. Counselling, on the other hand, requires careful selection, training, and supervision of counsellors in the special skills necessary to support the minority of bereaved people who are at special risk. For this group (but not for unselected bereaved people), counselling has been shown to reduce the incidence of psychosomatic symptoms and the consumption of drugs, alcohol, and tobacco (Parkes, 1981).

In the early stages of bereavement, individual or family support in the client's home is needed. The aim is to facilitate the expression of grief, to reassure the bereaved regarding the significance of the various physical and psychological 'symptoms' from which they are suffering, to ensure that they have time and space in which to grieve, to monitor the risk of suicide or other evidence of failure to cope, and to draw in other forms of help when this is needed. A good understanding of the psychological defences (or 'coping systems') of bereaved people is necessary in order to prevent pathological development.

As time passes, the emphasis will tend to move away from the expression of grief towards the restructuring of the client's assumptive world and the discovery of a new identity. At this time, group methods of counselling outside the home may be appropriate, and bereaved people can often help each other to find their way through difficulties. The counsellor acts as an anchor to the group, and thus requires training in some of the special problems of group work (Vachon *et al*, 1980).

In Britain, the only national organisation to provide bereavement counselling on a wide scale is *CRUSE* (see, also, Appendix), the organisation for widows, widowers and their families (for further information contact: *CRUSE*, Cruse House, 126 Sheen Road, Richmond, Surrey TW9 1UR). But several hospices are setting up bereavement services, and there are a number of local schemes which are worth supporting. Just as the hospices provide training for members of the caring professions in the care of the dying, so *CRUSE* provides training in bereavement counselling in each region. These organisations rely on the good will of psychiatrists and others capable of ensuring that a high standard of care is achieved. The psychiatrist who is willing to support a group of counsellors will be indirectly helping a very large number of bereaved people. Occasionally, he will need to take over if a counsellor is encountering special difficulties, and counsellors need to know that they will not be left unsupported if a suicidal threat is made. But such occasions are rare and, with experience, volunteer counsellors develop a high level of expertise; support given to front-line workers is time well spent and probably reduces the overall load on psychiatric services. A small journal, *Bereavement Care*, published by *CRUSE*, provides information of interest to all who offer counselling to the dying and the bereaved, and Worden's (1982) book, *Grief Counselling and Grief Therapy*, can be recommended as a good basic text for bereavement counsellors.

The treatment of pathological grief

Pathological grief can take several forms, and it would be surprising if any one method of treatment were to be appropriate and effective in every case. Much emphasis has been placed in the past on the importance of bringing about the expression of grief as a means of facilitating the work of mourning. Volkan (1972) has used 'linking objects' (e.g. personal possessions of the dead person) as a means of provoking 're-grief work', and Ramsay (1979) has translated a similar approach into the language of behavioural psychology. More recent

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modifications of his 'forced mourning' techniques have been evaluated by Mawson *et al* (1981), who showed some significant differences between patients who had been confronted with reminders of their lost spouse and others who had been encouraged to avoid such things and to distract themselves from grieving.

But these techniques are not uniformly successful, and I suspect that they are only appropriate when avoidance and repression of grief are evident. Chronic grief may be more appropriately treated by therapies aimed at increasing self-confidence and helping patients to find new directions in their lives. In such cases, it may be important to give people permission to stop grieving, rather than to collude with any tendency to regard grief as a sacred duty to the dead. Both individual and group psychotherapy can serve these ends.

Drugs are often misused as a means of suppressing grief, but they can have a place in conjunction with psychotherapy for those patients who are so distressed or depressed that they are a serious suicidal risk or unable to begin to communicate. In such instances, care should be taken to ensure that the means of treatment does not become the means of self-destruction. Drugs of low toxicity are to be preferred and brief hospital admission may be needed.

By and large, the treatment of pathological grief is rewarding for both patient and therapist, but we must take particular care to prepare our patients for the ending of therapy. We should not be surprised that people who have proved vulnerable to loss find it hard to lose the therapist who has helped them through a difficult passage in their lives. They need to be encouraged to express their grief in anticipation of the event, rather than postponing it until the therapy is over and there is nobody to help them through.

Appendix

Support for particular groups of the bereaved can be obtained from : The Association for the Study of Infant Death, 5th Floor, 4 Grosvenor Place, London SW1; Gay Bereavement, c/o *Gay News*, 1a Normand Gardens, Greyhound Road, London W14; and The Compassionate Friends (for Bereaved Parents), 5 Lower Clifton Hill, Bristol BS8 1BT.

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