Dealing with loss and grief

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Remember

• An anticipated death has effects on those dying and on those 'shouldering the burden'. For example, a young adult facing death will have a sense of being cheated of life. He or she may be caught in a state of transition, having achieved so much that was meant to be a 'springboard' for the rest of his or her life. There is massive frustration and disappointment in not being able to take this hard earned labour to fruition in personal, work or social domains.

• The impact of the death of a loved one can be influenced by:
– its slow transition or suddenness
– its 'unnecessary' or accidental qualities
– its frequency or rarity
– the horror of its happening
– the memories of other 'victims' of a particular disease
– individual, racial or cultural fears or fantasies about death.

• The symptoms of grief and the time scale vary considerably in different individuals. The symptoms often continue for months or years.

• Children will have different responses to the loss of a loved one according to their age. The following points about children and grief come from the National Association for Loss and Grief (NSW) Inc.

• Up to 2 years old, an infant will pick up on grief and may change eating, sleeping and toilet habits.

• For a 2- to 6-year-old child, the family is the centre of the child's world. There is no understanding of time or death. The child thinks dead people continue to do things (eat, drink, go to the bathroom), but only in the sky. The child has magical thinking: you wish it, it happens (bringing the dead back or wishing someone was dead).

• At 6 to 9 years old, children are starting to see death as a person or monster who takes you away. They fail to accept that death will happen to them – or to anyone (although they begin to suspect that it will).

• At 9 to 12 years old, children may see death as punishment for poor behaviour, and they need reassurance that wishes do not kill. They ask more about 'what happened', and worry about who will provide and care for them.

• Teenagers view death as inevitable, universal and irreversible. Yet, they see themselves as invincible ('it will not happen to me'). They may feel guilt, anger and even some responsibility for the death that occurred, and are not sure how to handle their own emotions (public and private).

Assessment

• Ask about previous forms of loss. One loss often impinges on another. Past loss can either sensitise people to current loss or make them more resilient.

• Types of loss include:[1]
– loss of a significant person, through death, desertion or divorce
– loss of part of the physical self, e.g. disfigurement, loss of a limb, organ or hair, any outward change, loss of body image (through surgery, burns, accident), loss of function through stroke, paralysis, deafness, blindness, arthritis or infertility
– loss of part of the psychological self, e.g. loss of memory, judgement, pride, control, status, usefulness, independence, esteem, values or ideals
– loss of part of the social self, through retrenchment or geographic moves
– loss of part of the community and cultural self, such as through immigration or refugee experience
– loss of external objects, such as possessions, money and 'symbols of identity' (e.g. photographs, artefacts), through burglary, robbery or natural disasters
– developmental loss, e.g. growing up and leaving home, separation from friends, exam failures, school to work transition, marriage, loss in old age, multiple cumulative losses
– loss of the hoped for future (e.g. a 40-year-old woman without a partner who faces the loss of the dream of a husband and children).

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Management

- Use four key communication skills:
  - listen to the patients you are supporting and the problems or concerns they have
  - acknowledge (feedback) their concerns; this may just involve your recognising that they are having some difficulty
  - tell them what you are able to do and whether you will be seeking further specialist opinion; give them options so they can be partners in knowledge acquisition and in the coping process
  - encourage them with a positive comment, or give some assurance about their possible emotional and organic reactions to their grief and its management.
- For bereavement, the ideal scenario would be the following steps:

1. resolution of loss
2. satisfactory adjustment
3. reintegration into usual life
4. new and satisfying attachments.

- The period six to eight weeks after the death is frequently a critical time in social terms.
- Some factors affecting the outcome of bereavement are:
  - the previous relationship with the deceased
  - type of death
  - response of family and social network
  - concurrent stress or crises
  - sociodemographic factors (age, sex, cultural, racial).
- Look for complicated mourning. Some pathological patterns of resolution possibly requiring specialist referral are:
  - general (nonspecific) symptomatology
  - anxiety states (phobias, conversion states, dissociative reactions)
  - depression – it is important to recognise suicidal thoughts and behaviours
  - acting out disorders (antisocial, sexual, eating)
  - dependency on alcohol and drugs
  - altered relationship patterns
  - increased vulnerability due to prior sensitisation
  - anniversary phenomena (important dates, including birthdays)
  - enhanced vulnerability, if defences include lifelong tendency to denial, reaction formation or vigour (gymnasium, sports, preoccupation with body image). MT

Reference

1. Simos B. A time to grieve: loss a universal human experience. New York: Family Service America, 1979.

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