

## Grief Revisited

BY Ng,<sup>1</sup> MBBS, FAMS, M Med (Psychiatry)

### Abstract

The article serves to examine the cultural influences on attitudes towards the deceased and bereaved, as well as on the practice of mourning, and to revisit normal and pathological variants of grief. Grief is a subjective state of psychological and physiological reaction to the loss of a loved one. Reaction to the loss is experienced internally in a uniform manner across cultures. However, mourning, the voluntary social expression of the loss, varies from culture to culture. Rituals provide a standardised mode of behaviour, which helps to relieve the sense of uncertainty or loss. There were reports of ghost sightings involving foreign tourists in the 6 worst-hit southern provinces in Thailand following the tsunami tragedy. This phenomenon of “mass hallucinations” is understandable from the cultural perspective. New models of grief have been developed to account for the individuality and diversity of grief and to encompass the social, behavioural and spiritual dimensions of loss as well as those of the psychological and physical. Clinically, the duration of grief reactions varies widely, depending on the nature of the loss and the connection to the deceased. In the case of the tsunami tragedy, with relatives missing, homes swept away and familiar neighbourhoods turned into wastelands, many victims are likely to have complicated grief. Traumatic grief, which includes a prominent component of separation distress characterised by yearning and searching and frequent “bittersweet” recollections of the deceased, has been associated with long-term dysfunction. Grief work utilising the traumatic grief treatment protocol appears to be a promising intervention.

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*“When it is impossible to carry out traditional rituals that have great meaning and serve to comfort the bereaved, the stress of bereavement is amplified.”*

Eisenbruch, 1984<sup>1</sup>

More than 225,000 people across Asia perished in the cataclysmic tsunami unleashed by the Indian Ocean earthquake on 26 December 2004. At this point in time, as people try to overcome the shock and pain of coming face to face with multiple deaths and losses, it may be relevant to look at the cultural influences upon attitudes to the deceased and bereaved, as well as in the practice of mourning, and to revisit normal and pathological variants of grief.

Bereavement defines an objective state of having experienced the loss of a loved person through death, while grief is a subjective state of psychological and physiological reaction to that loss.<sup>2</sup> Reaction to the loss is experienced

internally in a uniform manner across cultures. However, mourning, the voluntary social expression of the loss, varies from culture to culture. Manifestation of sorrow or lamentation for the death of a person is usually indicated by wearing black clothes or a black armband, hanging flags at half-mast, and other cultural rituals.

### Rituals and Mourning

According to cultural anthropologists, rituals provide a standardised mode of behaviour which helps to relieve the sense of uncertainty or loss. Everyone knows what to do, and how to act under those circumstances, and this restores a sense of order and continuity to their lives. It also enables the bereaved to adjust slowly to the fact of death, and to see it not as the end of one cycle, but the beginning of another.<sup>3</sup> Religious and cultural rituals also comfort and reassure the mourners by helping them to make sense of death and personal loss. Rituals may either relieve or intensify anxieties

<sup>1</sup> Department of Behavioural Medicine  
Singapore General Hospital, Singapore

Address for Reprints: Dr Ng Beng Yeong, Department of Behavioural Medicine, Singapore General Hospital, Outram Road, Singapore 169608.  
Email: gdmnby@sgh.com.sg

about death. Anxiety concerning immortality and the afterlife may be decreased, but the loss itself, the need for social readjustment, and the possible existence of spirits and ghosts may precipitate additional anxieties in the living.<sup>4</sup> There were reports of ghost sightings involving foreign tourists in the six worst-hit southern provinces in Thailand following the tsunami tragedy.<sup>5</sup> This phenomenon of “mass hallucinations” is understandable from the cultural perspective: the Thais believe that spirits can only be put to rest by relatives at the scene of the disaster.

The practices and duration of mourning vary widely from culture to culture. This wide cultural variation is likely to confuse the healthcare worker when evaluating the bereaved person from another culture. In such a situation, it is pertinent to inquire about customs, beliefs or cultural norms for the expression of bereavement. An appreciation of the specific culture’s view of bereavement and a careful delineation of the person’s relationship to the deceased can help the healthcare provider avoid the pitfall of diagnosing someone with psychotic depression when uncomplicated bereavement really exists.

Historically, the Chinese have valued longevity. Consistent with their reverence for long life is the belief that the death of a young person is a sign of an evil spirit at work, and hence a threat to other people. They also believe that, at death, the body-soul system is dispersed and the dead person becomes a sacred ancestor.<sup>6</sup> It is believed that if a body lies with its eyes wide open, the person did not die in peace. This superstitious belief may compound the sadness experienced by the bereaved and result in severe self-blame and guilt in the relatives.

In Buddhist communities, disposal of the deceased may take place days or months after death, and involve cremation, burial or burial followed by exhumation and cremation. Buddhists, like Hindus and Sikhs, believe in rebirth after death. The corpse of the deceased may have little significance in itself. Uncremated Buddhists are buried on their backs with the head facing north, which is believed to have been the Buddha’s dying position.<sup>4</sup>

Buddhists are taught not to develop intense attachments to material things and to those around them.<sup>7</sup> They may be less vulnerable to psychological distress and disorders arising from loss, including abnormal and debilitating grief reactions. Also, some of the meditation exercises found in Buddhism can potentially enable a person to cope with the problems of living with greater calmness and assurance.<sup>7</sup>

For a Muslim, death marks the transition from one state of existence to the next. When a Muslim dies the eyes and mouth are closed and the limbs straightened. His/her body should ideally face the direction of Mecca.<sup>8</sup> The body is washed and shrouded in simple, unsewn pieces of white cloth. A funeral prayer is held in the local mosque, and

family and community members follow the funeral procession to the graveyard, where a final prayer is said as the deceased is buried lying on the right side, head toward the north, feet towards the south, and the face turned toward Mecca. Events occur in rapid succession and in many cases the dead are buried within hours of death.<sup>9</sup> Muslims must bury the dead immediately, according to the Hadith (the traditional sayings of the Prophet Mohammed). Islam strongly prohibits wailing following death, yet the practice continues in many quarters. This pre-Islamic custom originally existed to express the sense of loss.<sup>8</sup> Muslims continue to oppose cremation, because Islamic doctrine holds that the dead, like the living, can feel pain.<sup>9</sup> Great distress may be caused if a postmortem examination is needed, especially for Muslims, whose belief in the resurrection of the body makes the idea of mutilation abhorrent.<sup>10</sup>

Hindus have caste and family traditions concerning the washing and dressing procedures, which are done by relatives of the same sex. Ganges water is usually used to purify the body. On the Indian subcontinent, Hindu and Sikhs dispose of the body of the deceased within 24 hours.<sup>10</sup> Hindus consider the bereaved family to be “unclean” for 10 days, and requires adults to fast, not shave, and to enter seclusion for this period. A strict daily ceremony enables the soul to acquire a spiritual body over the next 10 days. There are further rituals at one, three and six months.<sup>10</sup> Spouses and sons must observe a 12-month mourning period.

### **Coping Behaviour**

In many different cultures people show some signs of grieving, although the expression of grief is very variable. The healthcare provider should discuss openly with patients and their families their cultural explanations of the cause of their symptoms, their past coping strategies, and their expectations of treatment. The coping mechanisms can be functional or dysfunctional. Functional coping could facilitate the patient’s adaptation to his or her new environment; for example, belief in fate or karma would help patients endure their misfortune. Belief in the idea that “good fortune follows catastrophic events” would help patients to maintain hope for a better future and to focus on new dreams and new priorities in their country.<sup>11</sup>

Traditionally, grief has been described as a time-bounded process consisting of phases, stages and tasks. New models of grief have been developed to account for the individuality and diversity of grief and to encompass the social, behavioural and spiritual dimensions of loss as well as the psychological and physical.<sup>12</sup> Given our growing understanding of the interplay between loss, coping, personality and social factors, it is likely that our models of grief will continue to be refined.<sup>12</sup>

Recent functional imaging research has revealed that grief is mediated by a distributed neural network that subserves affect processing, mentalising, episodic memory retrieval, processing of familiar faces, visual imagery, autonomic regulation, and the modulation of these functions.<sup>13</sup> The findings may provide new leads in understanding the health consequences of grief and the neurobiology of attachment.

### Major Depression versus Complicated Grief

Symptoms of depression are commonly observed during bereavement. In normal bereavement, a person experiences symptoms such as sadness, disturbed sleep, agitation, and decreased ability to carry out day-to-day tasks. These symptoms tend to resolve themselves without treatment in two to four months, as the bereaved person goes through a process of gradual waning from remembered experiences with the loved one and begins to live with the reality of the loss.<sup>14</sup> Most bereavement programmes support families for 1 year. However, grief is known to persist for extended periods of time and newer models of grief criticise the 1-year time frame. The second year following grief can be especially challenging because the emotions can be as strong as those experienced in the first year but the bereaved person feels less comfortable sharing the pain and loss.<sup>15</sup> Clinically, the duration of grief reactions varies widely depending on the nature of the loss and the connection to the deceased.

The incidence of complicated grief is unclear. One problem is that complicated grief has not been consistently defined. In the case of the tsunami tragedy, with relatives missing, homes swept away and familiar neighbourhoods turned into wastelands, many victims are likely to have complicated grief. Significant risk factors for complicated grief for these victims include: the untimely death of their loved ones; the failure to recover the bodies; sudden unexpected deaths; multiple concurrent stressful events and losses. Other risk factors for complicated grief are: if the death had arisen from an accident; if the survivor's negligence had caused or contributed to death (in fantasy or in reality); a stormy relationship before death; poor social support; and dissociative states at time of trauma, e.g., an altered sense of reality or time. If a parent had been forced to give up one child to save another, the consequent guilt may be unbearable for the bereaved parent. Inadequate grieving may lead to depression, either immediately following the loss or at some later time when the person is somehow reminded of the loss.

Raphael<sup>16</sup> identified traumatic circumstances of the death as a risk factor for adverse health outcome following bereavement. Parkes and Weiss<sup>17</sup> identified the "traumatic" effects of sudden unanticipated death on the adaptation of the bereaved. Those suffering such unanticipated losses,

compared with those with long forewarning, showed greater disbelief initially and more severe disturbance, with anxiety, self-reproach and feeling of abandonment.<sup>17</sup> The long-term outcome for those with anxiety was also worse.

The following symptoms are suggestive of major depression rather than bereavement:

1. Excessive guilt [Intense grief is characterised by the absence of shame or significant guilt. Guilt, if it exists, is that of omission (what the bereaved person may have failed to do) rather than commission (the recognition of malevolent intent)].
2. Thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person.
3. Morbid preoccupation with worthlessness.
4. Marked psychomotor retardation.
5. Unremitting and marked functional impairment.
6. Hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person.
7. Suicidal ideation.
8. Hopelessness.<sup>18</sup>

Using a structured diagnostic interview, Horowitz et al<sup>19</sup> assessed 70 subjects whose spouses had died. They found that a new diagnosis of complicated grief disorder may be indicated. Its criteria would include the current experience (more than a year after a loss) of intense intrusive thoughts, pangs of severe emotion, distressing yearnings, feeling excessively alone and empty, excessively avoiding tasks reminiscent of the deceased, unusual sleep disturbances, and maladaptive levels of loss of interest in personal activities. Complicated grief is predictive of serious outcomes like cancer, heart attacks, and suicidal ideation.

Criteria for identifying a clinically significant condition involving grief were unavailable until the development of the Inventory of Complicated Grief.<sup>20</sup> Individuals who score >25 on this scale endorse a constellation of symptoms, including preoccupation with thoughts of the deceased, longing, yearning and searching for the deceased, disbelief and inability to accept the death, avoidance of reminders of the loss, auditory and visual hallucinations of the deceased, bitterness and survivor guilt over the death, and symptoms of identification with the deceased. This condition, called traumatic grief, has been associated with long-term dysfunction. The name of these symptoms were changed from "complicated" to "traumatic" as the latter captures more precisely the two underlying dimensions of the syndrome (i.e., trauma and separation distress). The Inventory of Complicated Grief was designed to exclude depressive and anxiety-related items in order to focus exclusively on the symptoms of traumatic grief.

Traumatic grief and post-traumatic stress disorder (PTSD) are similar in that both are stress response syndromes. They share symptoms of intrusive thoughts, emotional numbness, detachment from others, irritability, and anger. The two disorders are different in at least two ways. First, traumatic grief includes a prominent component of separation distress characterised by yearning and searching and frequent “bittersweet” recollections of the deceased. Individuals with traumatic grief often believe that grief keeps them connected to the deceased and/or that to grieve less would be a betrayal to the deceased. Such symptoms are not seen in PTSD. Second, in traumatic grief, the bereaved may search the environment for cues of the deceased, whereas in PTSD, the patient has fears that the traumatic event will be re-experienced.

### Grief Work

Typical themes in the dysphoric thoughts of those who have experienced a painful loss include: 1) Fear of repetition of the event, even in thought; 2) Shame or helplessness at being unable to postpone or prevent the death; 3) Rage at the person who died; 4) Guilt or shame over aggressive impulses or destructive fantasies; 5) Survivor guilt; 6) Fear of identification or merging with the victim; and 7) Sadness in relationship to the loss.<sup>18</sup>

The therapist will need to be mindful that in many Asian countries, death and dying are cultural taboos that are thought to bring bad luck to people, and individuals are hence reluctant to talk about these issues. Some bereaved individuals can only express their emotions in private (“silent grief”), and thus deprive themselves of the support from society at large. In grief work, the therapist facilitates mourning and gradually helps the patient to find new activities and relationships to compensate for the loss. Shear et al<sup>21</sup> described a treatment programme for traumatic grief, which used imaginal re-living of the death, in vivo exposure to avoided activities and situations, and interpersonal therapy. The goals of traumatic grief treatment include reducing the intensity of grief, facilitating the ability to enjoy fond memories of the deceased, and supporting re-engagement in daily activities and relationships with others. The traumatic grief treatment protocol appears to be a promising intervention for debilitating grief.

### REFERENCES

- Eisenbruch M. Cross-cultural aspects of bereavement II: Ethnic and cultural variations in the development of bereavement practices. *Cult Med Psychiatry* 1984;8:315-47.
- Marwit SJ. DSM-III-R, grief reactions, and a call for revision. *Prof Psychol Ref Pr* 1991;22:75-9.
- Helman CG. Culture, health and illness. Oxford (Great Britain): Butterworth-Heinemann, 1994.
- Lessa WA. Death customs and rites. London: International Learning Systems, 1976.
- Galle. Trauma shows up in drawings and hallucinations. *The Straits Times*, 15 January 2005; Main Section:10(col. 6).
- Aiken LR. Dying, Death and Bereavement. 4th ed. New Jersey (USA): Lawrence Erlbaum, 2001.
- de Silva P. Buddhist psychology and implications for treatment. In: Bhugra D, editor. *Psychiatry and Religion*. London: Routledge, 1997: 112-24.
- Aziz Sheikh, Abdul Rashid Gatrad. *Caring for Muslim Patients*. Oxon (UK): Radcliffe Medical Press, 2000.
- Bardis PD. *History of thanatology*. Washington, DC: University Press of America, 1981.
- Firth S. Cross-cultural perspectives on bereavement. In: Dickenson D, Johnson M, Katz JS, editors. *Death, Dying and Bereavement*. 2nd ed. London: Sage, 2000:338-46.
- Du N, Lu FG. Assessment and treatment of post-traumatic stress disorders among Asian patients. In: Lee E, editor. *Working with Asian Americans*. New York: The Guilford Press, 1997:275-94.
- Payne S, Horn S, Relf M. *Loss and Bereavement*. Buckingham: Open University Press, 1999.
- Gundel H, O'Connor MF, Littrell L, Fort C, Lane RD. Functional neuroanatomy of grief: an fMRI study. *Am J Psychiatry* 2003;160: 1946-53.
- Viederman M. Grief: normal and pathological variants. *Am J Psychiatry* 1995;152:1-4.
- Davis GF. Loss and the duration of grief. *JAMA* 2001;285:1152-3.
- Raphael B. Preventive intervention with the recently bereaved. *Arch Gen Psychiatry* 1977;34:1450-54.
- Parkes CM, Weiss RS. *Recovery from Bereavement*. New York: Basic Books, 1983.
- Horowitz MJ. *Stress Response Syndromes*. Northvale (New Jersey): Jason Aronson, 1976.
- Horowitz MJ, Siegel B, Holen A, Bonanno GA, Milbrath C, Stinson CH. Diagnostic criteria for complicated grief disorder. *Am J Psychiatry* 1997;154:904-10.
- Prigerson HG, Maciejewski PK, Reynolds CF 3rd, Bierhals AJ, Newsom JT, Fasiczka A, et al. Inventory of Complicated Grief: a scale to measure maladaptive symptoms of loss. *Psychiatry Res* 1995;59:65-79.
- Shear MK, Frank E, Foa E, Cherry C, Reynolds CF 3rd, Vander Bilt J, et al. Traumatic grief treatment: a pilot study. *Am J Psychiatry* 2001;158:1506-8.