

Coping with Grief, Part I

Overview

The Integrative Health approach can be built around the Circle of Health, which emphasizes the importance of personalized, values-based care that draws in mindful awareness and eight areas of self-care: Physical Activity, Surroundings, Personal Development, Nutrition, Recharge, Family, Friends and Coworkers, Spirit & Soul, and Mind and Emotions. Conventional therapies, prevention, complementary and integrative health (CIH) approaches, and community also have important roles. The narrative below describes how an Integrative approach could have an impact on a person coping with grief.

Depending on individual needs, an Integrative Health approach to grief may be quite different from an approach to depression, and of course, it will vary based on each individual's needs. A person's health plan may incorporate a variety of self-care, conventional care, and complementary health approaches, as described below.

To learn how to work with people with grief, it is important to 1) recognize the possible role of grief as a cause or in the exacerbation of clinical symptoms, 2) increase your ability to support a grieving patient within your own time limitations, comfort level, and knowledge in this area, and 3) know when to refer a patient to a grief specialist, empowering patients to optimally cope with their grief and integrate a loss into their lives. Keep reading to learn more about the evidence for the efficacy and safety of different approaches that might be helpful for you and for others.

Note: This overview focuses on grief related to a death loss, with some pertinent information included on other types of losses. A more complete focus on other types of losses (such as disability, divorce, job loss, effects of natural disasters) is beyond the scope of this overview. However, you are likely to find the concepts and suggestions helpful and adaptable when working with someone who has experienced any sort of significant loss.

Meet the Patient

Jim is a 66-year-retired EMT. He has been divorced for 25 years. He does not have children, and he lives alone. Over the years he has had a couple bouts of mild to moderate depression when relationships ended. A knee injury has limited a few activities he previously enjoyed, such as softball. He likes to watch sporting events and to spend time outdoors. He came into the medical center with new-onset back pain, difficulty sleeping, and fatigue.

Personal Health Inventory

On his Personal Health Inventory (PHI), Jim rated himself a 3 out of 5 on all of the following: his overall physical, mental, and emotional well-being, and what it is like to live his day-to-day life. In response to the questions, "What do you live for? What matters to you? Why do you want to be healthy?" Jim wrote:

What really matters to me are my sister and her family, being on friendly terms with the neighbors, and finding productive ways to spend my time when I retire.

Jim rated himself on where he is and where he would like to be in each of the eight areas of self-care. In all but one area, he rated himself lower now than he would like to be. Finding no specific medical reasons for Jim's symptoms upon physical exam or lab tests, Jim's clinician used the PHI to learn more about Jim's life:

- Physical Activity. Fatigue and pain have resulted in Jim being sedentary.
- Recharge. He has not been getting enough sleep, even though he tries. He has been waking up much earlier than normal and not feeling refreshed by any activity.
- Nutrition. He has started picking up more carry out food and eating more than he should. He has increased his intake of beer and soda.
- Personal Development. His job is fine. He has been thinking about things that he would like to do when he retires in a year. He finds it hard to think about that now. His nephew was in an automobile accident a month ago and may not live. He was planning to do many activities, like woodworking projects, with him.
- Family, Friends, and Co-workers. He is close to his sister and nephew, has a few buddies at work, and some good neighbors. He is not seeing them as much now. He feels guilty when he does not go to the hospital to see his nephew. "It's very hard. My throat feels so tight, it's hard to talk, and when I'm in his room, I feel physically weak."
- Spirit and Soul. Jim thinks that his best years may be over and says some of them were not so great. He wonders if he will be healthy enough to enjoy life. "It's hard to find purpose and meaning sometimes when you've seen some of the things I've seen in the service. And now my nephew, he's just a kid, 24. It zaps your spirit." "It would be good to feel at peace. I'll keep trying."
- Surroundings. Jim feels better when he is outdoors in nature.
- Mind and Emotions. Jim learned some breathing exercises in the past. He knows some guys who have tried tai chi and yoga.

For more information, go to [Jim's PHI](#).

Introduction: About Grief

One hundred percent of patients will experience major losses in their lifetimes. While most people cope well with this universal experience and will not need clinical intervention, the health consequences of grief can be far-reaching.¹ Studies have linked bereavement or grief to depression, anxiety-related symptoms and disorders, impaired immune function, poorer physical health, increased physician visits, increased use of alcohol and cigarettes, suicide, and increased incidence of and mortality from conditions such as cardiovascular disease.²⁻⁵

Depression is one explanation for Jim's symptoms. He experienced mild/moderate depression twice—the first time when he divorced 25 years ago and again when a subsequent relationship ended eight years ago. When considering a diagnosis of depression, it is important to learn what, if any, major losses the patient has experienced. Many grief symptoms are consistent with those of depression.⁶ In fact, it is likely that many patients are labeled as depressed when in reality they are grieving a major loss.^{7,8} One study based on survey data from more than

8,000 Americans suggests that the prevalence of major depressive disorder (MDD) may be reduced by almost one-fourth if individuals who are grieving major losses such as marital dissolution, job loss, natural disasters, severe physical illness, and failure to achieve important goals are excluded from depression statistics as are those who have experienced a loss through death.⁹

Grief Reactions

Grief is more than emotion; it also encompasses behavioral, cognitive, physical, and spiritual elements.^{10,11} The grief experience varies widely and is influenced by many things such as a person's age, gender, relationship with the deceased, culture, personality, previous experiences, coping skills, and social support. Cultural differences in grief are enormous, and it is very important to be aware of them to avoid compounding the individual's distress when trying to help.¹² What is considered typical in one culture may be seen as pathological in another.

Grief researcher William Worden has identified some grief reactions that are common in our society.¹⁰ Jim is showing a number of these reactions: 1) waking up too early, 2) eating too much, 3) withdrawing from others, and 4) fatigue. When he is in his nephew's hospital room, he feels 5) tightness in his throat, and 6) muscle weakness.

Several informative grief studies have been done in military populations. The military has its own culture that can greatly affect the grieving process. There is no universal military culture, but one common trait seems to be stoicism. Soldiers are taught to handle anything and how to live in survival mode; they learn to disconnect from their emotions.¹³ Stoicism contributes to survival and military success but can cause problems after returning home. It may later make grieving more difficult, hindering the process. This can be true people experiencing intense stress in other contexts as well, and this could certainly be the case with someone like Jim, who worked as an EMT for over 30 years.

A study of 1,522 infantry soldiers surveyed six months following deployment to Iraq or Afghanistan in 2008 found that over 20% reported difficulty coping with grief over the death of someone close.⁵ Controlling for confounding factors, researchers found that this grief contributed to a high physical symptom score (number of symptoms and their severity).

Jim is experiencing three out of the five most common symptoms reported this study: fatigue, sleep problems, and back pain⁵ (The other two, which he does not have, are musculoskeletal pain and headaches). Jim also feels that he has lost direction in life, and he is searching for meaning in loss—these are the types of spiritual adjustments that grieving individuals often work through.¹⁰

For more information on common grief reactions, refer to "[Grief Reactions, Duration, and Tasks of Mourning](#)" clinical tool.

Anticipatory Grief

Jim acknowledged that his nephew's condition is "killing" him. Jim is experiencing anticipatory grief.

Anticipatory grief occurs when a death or other loss is perceived as imminent and an individual begins grieving before the actual loss occurs.⁶ Mostly, it is a healthy experience; anticipation allows for preparation, development of coping strategies, and mobilization of assistance.¹⁴

Studies indicate that often anticipatory grief includes mourning over a series of shifting current losses as well as the eventual death, as an individual's health, abilities, and plans for the future fade.¹⁵ Anticipatory grief does not lessen the grief reactions that occur following the loss.¹⁵ One is a reaction to the expectation of loss and steps along that pathway; the other is a reaction to the finality of the loss. Awareness of the phenomenon of anticipatory grief allows the clinician to provide on-going support according to the needs of the patient and family. As individuals anticipate the forthcoming loss of a close relationship, grief may be rekindled over a significant previous loss that was not fully grieved in the past.

Disenfranchised Grief

Disenfranchised grief—hidden sorrow—is grief experienced when a loss is not or cannot be openly acknowledged, publicly mourned, or socially supported.¹⁴

The importance of the loss is identified by the person experiencing the loss and cannot be determined by the opinion of others. Examples of situations, which may lead to disenfranchised grief include the following:

Having an Unrecognized Relationship With the Deceased

This might be an ex-spouse, same-sex partner, partner from an extra-marital affair, former friend, or co-worker. Uniformed service members—especially those who served in combat with the deceased—have been greatly under-recognized when it comes to this type of grief.¹⁶ A study of 114 Vietnam-era combat veterans admitted to a PTSD inpatient rehabilitation unit identified that 70% scored higher (i.e., worse) on standardized measures of grief symptoms related to friends lost in combat 30 years previous than did spouses who were bereaved in the past six months.¹⁷ The investigators concluded that treating the symptoms of unresolved grief may be as important as treating fear-related symptoms of PTSD.

Experiencing Types of Losses that Often are Unacknowledged by Others

Some examples of unacknowledged losses include infertility, abortion, perinatal death, death of a companion animal, death of a very elderly person, loss of the personality in Alzheimer's disease, loss of ability, and loss of a role or status. The grief of family and friends of a someone killed in action may be disenfranchised by someone who comments that death should be expected for those who are on active duty during a time of war.¹⁶ veterans may experience disenfranchised grief after returning to civilian life and feeling pain over the deaths of enemy soldiers or civilians for whose deaths they were responsible.^{18,19} Fear of judgment can increase reticence in sharing these experiences with others.²⁰ Unmourned grief together with unforgiven guilt/shame is known as "soul injury."²¹ Opus Peace founder, Deborah Grassman notes, "Learning how to self-compassionately connect with the part of self holding the pain and shame allows people to re-connect with their soul—with who they really are."²¹

Facing Difficult or Unpleasant Circumstances of the Loss

This can occur when a death involves what some perceive as stigma (e.g., suicide, AIDS, or a criminal act), or when there are circumstances of the death too horrible to face (e.g., a wartime

atrocities). A survey of Iraq and Afghanistan veterans in 2017 revealed that 58% of participants knew a veteran who died by suicide.²² These unexpected deaths will likely be more difficult to accept.

Being Excluded from Social Support Because One is Assumed by Others to be Incapable of Grieving or Perceived as Not Being Strong Enough to Handle the Loss, Needing to be “Protected”

Children, adults with intellectual disabilities, and the elderly can fall in this category. Given the stoicism required in the military and the efforts to desensitize soldiers to taking life, others may view military personnel and veterans as lacking the ability to grieve.¹⁸

Experiencing Multiple Losses in a Short Span of Time, so that Some Have Not Been Acknowledged

In the military, this may involve deaths of several comrades and frequent moves with separation from one's family for support.²³ This may also occur for refugees, immigrants, and people who are repeatedly the focus of discrimination.

Disenfranchised grievers may not recognize that their own symptoms are related to grief. An important step is helping the person verbalize the importance and meaning of the relationship (or non-death loss). Health care practitioners are in a unique position of trust to recognize disenfranchised grief and start the process of validation and support for the grieving person.²⁴



Mindful Awareness Moment

Take a few minutes to sit in a quiet, peaceful, comfortable location where you will not be interrupted. This might be by a lake, in a wooded area or flower garden, or your favorite chair at home. Take some deep breaths, close your eyes, and when you are ready, turn your attention to any losses that you have experienced. This might be the death of someone close to you, the death of a patient, the end of a friendship or relationship, a decline in health status for yourself or someone else, a lost career opportunity, the effects of a natural disaster. Think back over the past month, year, or longer.

- What comes up for you? Is there a loss that readily comes to mind?
- Are you surprised by the particular loss that comes to mind or well aware of it?
- How recent is the loss?
- Is there more than one loss that feels particularly salient?
- How painful is the loss?
- What emotions do you feel as a result of that loss?
- What thoughts do you have about the loss?
- What physical sensations are you experiencing as you think about the loss?

If you have more time or during another quiet time, continue to explore your feelings related to loss:

- In what ways (both negative and positive) does the loss affect your daily life?
- How are you supported by others related to this loss? Is your loss disenfranchised (i.e., hidden from others)?
- What do you need to help integrate this loss into your life?
 - Acknowledge this loss to yourself?
 - More time to experience and work through the pain of the loss?
 - Share your thoughts and emotions with someone else?
 - Honor the deceased individual or your loss experience through an activity such as writing, building something, planting a tree, shrub, or flowers, creating a work of art, singing a song or playing music?
- If this exercise brings up particularly unsettling thoughts and emotions, what can you do right now to help yourself feel more at peace as you continue over time to cope with the loss? What characteristics, skills, and resources do you have that give you strength as you move through the grieving process?

* For more information, refer to "[Health Care Professional As Griever: The Importance of Self-Care.](#)"

Differential diagnosis requires talking with patients about known or possible losses, their reactions to those losses, and the time period involved. For someone who has had a significant loss and whose symptoms are ongoing, differentiating "typical" grief from the more debilitating "complicated grief" or from clinical depression or PTSD can be tricky. Shear offers clinicians a concise table comparing characteristics of these conditions.²⁵ (Refer to "the "Resources" section at the end of this overview.) Differential diagnosis may best be accomplished via referral to a mental health professional experienced in the area of grief for further assessment and facilitation/support of mourning. Patients can experience grief reactions coincidentally with anxiety, depression, and PTSD.

Typical Grief

While universal, "typical" grief can be profoundly painful and disruptive and may feel anything but normal to the person who is grieving.

Complicated Grief

In complicated grieving, symptoms are long-lasting and may intensify over time; the person has trouble accepting the death and resuming life. Something is getting in the way of the grief process and not allowing the person to adequately adapt to the loss.¹⁰

Estimates of the prevalence of complicated grief vary widely, based on circumstances and relationship with the deceased. An estimate published in 2011 indicates that 2-7% of those bereaved in the general public experience complicated grief.²⁶ Prevalence is high among veterans, a group at risk for disenfranchised grief. Literature notes that complicated grief is critically under-recognized and unaddressed in Servicemembers.²⁷ Two studies of active military personnel and veterans who served after September 11, 2001, found that about 80% had experienced the death of someone important to them and almost one-third of those met

criteria for complicated grief.^{28, 29} More information on complicated grief, is available in the ["Screening for Complicated Grief"](#) tool.

Screening for complicated grief has been found to be feasible and useful in primary and behavioral health clinics and military mental health clinics.^{30,31} The Brief Grief Questionnaire developed by M. Katherine Shear, MD, and Susan Essock, PhD,³² is an efficient tool to screen for complicated grief in health care settings.^{33,34} You can [download a copy](#) or also refer to ["Screening for Complicated Grief"](#) Integrative Health tool.

To Screen for Complicated Grief...

- Ask the five questions in the Brief Grief Questionnaire during a patient's appointment.
- Use with adults bereaved for at least 12 months and children who have been bereaved for at least 6 months.
- Screen all bereaved individuals who seek treatment for suicide risk, mood, and anxiety disorders as well. These conditions may require treatment earlier than 6-12 months post bereavement.

Major Depressive Disorder

Differentiating between grief and depression is complicated by lack of established criteria. The two share common symptoms. In complicated grief, longing and sadness are salient emotions.³³ For patients with Major Depressive Disorder (MDD), treatment such as antidepressants may help lift the depression, so that an individual is better able to focus on tasks of mourning.¹⁰

PTSD

An individual may have PTSD if the circumstances of the death were violent or traumatic. Reactions might include recurrent disturbing recollections of the death, avoidance of situations associated with the death, difficulty sleeping, difficulty concentrating, and angry outbursts.³⁵

How to Help

Perhaps the most important thing health care practitioners have to offer grieving patients is their compassion and understanding. Validation of the person's grief experience is important. At a minimum, one can offer sincere comments such as, "I'm so sorry for your loss" and "From what you have told me, you have really gone through a lot." The resources section at the end of this overview features a number of ideas for helping family members to help loved ones with grief. Referral to a grief counselor can be one important way to support patients.

Consider asking about

- The person who died
- The circumstances surrounding the death
- How the patient is coping
- The variety of emotions the patient has been feeling
- The challenges the patient is experiencing
- How the loss is affecting the patient's daily activities, social interactions, and work
- The patient's perception of the support provided by others³⁶

The PLISSIT Model

The PLISSIT model can be a guide for primary health care practitioners in assisting their patients throughout the grief process. PLISSIT is an acronym for **P**ermission, **L**imited Information, **S**pecific **S**uggestions, and **I**ntensive **T**herapy, a model developed by Annon to address sexuality issues.³⁷ It is very useful in other health care situations as well. The model includes four levels of intervention, ranging from basic to complex. It guides clinicians to support patients according to the clinicians' own comfort level and expertise as well as the needs of patients. Referrals can be made when patients' needs exceed clinicians' comfort, knowledge, and time.

Permission

Clinicians can initiate the topic of loss, giving patients the opportunity to talk about the experience. Some patients may choose not to do so. In our fast-paced, multitasking society, adults may feel pressured by themselves or others to resume their former lifestyle with minimal disruption. Clinicians can offer "permission" to grieve as needed. For many patients, this interest and support will be the only intervention needed.

Limited Information

Limited information will be helpful to other patients. This second level requires more knowledge about grief to answer patients' questions and dispel misconceptions. Many people know little about grief reactions until they experience them. People frequently ask if their reactions are normal and if they are going crazy. They can be relieved to learn that their reactions and the duration of their grief are similar to the experiences of others with comparable losses. If their experiences are different, they can be reassured that everyone grieves in her or his own unique ways. When appropriate, the clinician can educate patients about anticipatory grief or disenfranchised grief, so that griever will understand that their reactions are valid and the relationships are important ones, as well as receive reassurance that they have strength to cope.³⁸ Factual information in patient handouts and a list of grief resources (e.g., support groups) may be helpful.

Specific Suggestions

Fewer patients will require some specific suggestions. This level involves advanced knowledge and skill to understand a patient's unique situation and develop a plan. Clinician and patient can discuss the loss experience more thoroughly, collaboratively identify issues to be addressed, problem-solve, and choose helpful strategies. For example, for a patient distraught over the pain of grief, a clinician could help develop a healthy plan to work through the pain. This might involve: reassuring the individual that the pain will not always be so intense; identifying one or more people who are good listeners in the person's social circle to contact when emotions seem overwhelming; minimizing alcohol and other drugs; avoiding major decisions, which one might regret later; and choosing a form of physical activity that would be do-able with current energy level.

Intensive Therapy

A minority of patients will require intensive therapy. This final stage usually requires referral to a specialist in grief.



Author(s)

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