The Management of Ordinary Grief

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Considerable experience with the problem of ordinary grief has led to the development of some basic management principles which are presented in this paper. The discussion is centered around a case history which originated in a family practice setting. A transcribed interview with the patient emphasizes technique.

The working through of grief requires an early and open expression of the pain associated with loss of a loved one. After a discussion of the dynamics of anxiety, grief, and hostility that underlie a grief reaction, specific suggestions for means of helping the bereaved express their feelings and work out their grief are offered.

Beginning with Eric Lindemann's classic article in 1944,[1] there have emerged in the psychiatric literature descriptions of a definite syndrome associated with ordinary grief.[2-6] Considerable experience with the problem of grief has led to the development of some basic management principles. This information has filtered from psychiatry to family medicine with varying success. Every physician who finds himself dealing with death, and particularly the family physician to whom the bereaved frequently turns for help, will be considerably more effective in alleviating his patient's pain and suffering and, perhaps more important, will be more effective in preventing the development of a pathologic grief reaction, if he has a working knowledge of these principles.

We would like to illustrate these principles by (1) presenting a case history of one of our private patients, (2) presenting an edited version of an interview with this patient, and (3) discussing the management of grief in relation to this specific history and interview.

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Case History*

Mrs. M is a 65-year-old kindergarten teacher who suddenly lost her husband in May, 1973. In August, Mrs. M called her family physician and asked to be seen for pain in her right knee. Nothing was found upon physical examination, and she responded well to aspirin therapy. She was reluctant to talk about the death of her husband on this first visit, but was persuaded to return for a complete physical examination. At this second encounter, she did allow herself to talk about her husband's death and immediately broke down and wept.

This was her second loss of a loved one. A son had died, at the age of 18, of a progressive liver disease. Following this earlier loss, she cried and did not function normally for over three years.

She has two other grown children who are living out-of-state who came to her side at the time of the death. The family had apparently encouraged her to "stand tall," to "keep a stiff upper lip," and to carry on so that "Gramps would be proud of her." Also, the fear of having a prolonged grief reaction as she had when her son died reinforced her tendency to keep everything bottled up.

The local minister told her that God had been good enough to give her a wonderful husband for 41 years, and that she should not now begrudge His taking him back. She developed some somatic complaints. She was unable to sleep at night, constantly felt tired and exhausted, had to force herself to eat, and noted a tightness in her throat.

The family physician saw Mrs. M once a week for one half hour for the next six weeks. She reluctantly took an antidepressant** at night for a short period of time. The interview that is transcribed here took place at the end of this period. Following the conference, she was seen two or three times and then not again until the anniversary of her husband's death on May 21, 1974. While kneeling before her husband's grave she became lightheaded, experienced shortness of breath, and developed paresthesia in both hands. A brief examination and simple reassurance alleviated all of her symptoms. She continues to have moments of pain and grief at Thanksgiving, Christmas and birthdays, but has been able to carry on with her kindergarten work. As before, Mrs. M is able to give a great deal of love to the children and, in turn, the children all come to love "Grandma M."

Interview

This interview was originally conducted in Dr. Schmidt's community practice during a teaching conference as part of a medical student preceptorship in family medicine† that has been

*Names and initials have been altered.

**Amitriptyline, 75 mg h.s. from the time of the first visit to the third.
†Sponsored by the Harvard Family Health Care Program.

previously described.[7] The consulting psychiatrist was Dr. Edward Messner. Footnotes marked "T" discuss interviewing techniques.

PATIENT: Ours was a perfect life. He was good to everybody and he was good to me. I think some people in their sorrow cry because they regret, but I have absolutely no regrets. Oh, we had hard times. We were married in the Depression. We had it hard, but we were together. We had a boy that had eczema so badly that he had to sleep on isinglass. He couldn't even bear the sheets. Every morning my husband would get up with him and cover his arms and legs with tar. That was all the salve they had then. I think everybody loved him . . . (prolonged pause) . . . I loved being a mother and a wife . . . (pause) . . . but I hate being what I am, I just hate it. (tears, anger) . . . Forgive me for saying so, but I don't like it.

DR. MESSNER: You mean being alone – being a widow.[T1]

PATIENT: It was Dr. Schmidt who helped me the most. I was trying to tell myself how lucky I was. I have a nice home, and I have a wonderful son and a wonderful daughter. And I have a school, a kindergarten, and I love those kids. I am lucky, but Dr. Schmidt told me I was lonesome, and that's what I am. I'm awful lonesome . . . (long pause) Why did my husband have to die? He's only 68. (tears) . . . There is a lump in here (stomach) and it goes right up here (throat) . . . But I am sure I'm going to be all right soon. I am. Because I want him to be proud of me. About five years ago he said, "Edith, if I ever go before you I know you will stand on your own feet." And that's what I want to do.

DR. MESSNER: Well that's what you are doing. The fact that you are crying doesn't mean that you are not standing on your own feet. It is a natural thing to cry. You know, when a person cries it doesn't necessarily mean a feeling of regret. It's a feeling of sadness and loss.[T2]

PATIENT: But even the minister didn't help me. I thought the minister would help me. He didn't. He told me to read "The Hounds of Heaven." I did not understand the poem. I did not want to talk about heaven, I wanted to talk about my husband . . . (pause) . . . And there's one thing I can't stand in church. My husband was a deacon, and I can't stand it (now) when they (the deacons) walk down the aisle. The very last time, he went on a Monday, and the very last Sunday, I was sitting next to this woman. It's kind of foolish. She was kind of stiff, you know, kind of a narrow religion. And I just gave her a poke, and I says, "Louise, isn't he the handsomest deacon on the floor!" And she just looked at me as if I was crazy. But that's what I thought. (tears) He always looked so nice with blood hair . . . And the last day was my birthday . . . (pause)

DR. MESSNER: Tell us some more about your husband.[T3]

PATIENT: Well, it was my birthday, and I came waltzing out of the bedroom and said, "How do I look on my 65th birthday?" And he never gave me an inch. He replied, "I'm not saying." It was always that small talk. We were always fooling and always talking. We were always having fun. And he says, "It's your day, we'll do what you want to do." He had my breakfast all ready, and he had a beautiful card. There was a kind of irony in the card. It described three wishes – and the last wish – I wish we'll never part. Wasn't that odd? I thought that was strange. I sat there and I says, "Oh, this is so beautiful," and I was crying then, and he says "Oh don't cry." (tears) . . . I really try to think that we've never parted. I think that love is eternal.

DR. MESSNER: You certainly must have fond memories of all the wonderful things you shared.[T4]

PATIENT: Yes, I have, I have lovely memories. That day we dressed all up and we just went to a local restaurant. And I was glad because everybody was patting him on the back and saying. "Oh, you look pretty nice," and someone else would say "Pretty special fella." And I was just so proud. We saw everybody we knew. It was really lovely. After dinner he went to a ball game with the neighbor kids. He came home and told me about every single play. I don't really understand it, but we were sharing it. Then he went in and changed his clothes. He really felt good because he was going out in the garden. He loved that garden. He stepped out on the porch and the rain began. He said, "Holy cow, that's the third time I've tried to get out in my garden." It was showery all day . . . (pause)

DR. MESSNER: What was the cause of his death?[T5]

PATIENT: I wish I knew. They said it was a massive blood clot. He just went into his desk. He always wrote what he was going to do tomorrow and then checked it off. He wrote two things . . . One was about kindergarten. . . . He wrote those things, and I was doing the dishes. (pause . . . panic . . . tears) I suppose you've heard that awful noise. That awful noise. It sounded like a lawnmower. (gasping respirations) I said, "Alfred, what's that noise?" . . . I went in and he just slumped. I'm glad; he should go like that. He deserved to go like that.

DR. MESSNER: No suffering.[T6]

PATIENT: Yes, because my boy suffered, my boy suffered for two years. I'm glad, he just went out.

DR. MESSNER: What did you do then when you saw him?[T7]

PATIENT: I panicked. I knew it. I knew he wasn't ever going to talk to me again. I just . . . you just feel it. I called to the young boy that lives upstairs. He came down immediately. I was sorry he tried to give him artificial respiration. I was sorry he had to do that. And I called the ambulance and they came just like that. It was the firemen's meeting night. All the firemen came and they knew what to do. And I kept saying "Is it serious?" . . . Why did I ask them? I knew it. I just knew it. He didn't even get to the hospital, and I'm glad. I'm glad. I think it's terrible when they hitch people up to all those things . . . I'm glad he never even got there. I'm glad

[T1] Make explicit the condition she alludes to, in order to distinguish it from her acceptable self.

[T2] Assuring her that she is living up to her husband's expectations and her own ideal of herself, while offering approval of crying as a natural, acceptable, desirable way to express feeling.

[T3] Seeking specifics about the deceased to evoke detailed memories and their associated feelings.

[T4] An attempt to alleviate some of her discomfort by diverting her attention to pleasant memories, but still seeking details.

[T5] Back to the unpleasant memories.

[T6] An attempt to comfort and reassure her with this explicit clarification.

[T7] Again looking for specifics.

he died suddenly with no suffering . . . (tears)

Discussion

There is a natural history[1,3,6,8] for the syndrome of ordinary grief that is well illustrated in this case. The first reaction is one of numb disbelief. The bereaved is unable to accept the reality and finality of the separation. It is in this shock-like state that she carries out all the details of the funeral and burial. This state of confusion is enhanced as a host of family and friends crowd about the widow. Sometime after the burial, the true impact of the loss begins to be felt. Intense pain sets in, and great waves of emotion overcome the bereaved. Somatic symptoms develop, possibly including tightness in the throat, shortness of breath, or an empty feeling in the stomach. These waves of discomfort are precipitated by anything reminiscent of the deceased. The widow may not be able to sleep at night, complain of fatigue and exhaustion, and lose her appetite for food.

The physician is consulted because of these physical complaints. The patient does not usually come to the doctor complaining of grieving. In Mrs. M's case she used the minor knee complaint as a ticket of entry to the doctor's office, but was actually assessing his willingness to attend to her real needs. She apparently felt that she could trust him on the second visit, and allowed herself to weep. She mistakenly had been trying to keep her grief bottled up.

There is a considerable amount of evidence to suggest that the bereaved should be encouraged to express her pain openly. The most effective way for the physician to encourage the widow to express her feelings is to center the discussion around the deceased. One might stimulate a detailed recounting of a particular situation or event just prior to the death. When given the opportunity, Mrs. M talked about her husband quite readily. As described in the interview, the tears flowed when she told of her husband's giving her a birthday card, when she described his walking down the aisle of the church on the day before his death, and when she relived in detail the circumstances that surrounded his death.

Many patients will simply say "Oh, doctor, I am so unhappy," or "Doctor, life simply is not the same." By talking in these general terms the patient is protecting herself from experiencing the pain that would result from a detailed description of a particular event or situation involving the lost loved one. The physician must direct the conversation by saying something like this: Tell me about that birthday celebration – Where did you go? – What did you wear? – What did your husband wear? – What did you have for dinner?, etc. *One should encourage her to talk about her relationship with the deceased until her words flow without inhibition and carry with them the full expression of her emotion.*

The mental effort required to face the pain of the loss has become known as the *work* of grieving.[8] As this grief work is accomplished, there usually occurs in six to 12 weeks some noticeable lifting of the mood and lessening of somatic complaints. The average grief reaction comes to a reasonable conclusion in six to 12 months.

Certain cultural and religious customs help the bereaved work through her grief. The formal mourning rites of the Jewish religion demonstrate great wisdom in light of our recent understanding of the grieving process. The Talmud states that the mourner should be allowed privacy for her weeping and lamenting until after burial. Only then do family and friends visit the bereaved and are specifically encouraged to talk about the widow's (or widower's) loss. For one full year, mourning prayers are said daily in the Temple. This prayer is first said at the graveside, and the repeating of it later frequently brings forth tears. The widow is given a full year to resume her normal activities gradually. At each anniversary of the death there is a formal ritual in the home that includes the burning of a candle for 24 hours. These religious customs have the effect of repeatedly reminding the widow of her loss and forcing her to face the pain associated with it.

In addition to encouraging the bereaved to express her pain, the physician should have some knowledge of the psychodynamics of grief. A major factor in grief is an acute separation anxiety. This separation anxiety resembles that first encountered by all infants who experience helplessness when they cannot obtain the attention of a parent. The infant's existence literally is dependent on the care of the parents. The adult perceives the separation from a significant other as a threat to herself and feels helpless. She is alone, with no one to do the thousands of little things that the spouse once did.

The second major consideration is really another form of anxiety-guilt. There are ambivalent feelings in any significant relationship. Any hostile thoughts that were once directed against the deceased may be unconsciously felt to be responsible for his death. In addition, the bereaved may regret that she had not done some small thing that she had been meaning to do for the deceased.

The third major dynamic element is hostility. One can be confident that in most cases of grief there are repressed feelings of hostility directed toward the deceased. There are feelings of desertion and abandonment. On an intellectual level, these feelings are irrational and unacceptable to the patient. The husband did not choose to die and it would be irreverent to be angry at the dead. Nevertheless, these feelings are inevitably present on an emotional level, but the bereaved is usually not aware of them.

When a physician is consulted, he can enhance the healing process by anticipating that the bereaved is experiencing anxiety, guilt, and hostility, and can direct the discussion in a fashion that will help uncover these painful emotions. Once the patient is able to express her anxiety, the physician is frequently able to reassure her that the fears are not realistic. By helping her examine alternative options, he is able to aid her in making important decisions. In addition, time itself will usually prove to the widow that she is not as helpless as first imagined. The physician can support the bereaved while she is proving herself.

Feelings of guilt and hostility are especially difficult to uncover. Psychiatrists have learned that these repressed feelings are frequently responsible for the development of a pathologic grief reaction. The pathologic grief reaction is one that is either very intense, resulting in complete incapacity, or unusually prolonged. Pathologic grief reactions may be manifested by serious and lasting psychiatric symptoms. These may include a marked depression with suicidal ten-

dencies or regression to a primitive defense mechanism such as delusional projection, massive denial, or schizoid fantasy. The patient might become completely withdrawn or exhibit immature behavior. A pathologic grief reaction is probably best managed by a consulting psychiatrist. This paper, written for the family physician, focuses only on ordinary grief. For a discussion of pathologic grief we refer the reader to chapter XII of John Nemiah's *Foundations of Psychopathology.*[8]

By gently probing and prodding, the physician may be successful in encouraging the bereaved to express overt anger toward the deceased. The tendency of the inexperienced may be to react with shock and disapproval, but this would only serve to suppress the anger further and increase the guilt. The knowledgeable physician will help the patient by understanding and accepting this hostility as a normal element of the dynamics of grief. Furthermore, the explicit reassurance that this hostility is a normal and a natural reaction to separation will help alleviate the guilt experienced by the widow as these feelings of hostility surface. Unverbalized anger is often directed against the self, leading to depression or even suicide.

The use of medication in the management of grief requires more discrimination than is generally recognized. During the initial stage of shock, mild sedation* may be helpful. However, prolonged use of sedation is undesirable. This sedation may help the patient maintain a calm outward appearance, but may actually interfere with the expression of her feelings that is so necessary for working through grief.

If grief is complicated by depression, antidepressants** should be considered, but we caution that these drugs should not be used merely to counteract feelings of sadness. Antidepressants are most effective when a depressive reaction involves a change in mood and "vegetative" signs. The latter include insomnia, especially early morning awakening, anorexia, weight loss, constipation, and fatigue. By giving the total daily dose of the tricylic antidepressants at the hour of sleep, one can obtain immediate relief for the insomnia and avoid the mild sedative effects of the drugs during the waking hours.

The busy practitioner is often tempted to hasten the end of a patient encounter by prescribing a drug. We believe medication has only a minor role in the management of ordinary grief. Far more effective for the bereaved than medication are periodic discussions with a skillful and empathetic family physician who can help her face the pain of the loss.

*Diazepam or chlordiazepoxide.

**Amitriptyline or Imipramine, as examples.

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