Episode 050: The Process of Grief

Joseph Wong (MS3), Tyler Rigdon (MS2), David Puder M.D.

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There are no conflicts of interest for this episode.

On today's episode of the podcast, I am interviewing Maris Loeffler, LMFT. We cover different types of grief (acute, complicated, traumatic, etc.), attachment styles in relation to grief, and some helpful things to consider in caring for a grieving patient as a mental health provider.

An Overview of Grief

This article complements the above podcast, with some research findings we did not talk about in detail, and is written for mental health professionals to understand some of the research behind grief work.

Grief is the multifaceted response—emotional, behavioral, social—to a loss or major life adjustment (like a divorce, loss of a job, etc.). Bereavement is the process of grieving specific to the loss of affection or bond to a person or animal (Parkes & Prigerson, 2013; Shear, Ghesquiere & Glickman, 2013; Shear, 2015).

Some of the signs and symptoms of grief are:

- somatic symptoms (e.g. choking or tightness in the throat, abdominal pain or feeling of emptiness, chest pain)
- physiological changes (e.g. increased heart rate and blood pressure, increased cortisol levels)
- sleep disruption and changes in mood (e.g. dysphoria, anxiety, depression, anger)

(Buckley et al., 2012; Lindemann, 1944; O'Connor, Wellisch, Stanton, Olmstead & Irwin, 2012; Shear & Skritskaya, 2012; Shear, 2015; Zisook & Kendler, 2007)

Medical and psychiatric complications can also arise due to grief and include:

- An increased risk for myocardial infarction
- Takotsubo cardiomyopathy (Broken Heart Syndrome)

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- The development of mood, anxiety and substance-use disorders (Cheng & Kounis, 2012; Keyes et al., 2014; Mostofsky et al., 2012; Shear, 2015).

Acute grief begins after a person has learned of the passing of a loved one (Shear, 2015). During acute grief, a person may experience immense sadness, yearning for the deceased, and persistent thoughts of the decreased (Maciejewski, Zhang, Block & Prigerson, 2007; Shear, 2015). Auditory and visual hallucinations are benign hallucinations commonly found in acute grief and involve the person seeing, talking to or hearing the voice of the deceased (Grimby, 1993).

The process of grief has long been seen through the lens of Kubler-Ross' 5 stages of grief (denial, anger, bargaining, depression and acceptance). Now, however, it is now more commonly understood that the process of grief is not as linear or predictable as originally posited by Kubler-Ross, and that there may not even be stages of grief that a person has to pass through in their grieving process (Maciejewski, Zhang, Block & Prigerson, 2007; Stroebe, Schut & Boerner, 2017).

Most bereaved individuals are able to progress from acute grief to integrated grief, in which the individual has adapted to their grief and is able to once again enjoy daily life and activities (Shear & Mulhare, 2008; Shear, Ghesquiere & Glickman, 2013). About 6 months after the loss of the decreased, negative grief indicators (e.g. disbelief, yearning, anger) are in decline (Maciejewski, Zhang, Block & Prigerson, 2007). Thus, this transition from acute grief to integrated grief means that the individual only experiences grief as a temporary period rather than a prolonged chronic state. However, approximately 10% to 20% of people who lose a romantic partner do not transition from acute grief to integrated grief and instead transition to complicated grief (prolonged grief disorder) where the individual experiences grief for a longer period of time than expected to the point where it causes impairment in daily functioning (Bonanno & Kaltman, 2001; Shear, 2015).

Complicated grief is more common in parents who have lost children, when the loss of the decreased is sudden or violent (e.g. suicide, homicide, accident), and is less common after an expected loss (e.g. chronic illness) (Meert et al., 2011; Mitchell, Kim, Prigerson & Mortimer, 2005; Nakajima, Masaya, Akemi, & Takako, 2012; van Denderen, de Keijser, Kleen & Boelen, 2015; Young et al., 2012). Complicated grief has been found to be most prevalent in women above 60 years old (Kersting, Brähler, Glaesmer, & Wagner, 2011).

Complications of complicated grief include:

- sleep disturbances
- suicidal ideation
- substance use disorders

- decreased immune function
- increased risk for cardiovascular disease and cancer (Buckley et al., 2012; Shear, 2015).

Like acute grief, the symptoms of complicated grief involve intense yearning for the decreased and persistent sadness. In complicated grief, these symptoms are accompanied by the fact that the individual is unable to accept the reality of the death of the deceased, and has intrusive thoughts or images of the deceased, and excessive ruminations and recurring negative emotions (e.g. anger, guilt, bitterness) surrounding the death Shear & Mulhare, 2008; Shear, 2015; Simon, 2012). Individuals with complicated grief commonly avoid situations, events or places that remind them of their loss and are fixated by viewing, touching or smelling momentos left behind by the decreased (Shear, 2015).

Attachment Styles and Grief

Attachment theory was first established by Mary Ainsworth in the 1960s and 70s and applied to children with 4 attachment styles in children being classified:

- secure attachment
- insecure attachment
    - Anxious-ambivalent
    - Anxious-avoidant
    - disorganized (Bartholomew & Horowitz, 1991)

In the 1980s, attachment theory was extended to adults and 4 attachment styles were also classified:

- secure attachment
- insecure attachment
    - Anxious-preoccupied
    - Dismissive-avoidant
    - fearful-avoidant (Bartholomew & Horowitz, 1991)

The anxious attachment style reflects worry concerning the availability of the attachment figure, while the avoidant attachment style reflects a tendency to keep at arm's length from attachment figures (Shear & Shair, 2005).

Secure attachment style is characterized by low anxiety and low avoidance.
Anxious-preoccupied is characterized by high anxiety and low avoidance, dismissive-avoidant is

characterized by low anxiety and high avoidance and fearful-avoidant is characterized by high anxiety and high avoidance (Shear & Shair, 2005).

It has been well-documented that bereaved individuals with insecure attachment styles are at risk for increased grief symptoms. Insecure attachment styles have been found to put spouses of terminally ill patients at greater risk for traumatic grief symptoms (Van Doorn, Kasl, Beery, Jacobs & Prigerson, 1998). Individuals with an anxious ambivalent attachment style that lost a close friend or family member in the previous year experienced greater levels of grief and depression, while individuals with an avoidant attachment style experienced greater somatic symptoms in comparison to individuals with secure attachment styles (Fraley and Bonnano, 2004; Wayment & Vierthaler, 2002).

Below are the prototypic behaviors and characteristics of the adult attachment styles with respect to grief.

Anxious Attachment

Typically occupied with fear of abandonment, exhibits hypervigilance and seeking behaviors. Afraid that their partner might leave them.

Patients with anxious attachment styles latch onto items or articles of clothing; however, people can normally hold onto momentos as part of the grieving process, so further investigation should be done to differentiate the two.

Avoidant Attachment

Fearful of intimacy and emotional engagement. Prefers to process things alone. They withdraw with signs of emotional neediness from partner.

How does this attachment style impact the grieving process and hinder healing?

- Have trouble with acknowledging the depth/importance of the relationship.
- Don't like to be vulnerable in the relationship.
- Avoid fully looking within themselves and processing their grief response.
- By pushing down their emotions, it makes it hard to get through the grief process ,as when you grieve, you need to feel emotions, and it makes it difficult to process emotions if you're not acknowledging them.
    - Maris' approach is to work with the body if they can't put words to what they're feeling as part of the grief process. People with avoidant attachment styles have

more somatic symptoms (headaches, stomachaches), so putting that into words for them can help them better understand their grief process.

Disorganized Attachment

Kids with disorganized attachment have no organized way of regaining connection. They later will have higher rates of dissociation. Patients with high amounts of dissociation will need to feel grounded and present to process through things, and learning when someone is dissociating will be helpful to help them progress in their emotional development. I (Dr. Puder) often look for microexpressions in the midst of someone dissociating to help me know what emotions are felt but not being allowed to experience.

Other Considerations

The following are some of Maris' considerations that have helped her in approaching a patient with grief.

- One of Maris' grounding principles is centered around, "When I bring a person into the room, I need to understand what they need." This mindset helps her to just let the client speak their story for the first few sessions, after which she will begin formulating her own ideas about the client's grieving process. In a non-confrontational manner, she will ask questions like the following to dig deeper.
    - "I'm noticing that it's difficult for you to talk about the funeral."
    - "It feels like you get angry when you notice how your brother is handling the situation."
- Realize a patient's grief hits them after the funeral service. After the deceased has passed and before the funeral, usually family members and friends gather to give support to the grieving. However, after the funeral, those people are no longer there and the patient is left alone. Consider this timeline when helping the patient through their grieving process.
- Sometimes it's difficult to determine the fine line between supporting a friend with grief and exhausting them with your presence. So what are the things to consider in comforting a friend with grief?
    - Firstly, it depends on your relationship with the person
    - Second, ask them what would be most helpful for them at the moment
        - Right after a loss, everyone comes around, but sometimes people want to be left alone and it can be exhausting for the person in question to feel overburdened with emotional comfort.

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        - Sometimes it's valuable to check in and reach out. That alone can make an impact, even if you can't find the right words to comfort the person.
- **The importance of personally going through therapy cannot be understated in this line of work. Even therapists need therapists, and being a patient can help you become a better therapist by allowing you that first-person perspective.**
- Some patients may be doing really well with therapy for a period of time, but encounter roadblocks associated with life events without the presence of the decreased (first Christmas or the first anniversary after the loss of their loved one). The patient may need to revisit their grief once again, and that's perfectly fine—grieving is not linear, nor is it the same for everyone.
- Every patient has their own way of talking about and processing their grief. Certain patients may even repeat the process of the passing of the decreased over and over. While it may be repetitive to hear the same thing every session, allowing the patient to talk about their experience helps the patient with their process of grieving.
- Some patients might feel a lot of guilt towards themselves while grieving. Normalize the feeling of guilt, express the difficulty in feeling things, and help them look at the guilt with less judgement.
- Some patients may even feel anger towards the deceased, which they might have difficulty acknowledging or getting it out. It is common for people to remember the decreased in terms of their good aspects or attributes, but that may not always be the case for the patient. Allow them the space and time to express their negative emotions, which may not always be apparent on the surface in their grieving process.

Maybe at some point, you have thought to yourself that you don't have the ability to process grief with your patients or that it simply isn't your strong suit. I hope that some of the points brought up in this podcast will be helpful in your own practice and journey as a mental health provider.

Connect with *Maris Loeffler, LMFT on Instagram*, Linked In, Psychology Today