LOSS AND TRAUMA

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Introduction

Looking at the program of seminars, I find the current one is titled with especial ambition. This is because it is the only seminar which deals with a theory of how illnesses form. What I mean, is that a seminar on loss and trauma implies a theory that external events like loss and trauma are causes of disruptions to otherwise life enhancing homeostasis, like the logo of the International Society for Traumatic Stress Studies, where an object falling into a still pond causes turmoil, and the ripples radiating from the central disruption are the symptoms with which patients come to us. Treatment then has to deal with the ripples and the initial cause, and readjustment to current conditions where the pond is still again.

The opposite at least implicit theory is that conflicts and disruptions are internally derived, i.e. the pond is innately seething from within, and treatment is the internalization of the good conflict free therapist to replace the innate sexually and aggressively neurotic mind of the patient. In this picture external events only feed into the natural rifts and swirls of people's minds.

People can only take home one or two messages at best from seminars, often an emotionally laden metaphor or a picture. My basic take home message is that you should take home the first picture, the one with disruption and ripples. Or, to use another metaphor, unless something goes wrong, we go along our life paths like fruits on a tree, which bud, grow, ripen and fall. This process is interrupted by lightning and earthquakes, violent shaking of the tree or worms penetrating the apples.

Violent shaking and lightning evoke protective capacities called stress responses, to deal with stressful events. When very adverse or life threatening events overtake us, traumatic wounds occur, but we still have capacities to buffer ourselves from death. However, traumatic wounds do not leave us unscathed. They leave scars and abscesses. Traumatology is a sophisticated developing discipline, which explores which types of events cause what types of consequences, requiring which types of treatments.

We will look at a section of traumatology, which deals with loss. Then we will have a look to see where loss fits in with trauma generally. This will give us a taste of the theory of traumatology and its contribution to a theory of psychopathology and psychosomatic medicine.

Clinical case

In an outreach program in Mt Macedon 4 days after the 1983 Ash Wednesday bushfires, we visited a 74 year old man who kept repeating his thankfulness for his house being unscathed except for a singed hedge. He pointed out the contrast with houses on either side of him which had burnt down, and the massive over 100 years old trees across the street which had burnt and become uprooted.

In a follow up outreach visit two weeks later, we found this man suffering an unequivocal major clinical depression. He had withdrawn himself to the innermost reaches of his house, and all his blinds were drawn. He was not aware why he was depressed, but he knew that he did not want to live anymore. However, it took relatively little effort to find out the dynamics of his depression.

The point was that though he and his house survived, he had lost his world. He described the world around him as a moonscape. He realised that he was too old to see it regrow. There was no point to his life any more. He could not confide this to anyone, as everyone thought that he was lucky, as he himself had thought. His desire to cry seemed self-indulgent.

We confirmed that the loss of his world as he had known it was a big enough event to cry for. He gratefully cried and grieved, and his depression lifted. He saw that his world was not over. For instance, his neighbours were alive, and his home could be a base for them as they rebuilt their houses. He would leave a mark in the future.

I will refer to the lessons from this case as we proceed.

Loss

By loss in psychiatry we frequently mean bereavement i.e. loss of a person through death. Loss of this nature is the most potent stressor in civilian stress scales, and is a common precursor to depression.

Loss of people is frequently confused with separation. We may say that little Johnny is lost in the supermarket, when he is only temporarily separated from his parents. Similarly bereaved people may feel only separated temporarily from the deceased loved ones, expecting them to return, and searching for them.

By loss here, I mean a realization as with the bushfire man, that something very meaningful is irretrievably gone. The dead person will never return. I do not mean temporary separation.

Loss may be of objects other than people – environment, as we saw, work, house, pets, and intangibles such as trust, self-worth, and love.

Consequences of loss under usual circumstances

Loss, which is not traumatic, is followed usualy, we may say normally, by certain psychological, social, and biological consequences.

Psychological

Once appraisal of irretrievable loss is registered, there follow intense feelings often described as one's heart being wrenched, torn, wounded, or bleeding. This is followed by pangs of grief, associated with deep sobs, tears, and weeping. Tears are like a river of grief, which allows both renunciation, and retention of love, as it flows from a valley of emptiness to new hope. That is what the tears of grief facilitated for the bushfire man.

Social

Other people support the psychologically wounded like they would the physically wounded. They listen, share stories of the dead, and attend funerals and mourning ceremonies. Mourning process parallels the psychological grieving process.

Biological

Grief and sadness very sensitively (even just thinking about being sad) activate the parasympathetic nervous system, and activate the hypothalamic-pituitary adrenocortical (HPA) system, leading to increased cortisone secretion. At the same time, various parts of the immune system are suppressed, such as mitogenic lymphocyte activity. These physiological ersps are parallelled by feeling of tiredness, inactivity, and withdrawal.

Consequences under traumatogenic circumstances

Losses are traumatogenic if they are multiple (e.g., many relatives), heinous or gory (e.g., murdered), when the deaths were ambivalently desired, if grief would open the meaninglessness of life, or if there are constraints on grief and mourning (stiff upper lip, "You're lucky to be alive." Or there is a need to survive continuing stressors). In all these cases, to grieve would be dangerous or morally wrong or shameful. For instance, the bushfire man felt that to grieve would expose him to the ultimate futility of his life, plus he was ashamed to grieve as others were worse off than he.

Psychological

In traumatic situations, people may sink to the floor, overwhelmed and numb. There may be a sense of frozen tears, a cold numb feeling around the heart. Alternating with this feeling may be a sensation of a permanent renting or excruciating crushing agony of the heart. The sensations are associated with hopelessness and despair.
A feature of trauma is dissociation of the dangerous traumatic meanings of loss, probably into the right brain, where it stays in nonverbal unawareness.
Instead of sorrow and grief, the mood is depression and despair, which is sensed to be present for no apparent reason, like an illness. This is better than realizaton of total futility.
Those who give up permanently to their despair may die, as 40% just died in concentration camps. The sudden loss of hope can have a deadly effect in such situations.

Social

The person withdraws from other people. Exhaustion may require staying in bed for long periods.

Biological

There is intensification of the normal physiological responses accompanying grief. Cortisol levels increase. Widespread diminished immunocompetence has been found in T and B cells, natural killer cells, and humoral parts of the immune system.

Illnesses

Biological

Psychophysiological symptoms

Parasympathetic symptoms include fatigue, cold, nausea, loss of appetite, constipation, dizziness, arrhythmias and even sudden death.
Suppressed sobbing may be experienced as a lump in the throat.

Psychosomatic illnesses

Death of a spouse is the leading civilian life stressor and is associated with seven times the usual mortality and morbidity of the general population. Many of these illnesses are infections and cancers, probably associated with reduced immunocompetence.

Psychological

Unresolved or pathological grief

There are 3 types of pathological grief.

1. *Delayed, inhibited, or absent grief*
Grief may be inhibited through denial of loss, and other defences. Unexplained crying, though for fairly obvious reason if searched, resembles neurotic depression or adjustment disorder with depressive features.

2. *Chronic mourning*
The person is maintained as if alive, for instance their clothes are not touched for years.

3. *Conflicted or distorted mourning*
This is a result of conflicts with the person in life, and they are carried on in death. They manifest in anger and guilt with the dead person. Suffering the same symptoms as were suffered by the dead person may appease guilt.

Grief symptoms, whether normal, unresolved or traumatic may recur and intensify around anniversaries, or other symbolically pertinent times.

Depression

Clinical depression includes maladaptive and traumatic psychological (depressed mood, despair), as well as biological (e.g., high cortisone levels, parasympathetic activity), and social (e.g., withdrawal) responses. (It also evokes judgements of being inadequate, despicable, disposable.)

Because of traumatic dissociation and other defences, conscious awareness of the connection to the original loss event is disrupted, leaving an impression of the illness coming out of the blue, or for some innate reason.

Depression, a frequent diagnosis in psychiatry, is the commonest illness arising from catastrophic events, and is the commonest comorbid condition of PTSD. Its traumatic origins must be always considered.

Social

As well as exhaustion and withdrawal, social defences against traumatic loss may be part of depression. They include alcohol and substance abuse, work addiction, premature liaisons and promiscuity, doctor attendances with a variety of symptoms, shop lifting delinquency, suicidal behaviour.

Trauma

The stress and trauma of loss is but one of eight similar potentially traumatic situations. I will indicate 8 situations of trauma. Each is associated with a means of survival not succeeding.

TRAUMATIC EXPERIENCES

SURVIVAL STRATEGY	TRAUMATIC SITUATION	TRAUMA RESPONSE
GOAL SURRENDER; ADAPTATION	Loss	Depression, despair, given in
GOAL ACHIEVEMENT; ASSERTIVENESS	Goal frustration	Impotence, powerlessness
FIGHT	Kill or be killed	Violence, murder
FLIGHT	Engulfment	Panic, annihilation
RESCUE	Overburdened	Anguish that caused death
ATTACHMENT	Separation	Abandonment, helplessness
COMPETITION	Defeat	Elimination
COOPERATION	Betrayal	Exploitation, abuse

Theory

We see that loss evokes a specific survival strategy called goal surrender or adaptation. We saw that responses to loss may be adaptive (grieving process) and maladaptive (depression, despair), biological, psychological and social aspects.

Maladaptive responses if intense enough, create a wound, a trauma, in which these responses are focused as in a lens. Then they are refracted from it and filtered via defences such as dissociation, into an array of biological, psychological, and social illnesses.

Once a maladaptive course culminating in trauma has occurred following loss, to return to an adaptive process of grief, the person must believe that to do so will lead to a meaningful, purposeful life. This is what happened with the depressed bushfire man. He dared to hope again. The hope released his sadness, tears, grief. But they were worth it, because in a new, even if compromised life, he still had a purposeful place. Trauma therapy involves first and foremost giving safety and hope.

That is what Beverley Raphael means when she says that in traumatic loss, the trauma has to be dealt with before grieving and mourning can take place.

What is true for surrendering goals and adaptation to loss is true for each of the other traumatic situations and the survival strategies dealing with them. For instance, facing a disrupted attachment bond with its consequent feelings of traumatic abandonment and helplessness may be faced only after one establishes trust in a secure therapeutic relationship. In it, one may grapple with the original separation experiences.

A final level of complexity for today is that more than one survival strategy may be present in any situation. For instance, loss may overlap with an experience of ruptured attachment as well. This explains the common searching for the dead person, and the anger and guilt felt toward them – i.e., as if they were still alive and the separation is not final.

Some of the defensive actions against loss and depression involve the defensive use of other survival strategies. Using attachment is one means, substituting separation for Overwork may involve excessive goal achievement. Finding substitute partners is an attempt to utilise cooperation to avoid loss.

This is where I will leave loss and trauma today. I have not mentioned the fulfilling aspects of good grief and of other survival strategies; manifestations of trauma and loss in other than individual settings; their manifestations over the life cycle; morality, meanings and spiritual dimensions arising from them.

But I will finish with the take away message once more - symptoms and illnesses are results of external events, which have caused internal turmoil. These events and turmoils can be diagnosed and given specific treatments. I have used loss as an illustration of how it may be grieved adaptively or it may lead to trauma and a variety of illnesses such as depression. Treatment must include their origins.

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