Symposium

Death and the Family

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Death in the family is the closest experience to our own death. It is a major stress, and as such has major implications for the physical, psychological and social equilibrium and health of the individual

The death of a family member is, like severe personal incapacity, a poignant reminder of that part of our lives which we tend to deny — i.e. our own death. Death to most means helplessness in the face of an overwhelming force, the clear evidence that all human power is totally inadequate. The inert vulnerability demonstrated by the loved dead person indicates, as nothing else can to the same extent, the fragile nature of our own existence. The powerlessness and insecurity in the face of death reverberates with and reawakens childlike fears of helplessness and abandonment. This is what we try so hard not to feel [1].

Furthermore, there are strong identifications between family members. It is as if a great part of the self, a huge investment of one's identity is suddenly amputated when a family member dies. In fact, amputees react similarly to their loss as the bereaved to theirs.

The Psychobiology of Bereavement

The family represents the inner nucleus of safety for all animals. Biologically, it is the family which protects from extinction, and this awareness, especially in humans, is perpetuated throughout life. Attachment, particularly the reciprocal one between mother and child, is one of the strongest instincts for survival. Primitive biological survival comes more from attachment to the right object, than from any other drive, even that of hunger. Attachment remains a strong component of human motivation throughout life.

Thus, the irrevocable fragmentation of part of the family upsets security at its biological core. This is reflected in gross physiological, psychological and social dislocation following bereavement.

This dislocation is often manifested in illness. Holmes and Rahe [2] and others have shown that of all the psy-

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chosocial stresses which have been shown to precede illnesses of all sorts (physical and psychological), bereavement was the most virulent stress. For adults, death of a spouse headed the list (followed by loss of the spouse in other ways), with death of other relatives next. For children, presumably the death of parents is the greatest stress preceding organismic disruption. This seems to be confirmed by failure to thrive, increased mortality, varied psychological and somatic morbidity in children sent to orphanages.

For all these reasons, therefore, death of a family member is a stress of the first order, and ranks amongst the most feared disasters of life. Realisation of bereavement as a severe stress enables understanding of grief as the traumatic wound, and of mourning as the process of healing. During this process there is a realignment of one's image of security, of one's identity and of one's attachment drives.

The role of the clinician is to salve the wound and encourage healing.

The Psychophysiology of Bereavement

Bereavement as a Stress

Any factor which disturbs a prior homeostasis (an equilibrium which furthers continued survival) is a stress.

This stress may be physical, psychological or social (though usually a combination of the 3). The stress, or perception of an event as a stress, automatically initiates in the individual stress reactions which are biologically adapted in man's historical environment to counter stresses. The features of these stress reactions include activation of the autonomic nervous system with its sympathetic and parasympathetic components.

If such activation is not adaptive, or is perceived to be dangerous or inappropriate in its own right, defences will be called in to suppress, redirect or modify the expression of the stress reactions. For example, if a need to cry or collapse creates anxiety through shame and guilt, this aspect of grieving may be blocked by defences such as repression and dissociation. If, on the other hand, somatic expression of dysfunction is condoned, the bereaved may well redirect the attention of their distress on to the psychophysiological aspects of the stress reaction and thus communicate distress through permissible somatic complaints. Alternatively, blocked affect may be redirected into the field of action where it has some modified expression, e.g. in aggressive work immersion, reckless driving, increased drug, alcohol and nicotine intake, passive withdrawal, or clinging behaviour.

The problem with grief reactions being diverted from the psychological arena is that in humans, especially adults, bereavement is mainly a psychological trauma, in spite of its biological phylogenetic origins. Attempts to cope with grief in other arenas are not adaptive to restoration of security and healing of the psychic wound. This can only be achieved in the psychic arena through the process of mourning. Similarly, a deep laceration can only heal in the somatic field.

If proper healing does not take place, large scars and areas of vulnerability remain in the psychic area, maladaptive behaviour is present in the area of action, and the somatic area is also left to absorb the stress in the form of symptoms and illnesses. Thus, it is essential that the clinician strives to promote thorough healing of the bereaved patient, in the same way as he would a physically injured patient.

Bereavement is seen as separation from an attachment figure. Stress reactions have the biological function of reuniting the separated individual to the attachment figure

Stress Reactions as a Means of Overcoming Loss

If bereavement is a stress, then the stress reactions in the survivors may have some adaptive phylogenetic roots. Indeed, Bowlby [3] and Parkes [4] elucidate this clearly.

Bereavement is seen as separation from an attachment figure. Stress reactions have the biological function of reuniting the separated individual to the attachment figure. Crying and agitation may notify the absent mother where her child is, and of the child's need for the mother. Collapse, weakness, and becoming small indicate the need for protection and evoke care, as well as serving as protection against predators. On the other hand, anger provides the strength to overcome obstacles to reuniting, and serves as a warning to the returned object not to leave again.

Thus bereavement is initially experienced as a very dangerous separation. The reactions to it are as though reuniting were still possible, and the stress reactions are directed towards this purpose.

The ultimate catch to the bereavement question is that the stress reactions may be perceived as purposeless by those who intellectually understand death. Yet if the stress

reactions and associated feelings are not allowed their natural course, the mourning process which is also a healing process cannot proceed. There is therefore no escape from the pain of losing someone close, useless as the pain may at first appear.

Reactions to Death: The Process of Mourning

Mourning, like the dying process or the process of adjustment to any loss (which mourning resembles except that it is more intense), has overlapping phases. Some phases may be accentuated, others suppressed. The following is an indication of trends in the mourning process.

Any point in the mourning process is a compound of the stress reactions channelled into somatic, psychological and social arenas, in reciprocal relationship with body processes, psychological defences and sociocultural factors. The complex equilibrium set up by all these factors tends to progress towards adaptation to a new reality. If this does not occur, i.e. if there is a fixation on one or other factor, or if one factor is present in exaggerated form or out of phase, the condition becomes pathological and may well need intervention.

This model is no different to the holistic model of illness where stress may either be adapted to, or illness may result if the homeostatic equilibrium is too disturbed.

Acute Phase

Biological Features: In the acute phase the stress reactions predominate in great intensity. They have polarity; one or other pole may predominate, or they may fluctuate with each other, or at times be present concurrently.

At the one pole is the trophotropic reaction described by Gellhorn [5]. This subsumes the body reactions opposite to general arousal and includes the 'general adaptation syndrome' of Selye [6], parasympathetic nervous system activation, and the behavioural conservation-withdrawal reaction of Engel and Schmale [7]. The features are an initial cry of distress, followed by a tendency to collapse. Features and posture sag, the person looks 'ill', there is fatigue, and the body tends to become prone and take up as little space as possible. There is a propensity to faint, and overaction of this tendency may cause death. The phylogenetic biological survival value of this reaction lies in the advantage of 'playing possum' for a weak animal outside the orbit of protection, with possible predators around. 'Staying put' also furthers being found. Collapsing evokes 'picking-up' behaviour by members of the same species. Engel and Schmale believe that energy is conserved for future action in this phase.

The stress reaction at the other pole is the ergotropic one which is the arousal reaction. This subsumes activation of the sympathetic nervous system and includes the behavioural fight-flight response. Its features are an activation and tensing of muscles and posture, arousal of attention and consciousness generally, and sympathetic arousal which, if over-responsive in some individuals, may also lead to death. An apparently purposeless agitation is generally seen at this stage. The value of this reaction biologically is to fight or flee a source of danger, in this case one which threatens separation. Agitation may attract the lost person. Walking hurriedly within a small area may also enhance reuniting.

This phase may last from minutes to days.

The first steps in assimilating the stress lead to diminution of the extremes of the stress reactions. The less intense manifestations of their actions on the trophotropic side are the crying and sobbing which try to bring the lost back and evoke care. On the ergotropic side, sympathetic action is now more controlled and directed, though there are still waves of panic and arousal.

Parkes describes the pangs of grief (pining) which start in this phase and last in great intensity for about a fortnight. They seem to be part of the ergotropic system and they initiate searching behaviour.

Somatic symptoms relating to stress reaction activation begin in the acute phase. They are as varied as the effects of autonomic nervous system action. Common ergotropically activated symptoms are digestive disturbances (e.g. a lump in the pit of the stomach, indigestion, nausea), headaches, dry mouth, tremors, muscular aches and pains, palpitations, diarrhoea, insomnia etc. Trophotropically determined symptoms are tiredness, fatigue, apathy, a feeling of 'not being well', digestive disturbances and sleepiness.

Psychological Features: The acute trophotropic response is felt as being stunned, weak, losing all energy, the ergotropic one as fright, panic, alarm and anxiety. The affect analogous to the drive to search is felt as pining. The feeling arising from frustration at not being able to find is anger. The later trophotropic activation accompanying crying and sobbing is felt as acute sadness. The trophotropic counterpart to when searching is abandoned as useless, is the quiet despair, apathy and hopelessness of

TABLE I. Aspects of mourning

	Somatic	Psychological	Social	Defences	Treatment
Acute phase	Intense stress reactions Ergotropic (including sympathetic) and trophotropic (including parasympathetic activation) Intense somatic feelings associated with these	Stunned, agitated Anxiety, panic Crying, sadness, despair, apathy Pining	Support, help with feeding, decisions Funeral	Dissociation, isolation of affect, denial, repression Illusions	Prophylaxis, prepare for death Reassure about appropriateness of feelings Beware of too little emotion for too long
Intermediate phase	Persisting autonomic activity with associated symptoms All types of somatic illnesses Death Increased help-seeking through somatic symptoms Assumption of deceased's symptoms	Diminishing panic, despair and pining, though still waves of it at times Anger, guilt Identity crisis Identification with, idealisation of the dead 'Going over', 'working out' the situation	Fall in status, moderate help only Visiting cemetery, memorial services Religious, philosophical rituals and rationalisations	According to personality, e.g. work immersion, alcohol intake, diversion of anger into aggressive activity e.g. driving Expiatory activity to counter guilt, e.g. Identification religiosity Rumination	Explanation, reassurance of appropriateness of affects, e.g. irritability Watch for and treat fixation on a defensive pattern Psychotherapy Grief groups Treat somatic, psychological and social illnesses with reference to the initial grief
Resolution	Stress reactions settled down and modified Under control	Coming to terms with reality including death as part of life Self esteem rises Loss absorbed in a philosophy of life Enriched personality	Redefining of role and identity Redirection of emotions outwards	Their use diminishes as the trauma is absorbed	Nil if no fixations of the process detected

isolation and loneliness. Later ergotropic activation analogues are fear, anxiety and panic if intense, as well as inner restlessness, agitation and sleeplessness.

The intensity of these feelings may make the bereaved fear for his sanity.

Defences: In the initial stages these may parallel the primitiveness and intensity of the stress reactions. The first reaction of 'Oh, no!' expresses the extent of denial which may occur transiently. Other primitive defences countering the stress reactions are dissociation and isolation of affect. There may be an unreal dream-like quality to the bereaved's experience. Lesser degrees of denial continue.

A little later, by repression of thought, the bereaved may attempt to wipe out the memory of the dead from within, and everything to do with the dead is avoided. Alternatively, the pangs of pining may be mitigated by imagining that the dead loved one is still around. This may be rationalised as the person's soul hovering in the room comforting, or the bereaved may see the dead in illusions and even hallucinations, particularly at times of half sleep.

Social Features: These may complement or conflict with the needs of the bereaved. In the initial stages social factors often complement; the stunned family members are supported by relatives and friends. Often the bereaved

cannot make even simple decisions, and these are made for them. Concerned friends see that they are fed, consoled in their crying, soothed in their agitation. The first attempts to readjust them to reality are made. Attempts to overcome their panic in loneliness are made by visiting or staying with them. The absence of such support makes grieving very difficult, if not impossible, and augurs for trouble later.

One important feature of all societies is the funeral. The function of the funeral is to emphasise reality in a controlled manner with social support, after the initial primitive defences have waned, and reality can be absorbed to some degree. The defences of denial, isolation of affect and dissociation, as well as searching and illusions of finding, are unequivocably shown as useless. The funeral gives sanction to the full expression of feelings, which is necessary to initiate healing.

However, if those in the external environment cannot tolerate the danger that the bereaved represent, the latter may be enjoined to suppress their emotions and thus become ashamed and guilty about them. The bereaved may also be stigmatised by their misfortune and avoided. They may form a 'ghetto' of bereaved (i.e. those who understand'), or worse, even isolate themselves from each other and carry their suppressed feelings in separate islands.

Treatment: There is room for prophylaxis if the death is anticipated. The grieving process can be discussed and begun before death. Appropriate leave-taking, for example, may diminish later regret, guilt and anger.

In the acute phase of grief, the clinician can reassure the bereaved about the appropriateness of their experience. If he is asked for drugs to 'quieten' the widow, the relatives themselves may have excessive anxiety over the death and should be helped. So should those concerned about displays of emotion, etc.

The acute phase is the best opportunity to allow the intense feelings to come to the fore and to start dealing with them. Those who are afraid of the intensity or 'wrongness' of their affects and try to stifle them, may miss the opportunity to start healthy mourning, and lay the path for future problems. Studies show greater somatic and psychological morbidity among those who suppress their grief than among those who do not [8]. Therefore, the clinician, like the obstetrician, should allow nature to take her course, with only judicious interventions if something prevents this. He should not be deceived by calm exteriors and comments such as 'She is taking it so well'. This is an ominous sign of overactive defences.

The clinician must also be aware of the widespread autonomic dysfunctions present. Rather than extensive investigations or empirical medicines, diagnosis of symptoms in their proper perspective must be made, and then help given in the grieving process.

Intermediate Phase

This is characterised by attenuation of the somatic components of reactions to danger. There is use of more subtle defences and adjustment processes, flavoured more by the general personality of the patient. Some of the consequences of a distorted mourning process also begin to be apparent.

Somatic Aspects: It has been noted that the number of general practitioner attendances for widows is about 1 1/2 times that for controlled non-widows, and there is the same increase in morbidity of all types. Hospitalisation is 4 times as great while mortality is 7 times as great as for controlled non-bereaved [8]. This tallies with the premise that bereavement is the most potent stress leading to illness in ordinary civilian life.

The increased morbidity and mortality seems to be a result of a number of factors. Firstly, stress reaction activation, though possibly attenuated in this phase, may still be exacerbated in waves or chronically activated at low or even high intensity. Symptoms may be psychophysiological or psychosomatic (e.g. ulcer, asthma, coronary heart disease) in the predisposed.

Secondly, stress may be a contributing factor in any illness. The mechanisms in many illnesses are uncertain, although it would appear that mechanisms of resistance have ceased to function adaptively.

Thirdly, those who have no actual increase in symptoms may seek attention for earlier disorders because of greater feelings of vulnerability following bereavement, or as a condoned way to seek help, if normal grieving is blocked.

Lastly, there is a group who assume symptoms of the deceased through psychological mechanisms (see later) and then present them as their own.

The clinician should therefore make a conscious effort to look for illness among the bereaved, and bereavement among those ill.

Psychological Aspects: Unpleasant affects derived from stress reactions are mitigated by the frequent defences of denial, omnipotence, isolation of affect etc. The use of action may allow some discharge of emotion as in displacement activities, e.g. work immersion. Panic and

anxiety may be mitigated to a feeling of being on edge, or tenseness. Searching is mitigated to cemetery visits or dreams of reunion. Help-evoking behaviour diminishes. When habitual defences against anxiety are pathological, e.g. excess alcohol intake or helpless withdrawal, pathological patterns may come to the fore.

Two affects should be mentioned though they may initially appear in the acute phase. The first of these is anger, which may manifest itself in its attenuated form as irritability. Anger may have various bases. Initially, it may be a product of the fight-flight mechanism, where anger tries to overcome obstacles to retrieval of the lost object and punishes it for the separation. Later, anger may result from real frustrations at having to cope with added responsibilities, and at being forced to inhibit natural impulses directed habitually to the departed. Anger is also involved in the feeling of unjust punishment. This anger and blame on an external agency — God, doctors, or even the dead — are used to obviate the necessity of accepting the arbitrariness and lack of intentionality of death and one's inability to do anything about it. Lastly, anger is felt towards the dead for deserting the bereaved, and this is linked to negative feelings held for the departed in the past.

Although this anger is rational in a psychological sense it is not acceptable to the bereaved. It may therefore emerge as veiled aggression, whether in fantasy, somatic manifestations or action (e.g. reckless driving). It is important to recognise the aggression for what it is, rather than retaliate against it.

The second affect to note is guilt. In part, it is a reaction to the anger towards the dead; there is also guilt for surviving the dead. The affect provides the illusion that the bereaved was responsible for the death of the departed. Once again one's omnipotence rather than one's helplessness is reinforced. Guilt implies not only the power to have caused the death, but also the power of expiation to remedy the situation. These feelings may be institutionalised in a religious way. Through expiatory rituals and prayers the bereaved becomes 'good', is 'forgiven' and remains on good terms with the departed in heaven, whose eternal benevolent presence there is assured.

In the attempt to adjust to the new reality, 2 further processes should be noted. The bereaved's identity and self esteem suffer through depletion of the wealth of having the other person. Identification with the dead is an attempt to incorporate and not lose the dead. The bereaved may try to be like him, do things his way. Usually the idealised image is identified with. In particular, when intense guilt because of anger is felt vis-à-vis the dead, identification with the suffering of the departed may occur. This is the process underlying the assumption of the symptoms of the dead (see above). Not only identification, but also expiation, are served by the assumed symptomatology.

The second process, which will have already started in the acute phase, is the ruminative reliving of events leading to the death. This tends to happen with all traumas. Control is attempted in fantasy, and making sense of it all is one way to try to bring order to a disordered world.

Defences: Some defences may be carried over from the previous phase, i.e. denial, repression, dissociation and isolation of affect. In the current phase, expiation and identification have already been mentioned and are usual.

However, the bulk of defences in this phase are those characteristically used by the person at times of stress to deal with unwanted affects such as anger, fear, loneliness, depression and guilt. Knowledge of the bereaved's pregrief personality will help to recognise his reactions in mourning.

The clinician should make a conscious effort to look for illness among the bereaved, and bereavement among those ill

Social Aspects: The lowered self esteem of the bereaved is complemented by their fall in social status. This corresponds to the fall in the pecking order of widowed animals, and their subsequent adaptive protection by most of the group. In our isolated social units, this extra support may not be as great as needed. Indeed, after the first week or two, relatives and friends withdraw leaving the bereaved to cope alone at the height of their grief. However, the need for some more relatively circumscribed grieving and more leave-taking is acknowledged. Relatives and friends gather again at times of erections of tombstones, memorial services etc.

The need to rationalise death is helped by religious and philosophical theories of particular cultures. These may also enhance the sense of identification and expiation, as well as hope of a distant reunion.

Pathology and Treatment: None of the above stress reactions, mourning adjustments or defences require treatment. They are all normal components in the progressive equilibrium of the mourning process. However,

if there is a fixation upon any one of these factors, or if one of them is out of phase, inappropriately absent or intense, the condition should be viewed as pathological and in need of treatment. Any of the following features, for example, indicate that the grieving process is inhibited:

- Irritability persists or is intense.
- There are numerous somatic symptoms.
- There is excessive recklessness and accidents.
- There is excessive work immersion.
- There is excessive alcohol, nicotine or other drug intake.
- Searching, including frequent visits to the cemetery, an inability to give up a detail of the dead person's personal belongings, or a precipitate liaison with someone resembling the dead person is present.
- There is too much guilt, rumination or religiosity.
- There is too little sadness, anxiety or nostalgia.

Should the above features occur, one may expect increased maladaptive behaviour disturbance, somatic illness, and inappropriate channelling of affects into mental illnesses, such as depressive and anxiety states. The repressed unassimilated affects pertaining to grief are released here with a vengeance. This may happen in the intermediate phase, or at later times symbolically relevant, e.g. at an anniversary of the death, or in relationship to another loss.

Again the physician must be alert in a prophylactic manner to see that the mourning process is proceeding appropriately. Once a breakdown in the form of an illness of whatever nature occurs, this illness, e.g. depression, indigestion, coronary heart disease, accident proneness etc., must be treated in its own right. However, it is just as important to treat the underlying crippled mourning process. This will require psychotherapy. Bereaved groups may help.

Phase of Resolution

Biological Aspects: The stress reactions settle down and are under control, though memories still evoke modified reactions.

Psychological Aspects: Most of the work is now done in this arena. Time heals. One of its greatest attributes is that while it passes, the bereaved comes to learn of his survival in spite of the severe trauma. Events happen with which he copes well, and his self esteem rises. All this allows a reassessment of the sense of helplessness. As this sense diminishes, so do the stress reactions and the defences needed to cope with them. Recapitulation of the trauma may allow an ever more realistic appreciation of it. Finally, the bereaved comes to terms with the ultimate inevitability and helplessness in the face of death, while simultaneously being aware of the potentials and power of life.

The relationship to the dead changes. Despair changes to sorrow, then nostalgia. The dead person's ideal image as well as anger- and guilt-provoking image fuse into memories of reality involving the totality of the person's life and death. These memories enhance enrichment of the personality at the same time as emotional separation from the departed continues. This enables the now more mature bereaved to redirect his life.

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This ideal grieving, however, is probably very rare.

Social Aspects: A redefining of roles occurs. There is a rise in status of the bereaved. Functions and responsibilities are redistributed in the family. Realignment of attachments, including possibly to someone outside the family, occurs. New challenges have to be met, e.g. the children's resentment of a new step-parent.

Defences and Treatment: Where resolution does not occur, there will be a fixation in the intermediate phase of the mourning process, and attention must be given to this problem.

Factors Aggravating the Mourning Process

Factors which make the death particularly shattering and overwhelming will make reconstitution more difficult. The bereaved's perception of himself as vulnerable and in constant danger may dominate the picture for long periods of time, as in post-traumatic neuroses. Then the mourning process cannot proceed.

The most potent factor is multiple bereavement, as may happen in an accident. Sequential bereavement, or bereavement coupled with personal injury or loss of home and property follow in virulence.

Seeing a relative disfigured or mutilated adds to the trauma of his death. The suddenness of the death may give little time for prior preparation and also augments the trauma.

Some circumstances which perpetuate aspects of the mourning process make grieving more difficult. For example, death of the loved one by suicide or self-inflicted through carelessness etc. evokes rage and guilt which may be relatively difficult to assimilate. At times real guilt, e.g. death of relative through one's own careless driving, makes mourning more complicated. Where a death is particularly senseless and tragic, e.g. through murder or in war, rage and inability to assimilate the added senselessness of the death make grief difficult.

The lack of a corpse and funeral, as in wartime or death at sea, enhances denial and fantasies of reunion, which may interrupt the mourning process. Past incompleted grieving, inability to grieve fully because of being alone or in danger, or not having the personality or culture to enable one to express emotions are further inhibiting factors in the mourning process.

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Relationship of the Dead and the Bereaved

The more immature and the more dependent on the deceased the bereaved is, the more traumatic will be the loss. Thus a child-like widow or an old and sick dependent spouse will take bereavement of the caretaking spouse particularly badly.

A very vulnerable group are children themselves. They are truly dependent on adults for nurturing and for interpretation of the world of living and dying. Adults may feel loath to communicate to children at these times. Because the trauma of a dead parent or sibling is especially great for a child and the child's means of coping are not well developed, primitive defences may be used extensively by the child, giving the false impression that he is coping 'well'. Only in his actions and play may the true nature of affairs be seen.

Children bereaved at an early age may carry vulnerabilities for life, as seen by their propensity to psychological disturbances, e.g. depression and anxiety, later in life. Multiple losses and inability to grieve may lead to 'detachment', with consequent lasting inability to form close relationships and a tendency to antisocial personalities.

On the other hand, children with protective parents may take the death of grandparents relatively well, feeling the security of their parents close by. Similarly, supportive adults taking cognisance of a child's needs, can help the child through a parental bereavement with relatively little scarring.

The death of a child is particularly traumatic, partly because of the unpreparedness and untimeliness of such an event. For the parent the death of a child means an end to his illusion of immortality through the child. The identification with the child is strong, and the loss therefore great. Finally, the helplessness of man is reflected in the helplessness of a child. Each of us has a child in him whose helplessness we try to cover up. A child's death rips away the shield over our core vulnerability. It seems especially hard to assimilate that a helpless child should be smitten.

In summary, dying and bereavement are like birth, with natural phases which if not traversed appropriately lead to severe somatic, psychic and social wrenching and suffering. The analogy to birth is not fortuitous. Birth is the first loss of security in a chain of many subsequent such losses. Each of these losses has its pain and its challenges. Each challenge met increases our maturity and ability to live more fully through the cycle of our lives. □

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