

GRIEF, TRAUMATIC LOSS AND DEPRESSION

Talk to Victorian Branch RANZCP 11TH JUNE 2003

Thank you for inviting me to talk about grief, traumatic loss and depression. As so often happens, after a topic is decided, one thinks of a better one. So I would like to add two word to the beginning “Loss and”, to read “Loss and Grief, Traumatic Loss and Depression”. That will give you a better taste for what is to come.

Depression is perhaps the most common diagnosis in psychiatry. It is the most bandied about word in the community, relating to mental illness. With so many experts, starting with Jeff Kennett, having so much to say about it, I thought I may have been invited to speak from the point of view of my age, having spanned a career living with depression (other people’s I mean). However, what I will contribute that may be special is a view of depression from the perspective of traumatology. This will tie together loss, grief, traumatic loss and depression.

Road map for this talk

I will describe briefly the developing thoughts on depression to which I was exposed over the years.

I will note the emergence of loss, grief and trauma as relevant to the loss-depression process.

Next, I will attempt to make sense of how loss, grief, trauma and depression hang together and the dynamics involved. I will suggest that grief is the most adaptive response to loss, while depression occurs when grief does not occur, often in traumatic loss situations.

Some have said that depression is a hodge podge of symptoms and consists of a number of disorders. Thus it includes a depressed mood, but also irritability; apathy but also agitation; lack of sleep and appetite or hypersomnia and overeating, and so on. I hope to show that the variety of symptoms make sense by considering that a number of strategies of survival are evoked alongside the grief-loss process.

Finally, I will consider defences against grief and depression, and treatment of grief and depression. I hope to facilitate that through 3 clinical cases. The first will illustrate the nature of normal grief response, the second will demonstrate the evolution of depression, and the third is one of severe traumatic loss and depression.

Early history

My first introduction to depression was as a medical student, when in one of three lectures that comprised my undergraduate psychiatric training, Dr John Cade in Royal Park wheeled out a psychotically depressed lady. Sunken in despair, she was wringing her hands, and bemoaning how she had destroyed her family, and everything else, leaving the universe empty. This adds other features of depression – it may be mood congruent, or psychotic.

During my postgraduate psychiatric training in a Maudsley associated hospital in London, full of what we would call now seriously mentally ill patients, there was much excitement at the recently discovered antidepressants, like Tryptanol and Tofranil, which cured depression within three weeks.

Antidepressant cures gave a fillip to the ‘organic psychiatrists’, who said that obviously depression was a biochemical illness, no doubt with a genetic basis. We were able to tell our patients, “You have an illness like any other illness, like pneumonia or diabetes, and here is the chemical cure for it. No need to ask why you have it, it is probably something in your genes.”

By the way, the same was said of schizophrenia, based on recently discovered Largactil and Stelazine. Facetiously, I suggested that we could save ourselves much trouble if we routinely put all patients on antidepressants and antipsychotics, and released them automatically after three weeks. My comment was not appreciated. A third of a century later, as I was leaving public hospital work, I thought of saying it again. Lower paid CAT team members could administer these drugs routinely to seriously mentally ill patients. Think of the money that could save.

In those early days, much clinical debate revolved around distinguishing subtypes of depression – melancholia, agitated depression, psychotic depression, psycho-affective depression. In a way, it did not matter, as they were all considered endogenous depressions, relieved by antidepressants.

A part of me is nostalgic for the times when things seemed to be so simple. You have your diagnosis, your drug, and your cure. But I became sceptical of this simplicity, even with regard to antidepressants. Over the years I witnessed enthusiastic waves of ever newer antidepressants. It always turned out that the old guard were not as efficient and had more side-effects than the latest crop.

And then, these drugs were only say, 10-20% more efficient than placebos, which were effective in 60% of cases. I always thought that placebos should be investigated much more than drugs. Lastly, I found that many patients stopped taking antidepressants, because they felt that the drugs suppressed their emotions, and they felt like zombies. They seemed to crave to explore their feelings, even if they were painful.

Opposing the biochemical view of mental illness were the psychodynamic psychiatrists. They were given the domain of what was called neurotic depression, characterised by a depressed mood as against depression itself, copious crying, and awareness of the preceding loss. To me, and many others, the borderland between neurotic and endogenous depression was fluid.

I wondered to what extent the placebo had to do with talking to patients and giving them hope. At the time, in the Menninger Clinic in America, they treated severely depressed people without drugs. Through concentrated attention, encouragement, and fostering hope, depressions melted, and people started to deal with their life problems. I will return to depressions melting under one's eyes later.

Middle history

Over the decades, three new areas developed.

First, in the stress field, research such by Thurlow and Holmes and Rahe, indicated that the more stress people suffered, the more biological, psychological and social illnesses they were likely to incur. Certain stresses seemed to predispose to specific illnesses. For instance workers such as Paykel, found that losses, most of all loss of a spouse, predisposed to depression. Reciprocally, depressed people had suffered preceding losses. Depressed widows and widowers suffered increased rates of infections autoimmune diseases, and cancers, presumed to be due to high cortisone and suppressed immune levels accompanying depression.

Second, through workers such as Colin Murray Parkes, and our own Beverley Raphael, grief became clinically recognized. Its normal manifestations such as sadness, grief, pains in the heart, and phases of searching, bargaining and eventual acceptance, were described. Abnormal grief reactions, such as inhibited, chronic and distorted grief were seen clinically relevant, especially because of their associate with depression.

On this basis, in order to pre-empt depression and other chronic stress effects, following the Granville rail disaster, Raphael and her team treated relatives of the deceased at the morgue, and follow-up indicated some success of this intervention.

Out of the Granville experience grew the national Association for Loss and Grief, whose aim to the present day is to promote normal grief, and to avoid depression.

Third, traumatology emerged as a discipline, and PTSD as a disorder. Though depression is the most common disorder resulting from traumatic situations, and it is the most common comorbid diagnosis of PTSD, PTSD and depression have been seen as parallel, unconnected disorders. This is because of the pigeon hole, anti-dynamic bias of DSM in psychiatry.

An exception was Raphael, who noted that PTSD had to be treated before depression. For instance, a person still reliving a car crash, and terrified of its recurrence, is not ready to go through the grieving process for losses resulting from the accident.

Summarising so far, it seems to me that official DSM psychiatry with its emphasis on not looking for causes, has shut out loss and grief from its nosology. By implication, it has emphasised the old endogenous depression, and diminished neurotic depression to non-prestigious dysthymia and adjustment disorder with depressed mood.

Yet in clinical practice, loss, grief, traumatic loss and depression are commonly recognized.

Making sense of loss, grief, trauma and depression

I have been privileged to work concurrently in three settings. First, the emergency department of major hospitals, second acute traumatic situations such as bushfires, or the San Francisco earthquake, and third, private practice. On an ordinary day, I might

see loss and depression in its acute stages in the morning, and in its entrenched forms in the afternoon.

I would like to give one clinical example from each situation, and with increasing pathology. I will highlight what to my mind are 8 tasks that need to be addressed, before normal grief can proceed. These eight tasks belong to eight strategies of survival, whose details are in the table that was handed to you, **AND THE FIRST TWO COLUMNS OF THE TABLE ARE HERE IN THE OVERHEAD**. I do not have time tonight to go through the detailed manifestations of each survival strategy, but I will indicate how they interweave with normal, stressed, and traumatic grief and depression.

The first case is acute loss in the emergency department. The second is one of depression in a bushfire. The third is depression in a sexually abused woman who has been diagnosed as borderline. **Remove overhead.**

32 year old woman whose husband died in the emergency department

Caroline was a 32 y.o. mother of two small children, whose husband collapsed that morning. He was dead on arrival in the emergency department, though some attempts were made to revive him.

Caroline was shocked and confused, and grateful to be able to talk to someone in a private room in the emergency department.

She was bursting to tell her story. She said that she saw her husband Garry collapse suddenly that morning while he was dressing their two year old. He had been quite well that morning though a few

days previously he had been short of breath. He had suffered cardiac myopathy and arrhythmias over the last two years.

Caroline rushed to him, and applied all the correct resuscitative techniques that she had learned. Within three minutes, too, a doctor neighbour took over.

Caroline was anguished about whether she could have done anything to save her husband. She worried that the just past due date milk she gave him might have made him ill. We reviewed all the medical evidence and I said, “You naturally feel you should have been able to save him, and stop his suffering, but you did all you could and he did not suffer.”

She next wailed for him and in agitated state seemed to search for him. “I cannot live without his care for me”, she said. “Why did you leave me!” she accused. She described a severe painful pull in her chest that was explained as yearning. Her parents hugged her, and promised to stand by her. She settled down.

Caroline’s mood changed to anger. She blamed her husband for not having taken enough care of himself, being a workaholic, not caring for her. Enraged, she said, “I could have killed him, the way he carried on.” “You could kill the part of your husband that killed himself.”

Caroline next wondered whether the illness was contagious. She worried whether her children and she herself would die from her husband’s illness. Her husband now loomed as dangerous. She was reassured that they were all safe.

Next she considered why her husband had died and not her. It was not fair, she considered, that he, such a good and caring man, should go ahead of her. After a while she was resentful of him taking the easy way, leaving her to deal with the mess. I said, “His life and death is not a race. Neither of you had the power to decide who would die first.”

She became bitter at the wrecked dreams of marriage. “We had plans to have another child, to together see our children through school, see them married, be grandparents. What will become of me now? “It’s like your path has suddenly become blocked”, I said.

“I feel cheated. I’ve done everything right, I did not deserve this.”
“You feel cheated.” “Yes, by him, fate”.

Caroline then sobbed bitterly clutching at her heart, saying that it felt like it had been wrenched, wounded, was bleeding, and painful like the worst pain you could have. After some minutes she said, “I cannot believe it. It’s too much. I’ll cry forever. I seem to forget every now and then that it happened.” “Nature gives you relief between pangs of grief, lets you get on with life. The pangs do not go on forever.”

Between further waves of grief, Caroline started to make decisions – about what she would say to her children, allowing the children to see the body, and she made sure that whichever of her husband’s organs could be, would be harvested for transplants. She started making plans for the funeral.

Comment

OVERHEAD, REFER TO FIRST TWO COLUMNS IN TABLE Note that the survival strategies are laid out in different order in the table.

At the time of crisis or impact phase, Caroline tried to utilise every means of survival before she accepted her loss (see overhead). She tried to rescue her husband, she sought help from others, she made sure there was no further danger, flew to the sanctuary of the hospital, gave her husband total precedence, and cooperated with doctors. This was no time for grief yet, as she was still trying to salvage her husband.

In the post-impact phase, Caroline had to review, judge and make sense of her actions in the impact phase, and bridge them to the present and future. She could not start the grieving process, until she had this overview.

She had to be certain that she had done all that she could to save Garry; that she would survive without him, though she had depended on him for so much; she had to express her rage for him for having killed himself; she had to reassure herself that she and her children were safe from the cause of death; reassure herself that she had not won a contest as to who would have to die first; that she felt cheated and betrayed, punished even though she had done no wrong; come to grips with the fact that life had changed, her goals had been diverted; and that to let herself grieve was safe and helpful.

She was able to understand and let go her unsuccessful potentially maladaptive responses (see right side of table). In unresolved grief the maladaptive symptoms may persist, e.g., yearning, searching, anger with the dead, guilt for not having done enough, etc.

Grief allowed her, even so early, to start adapting to her new life and role. For instance, she asserted herself as widow (harvesting the organs, arranging funeral) and sole parent (taking charge of her children). Even though the loss was immense, and Caroline suffered acutely, she was undergoing normal, helpful grief.

A 70 year old bushfire survivor

Joseph was a 70 year old man whom we saw in a routine outreach situation. His house was surrounded by burnt down houses. He welcomed us, and told us how lucky he was to have only a singed hedge, while others around him lost their houses and belongings.

He told us that he felt well, counting his blessings.

During a visit a month later, he was totally different, suffering significant depression. His face looked depressed, his voice was monotonal and soft, he seemed tired and said he had no energy, no interest, enthusiasm, he could not sleep in spite of his tiredness. He withdrew from others. He had no idea why he felt depressed like this. Oh, yes, he still considered himself very lucky, but he said this without any conviction. All the curtains were drawn, though it was the middle of the day.

“Why are your curtains drawn?” we asked.

He looked more withdrawn. “Doesn’t matter.”

“What doesn’t matter?”

“Better not to talk about it.”

”Better not to talk about what?”

“No, I am lucky. Shouldn’t complain.”

“Maybe you should”, we gave him permission.

“Well, they all tell me how lucky I am. But all these others, whose houses burnt, will rebuild and have nicer houses, and see the trees grow again. I know

because I have been through a bushfire before. But this time I am too old for that. I'll just see this moonscape outside my windows till I die."

His face took on life. He told us about the fires, how he thought he would die, and that his fighting them with his meagre resources would not succeed. He did not know why his house survived and the others' did not. It did not seem fair. He felt guilty about that, and wondered whether he should have fought the fire at his neighbour's place rather than his own. He wished his own house had burnt, not the others'; with young children, what would they do? He was now all alone in this wasteland; he would rather be in the caravan park with the others. He also felt let down that none of his neighbours came to help him. Then he cried for his lost past, lost neighbours, lost forest, that could never be rebuilt. His depression was replaced by grief.

As with Caroline, we acknowledged each pain and suggested alternatives. Surely he was not wrong to fight for his own life first. It was not his fault that the other houses burnt. He had done a good job, actually, and when he could, he did help others. Now he could be a base for those around him who will rebuild. His experience from previous bushfires would be valuable, and he could be a model of survival. And look, the forest, and his garden were already regenerating, and he smiled.

Comment

This man could not grieve because he was denied validity of his grief by others (he was lucky), and he experienced his loss as traumatic, i.e. irretrievably damaging. He used denial and dissociation in order to not succumb.

Once (a) allowed to express himself, and (b) given hope that his life still had meaning, he could do the necessary processing of his till then frozen unsuccessful

strategies and their feelings, just like Caroline had. The result was that he could start his grieving process and adjustment to new circumstances.

Here was an example of severe depression changing to grief under one's eyes. It has become a daily experience for me in all three settings of my work.

A sexually abused depressed suicidal young woman

Cheryl was a 35 yo married woman with two children, referred to me after having taken an overdose. She said that life was not worth living.

I asked her what was the worst of it, and she thought and said, "It's the oppression, stretching to eternity. Depression is secondary." She described a violent paranoid husband who controlled her every movement, and that of her children.

She could not leave him, because he threatened that he would kill them. A couple of times she had fled to protect her children, and to her surprise he was contrite, and she returned. Actually she was overcome with anxiety on her own and she could not live without her husband.

Her relationship with her husband was a repeat of the one with her father who had sexually abused her. She had fantasies of killing her father, and when he suddenly died, she thought it was her fault. She had similar fantasies about her husband and she was terrified that he would suddenly die too.

She was stuck in this situation, she felt hopeless and despairing. Prior psychiatric help made her despair more. They diagnosed her as borderline personality, apparently a hopeless case.

This time Cheryl quickly developed hope that treatment with me could help her. She moved into a refuge, and this time fought through her attachment cravings. She became independent, assertive, capable mother. She came to see herself as innocent and lovable. She started to grieve the love she had missed out on, and the years she had lost.

Comment

For Cheryl grieving was not an option as she was threatened with death if she did not perform, she suffered complex PTSD (all the traumatic states in the far right column), and her traumas were still continuing.

She suffered not only depression, but also traumas pertaining to all failed survival strategies, and their associated maladaptive responses. Their unmodulated appearances warranted her diagnosis of borderline personality disorder.

Once given security and hope, Cheryl was able to start processing and understanding her responses. Her traumatic states resolved and with increasing coherence and awareness, she started her grieving process. Because of the extent of her traumas, she had a lot to grieve at deep levels. Nevertheless, she completed the same tasks as Caroline and Joseph, and she could organise her traumatic life and losses into memory.

Summary, Conclusion and Final Comments

The position I have taken here is that loss is adjusted to by grief. When awareness of loss seems dangerous, whether because it is surrounded by too much trauma, or

because it brings on the displeasure of those on whom one depends, grief is suppressed and depression may occur.

The apparent hodge podge nature of depression may be explained by the intrusion of extant survival strategies still trying to undo the loss. For instance, guilt for the lost person is a way of still failing to rescue him or her. Attachment remnants may be seen as protests for being abandoned, yearning, searching, and still trying to induce the person to return. Agitation in depression may symbolise searching, or attempts to flee, while anxiety in depression may be part of fear of abandonment, or fear of the source of death striking again.

We may conjecture that under ideal conditions, such as with Caroline, loss is followed by grief, and maladaptive symptoms on the right side of the table are present only transiently. Under less ideal circumstances, as with Joseph, the bulk of symptoms are in the right side maladaptive section, either overtly, or frozen. In more traumatic circumstances as with Cheryl, traumatic responses in the last column on the right are present in addition to the others on the right side of the table.

To finish this talk, I will apply this framework to the pits of psychotic depression.

Then I will apply it to defences, and treatment. I will finish on a poignant, hopeful note, so do not get too despondent.

Psychotic depression

Scanning the strategies of survival, we note unmovable convictions that one wilfully caused the death of the lost person; the dead person wilfully abandoned oneself to die and one is alone in the universe; that one murdered the dead person, and destroyed the

whole world; that the instrument of death is actively persecuting one, and one may die at any moment; that one is alive at the expense of all other people's deaths; that the world is stagnant, decaying; that there is only death, decay, and destruction in the future for oneself and the world; and oneself is rotting, decaying flesh, and is infecting the universe.

Defences

Defences may mitigate traumatic loss, and prevent awareness of existential meaninglessness, thereby avoiding suicide, they do so at the cost of symptoms.

Defences of denial, dissociation, repression and hypomania prevent awareness of the loss. An example of dissociation is a teenager who saw his family murdered. He said that he could not cry, but all the tears froze in his chest. He carried on not thinking about his tragedy, but felt as if he carried Antarctica in his chest.

In a similar sense, depression, with its unawareness, may be a buffer between traumatic loss and giving in.

Other defences may be specific to other survival strategies. Taking on a helping role, helping profession, constant martyrdom may defend against guilt of causing death; seeking death and union with the deceased, or alternately finding a quick substitute may defend against abandonment feelings; aggression, antisocial behaviour, delinquency, and turning aggression on oneself may defend against powerlessness and sense of having been betrayed; withdrawal, phobias, alcohol and drugs may defend against fear and helplessness; struggle against those who put you down, oppress, humiliate defends against being pushed out; promiscuity may defend against

disconnection; immersion in other goals, especially overwork may defend against life being meaningless.

Principles of Treatment

- A. Facilitate circumstances that promote hope and normal grief.
- B. Diagnose and look beyond defences
- C. Be sensitive to which survival strategy is being presented at any moment.
Facilitate substitution of adaptive alternatives for stressed and traumatised life strategies.
- D. Remember that you are a source of hope, and each movement will be tested on you.
- E. Remember a biopsychosocial outlook that may include drugs, and do not forget comorbid illnesses, ranging from common colds, through autoimmune diseases, to cancer.

Philosophical conundrum

Pain of loss is one of the worst pains humans have to suffer, and depression is like an epidemic in civilized countries. Yet I would like to conclude this talk with a hopeful speculation.

It starts with a question, “What is the use of grief? What is the point of crying over spilt milk?” One can see the use of fighting or fleeing, or clinging to someone, but what is the use of weeping? Tears are only symbolic of something.

It may be that grief is a recently evolved survival strategy associated with another recently evolved feature, namely love. The cost of love is grief. Yet grief, through simultaneous intense concentration on past and present, and use of symbols (another recent development), bridges both worlds. If you want to consider the conjunction of loss, love and symbols, consider the amount of literature, poetry and songs that are about the grief of lost love. Grief allows the old love to live and have an organic life in the new world. It remains in one's story and gives its share to the total meaning of life. Grief allows making the best of the lost and the new worlds.

In conclusion, we may see that loss, grief, traumatic loss and depression are fairly complex concepts, but one can make sense of them through, let us call it, a traumato-dynamic view.

SCANNING STRATEGIES OF SURVIVAL

1. MUST SAVE OTHERS	RESCUE
2. MUST BE SAVED	ATTACHMENT
3. MUST REMOVE DANGER	FIGHT
4. MUST FLEE DANGER	FLIGHT
5. MUST STRUGGLE	COMPETITION
6. MUST COOPERATE	COOPERATION
7. MUST ACHIEVE GOALS	ASSERTIVENESS
8. MUST SURRENDER GOALS	ADAPTATION

