

Initial
Event:
Loss of a
loved one.



Acute Stress Response

Increased blood flow to brain;
Increased production of
catecholamines (epinephrine,
norepinephrine, dopamine)
which help to facilitate cognitive
performance

Pupils dilate/Peripheral vision is reduced

Heart rate increases

Faster, deeper breathing

Increased blood flow to large muscle groups

Adrenal hormones (cortisol and DHEA) released, resulting in increased energy mobilization

Digestion slows dramatically

Blood pressure increases

Reactions

- Increased alertness
- Increased short term strength
- Increased ability to handle stress
 - Heightened ability to focus
- Increased oxygen to the brain
 - Faster, deeper breathing
- Heightened sense of smell
- Body and mind are hyper-alert

Other Responses

- Perspiration increases to cool body
- Muscle tension increases to prepare for "fight or flight"
 - Saliva production decreases
- Metabolism speeds up considerably
 - Inflammation increases
- Blood flow from skin surface is diverted to larger muscle groups & brain
 - Body extremities can change temperature
 - Blood pressure increases

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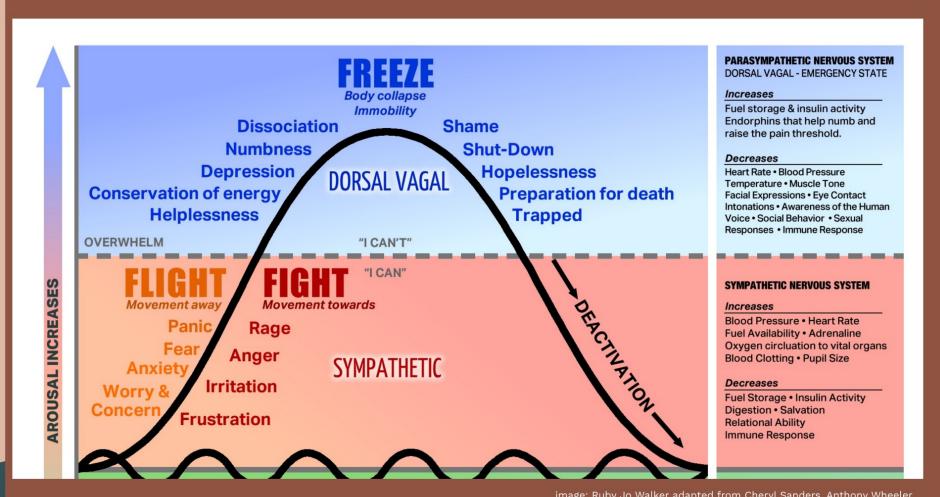
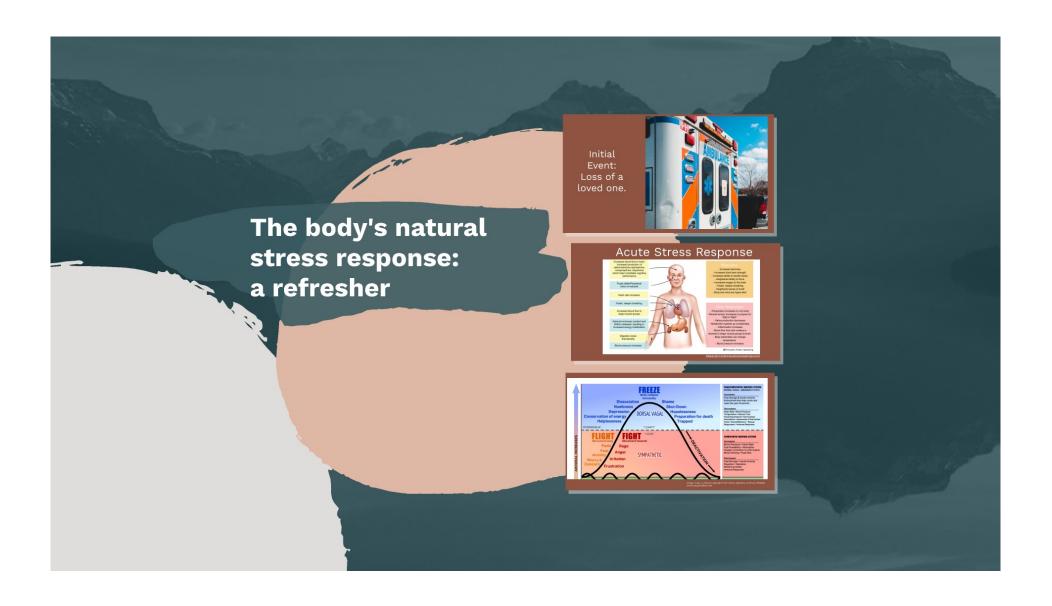
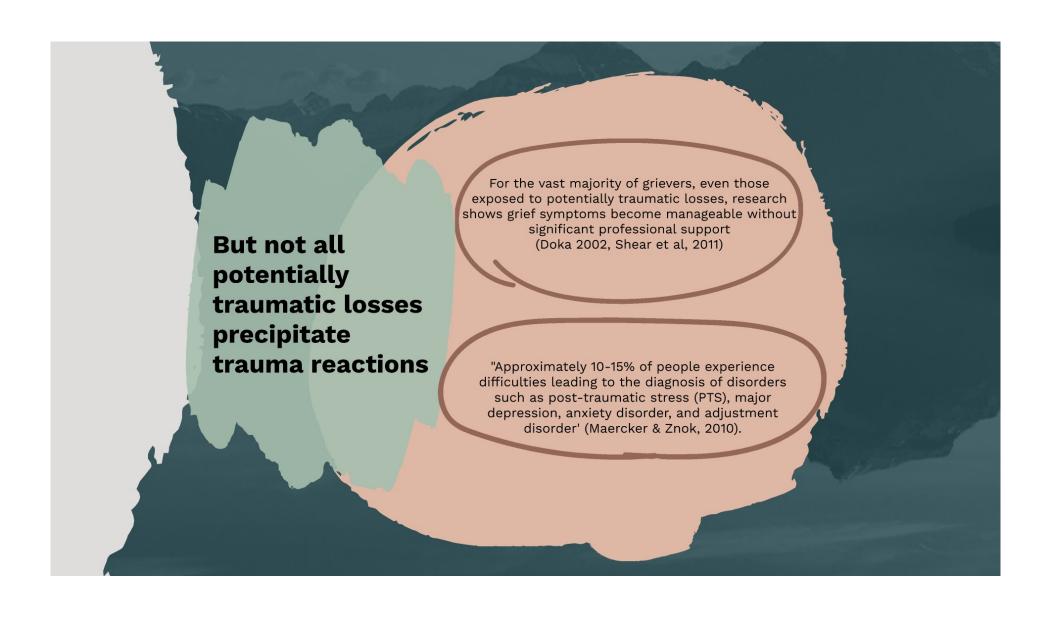


image: Ruby Jo Walker adapted from Cheryl Sanders, Anthony Wheeler www.rubyjowalker.com

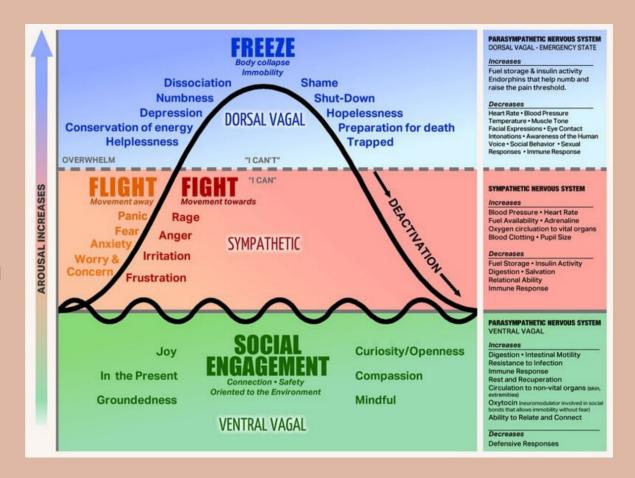




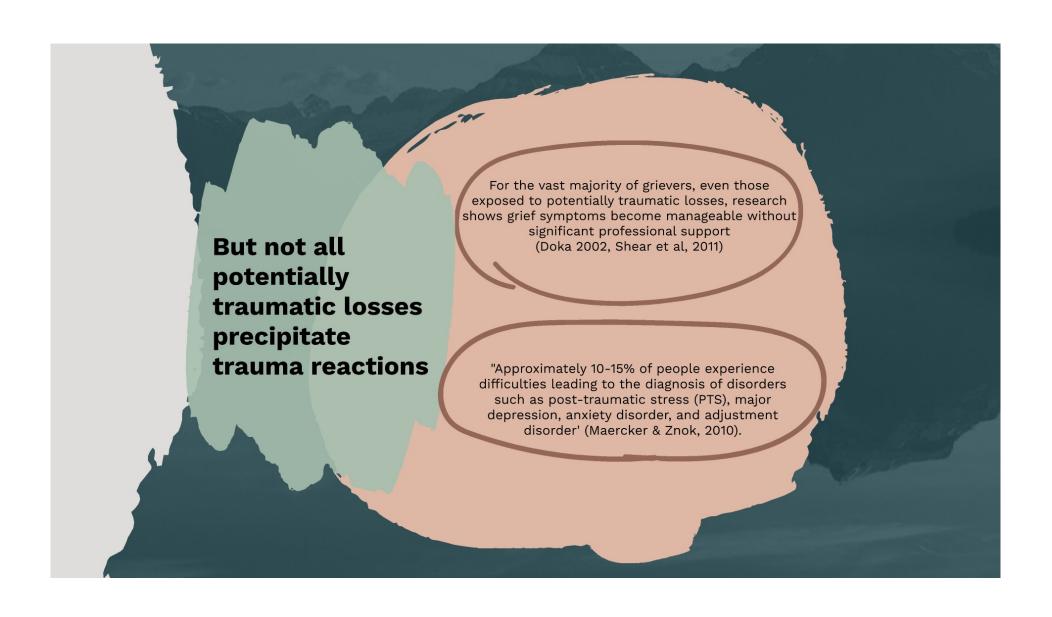
For the vast majority of grievers, even those exposed to potentially traumatic losses, research shows grief symptoms become manageable without significant professional support (Doka 2002, Shear et al, 2011)

For the majority of people, even those who experience potentially traumatic losses, acute stress subsides.

Their grief is intense and devastating, but that is the natural response to loss, and their sense of orientation to the environment, safety, ability to be "in the present" is generally restored.



"Approximately 10-15% of people experience difficulties leading to the diagnosis of disorders such as post-traumatic stress (PTS), major depression, anxiety disorder, and adjustment disorder' (Maercker & Znok, 2010).



Acute Stress Disorder (3 days - 1 month after the event)

Table 1.

DSM-5 Criteria for Acute Stress Disordera

Intrusions

- Recurrent and intrusive distressing trauma memories
- Recurrent distressing trauma-related dreams
- Flashback or other dissociative reactions as if the traumatic event was recurring
- Intense or prolonged psychological distress or physiological reactions triggered by trauma reminders

Negative mood

Persistent loss of positive emotions

Dissociative symptoms

- Altered sense of reality of surroundings or oneself
- Inability to remember important trauma details (not due to other causes)

Avoidance

- Avoidance of trauma-related memories, thoughts, or feelings
- Avoidance of trauma-related external reminders (eg, people, places, activities)

Arousal

- Sleep disturbance
- Unprovoked irritable behavior and outbursts of anger (eg, verbal or physical aggression)
- Hypervigilance
- Concentration deficits
- Exaggerated startle

Adapted from the Diagnostic and Statistical Manual of Mental Disorders, fifth edition.⁷

"A diagnosis of acute stress disorder requires the development or worsening of 9 or more of the 14 symptoms summarized here, occurring between 3 and 30 days after exposure to a traumatic stressor.

Acute stress disorder (ASD) was introduced in DSM-IV to describe posttraumatic stress disorder (PTSD) symptoms that (a) occur in the initial month after trauma and (b) predict subsequent PTSD. Longitudinal studies have shown that most people who develop PTSD do not initially meet ASD criteria, which led to the decision in DSM-5 to limit the ASD diagnosis to describing acute stress reactions without any predictive function. Recent longitudinal studies have challenged previous conceptualizations of the course of posttraumatic stress, and highlighted that people follow different trajectories of adaptation that are also influenced by events that occur after the acute posttraumatic period. (Bryan, 2017)

PTSD

(symptoms lasting greater than one month and creating functional impairment)

Criterion A: stressor (one required)

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- · Direct exposure
- · Witnessing the trauma
- · Learning that a relative or close friend was exposed to a trauma
- · Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B: intrusion symptoms (one required)

The traumatic event is persistently re-experienced in the following way(s):

- Unwanted upsetting memories
- Nightmares
- Flashbacks
- · Emotional distress after exposure to traumatic reminders
- · Physical reactivity after exposure to traumatic reminders

Criterion C: avoidance (one required)

Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- · Trauma-related thoughts or feelings
- · Trauma-related external reminders

Criterion D: negative alterations in cognitions and mood (two required)

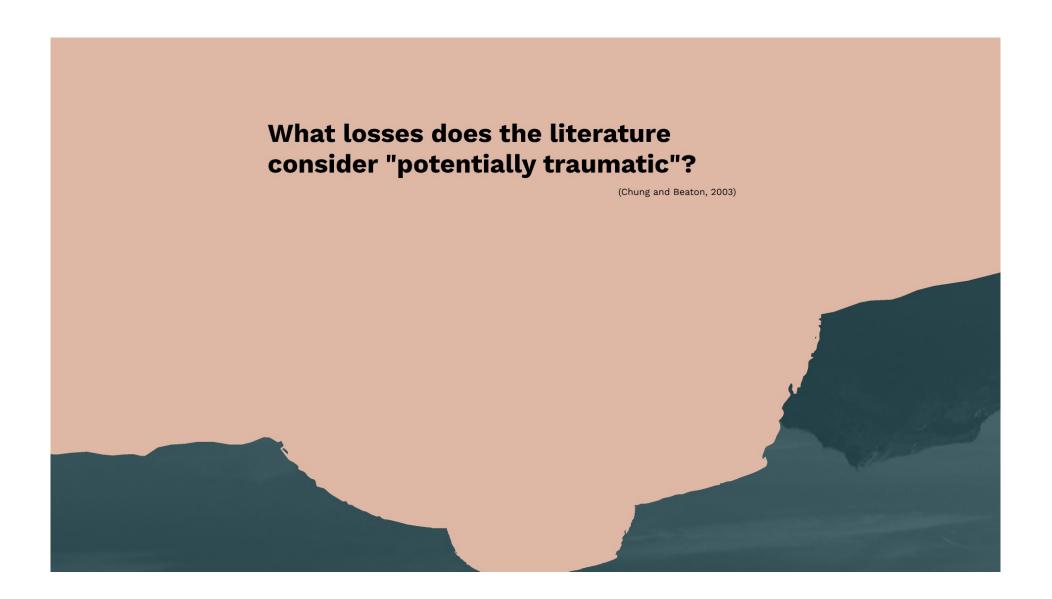
Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- · Overly negative thoughts and assumptions about oneself or the world
- · Exaggerated blame of self or others for causing the trauma
- Negative affect
- · Decreased interest in activities
- · Feeling isolated
- · Difficulty experiencing positive affect

Criterion E: alterations in arousal and reactivity

Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- · Irritability or aggression
- · Risky or destructive behavior
- Hypervigilance
- · Heightened startle reaction
- · Difficulty concentrating
- Difficulty sleeping



What losses does the literature consider "potentially traumatic"?

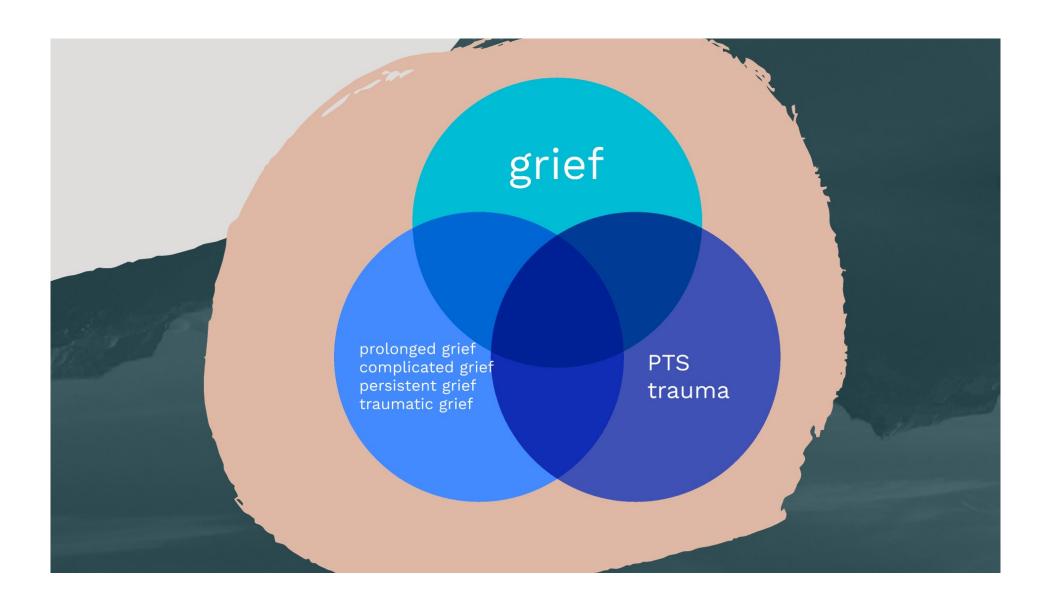
(Chung and Beaton, 2003)

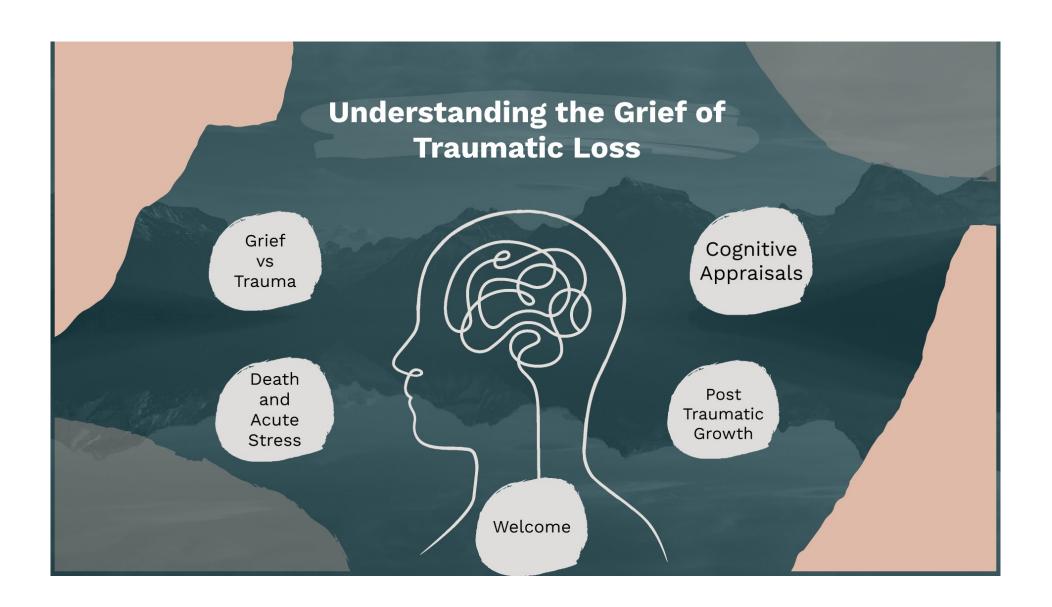
- occurs without warning
- violent
- perceived as preventable
- damage to the body
- a perpetrator with intent to harm
- perceived as unfair or unjust
- survivor's life was threatened.
- · survivor experienced multiple losses at once.

wait, there's more

(Chung and Beaton, 2003

- belief the loved one suffered.
- media attention
- difficult end of life decisions
- · lack of clear medical information.
- prolonged court proceedings
- lack of social support
- history of past trauma







A Brief History of Grief Theory

Lindemann Grief Work (1940s)

- 1. Emancipation from bondage to deceased
- 2. Readjustment to a new environment
- 3. Formation of new relationships

Five Stages of Grief (late 1960s)

- 1. Denial
- 2. Anger
- 3. Bargaining
- 4. Depression
- 5. Acceptance

Rando's 6 R's of Mourning (1980s)

- 1. Recognize the loss
- 2. React to the separation
- 3. Recollect and reexperience the deceased
- 4. Relinquish old attachment
- 5. Readjust to a new world
- 6. Reinvest emotion energy

Two-Track Model of Bereavement (1990s)

This theory suggests that the impact of loss is felt in two different domains: biopsychosocial functioning (so things like somatic concerns, anxiety or depression, relationships, self-esteem, etc) and also in the relationship with the person who died (so thinks like emotional closeness to that person, conflict, positive and negative perceptions with thinking of the person, or preoccupation with the death). This theory suggest that to assess and cope with grief, someone needs to attend to both of theses "tracks".

Freud (1920s)

To recover from grief you must express grief and detach emotionally from the deceased.

Bowlby Four Stages (early 1960s)

- 1. Shock & Numbness
- 2. Yearning & Searching
- 3. Despair & Disorganization
- 4. Reorganization & Recovery

Worden's Tasks of Mourning (1980s)

- 1. Accept the Reality of the Loss
- 2. Work Through the Pain of Grief
- 3. Adjust to an Environment in which the deceased is missing
- 4. Find an enduring connection with the deceased while embarking on a new life

Dual Process Model of Bereavement (1990s)

Oscillate between loss-related stressors and life-related stressors. Important to take a break from your grief

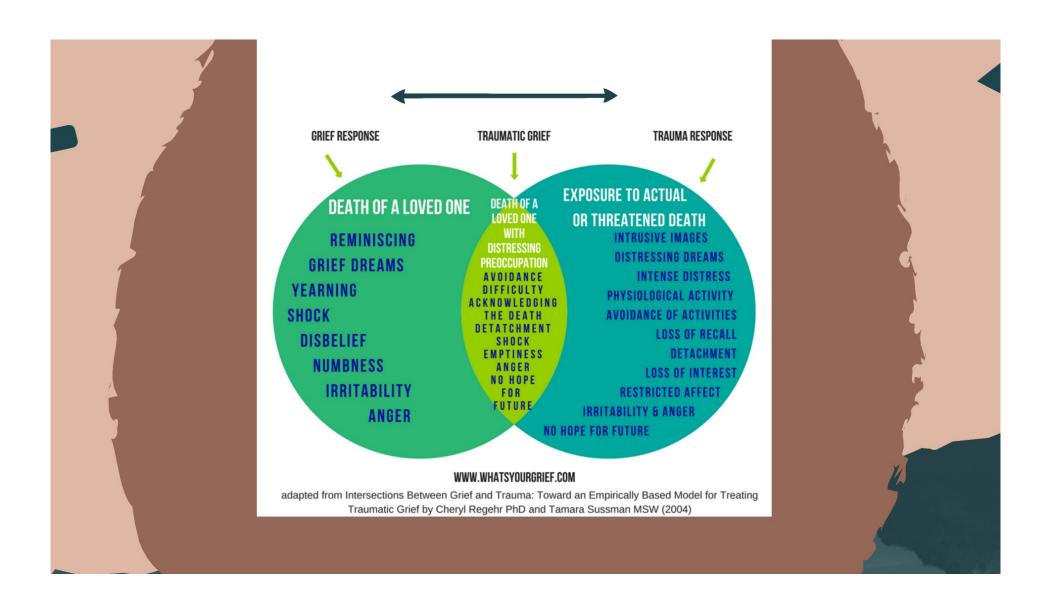
Continuing Bonds (1990s)

This theory upended the idea that grief was about "letting go" or "moving on" and says instead that people normally and naturally create continued connections with their loved ones who have died. These 'bonds' stick around forever.

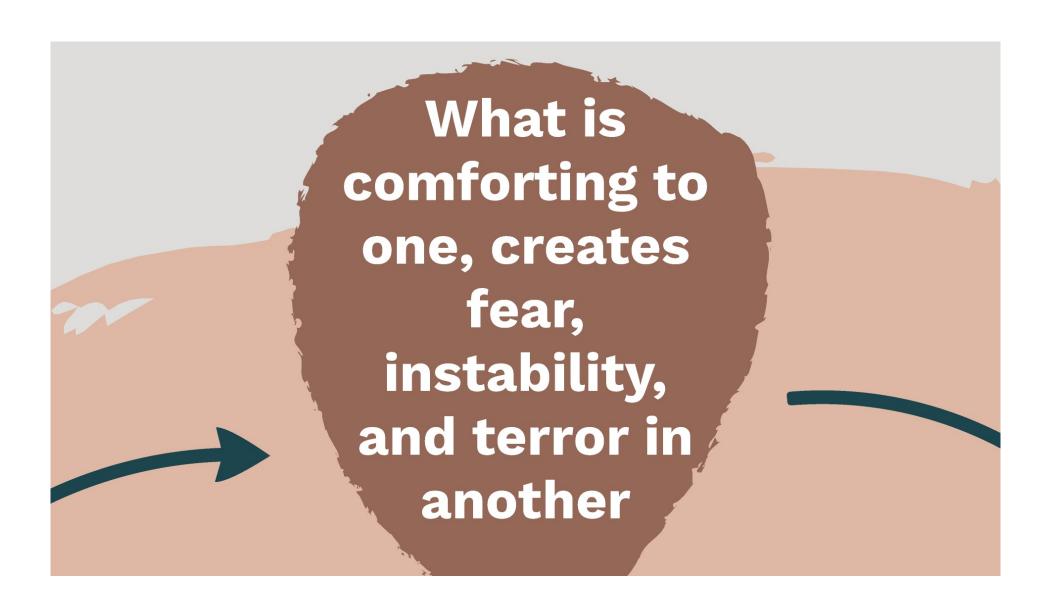
A few truths about grief

- Grief is the normal, natural reaction to loss
- It is not problem to be solved; it is our reaction to death and non-death losses.
- There are no predictable stages or phases
- Grief unique based on the person, their culture, social and religious norms, existing coping capacity, personality, and relationship with the person who died.
- Grief is an emotional, cognitive, behavioral, spiritual, and existential experience.
- We grieve in some form forever
- The loss remains with us, so our grief remains with us. We just learn to adapt, integrate, and carry it differently with time. Our grief holds pain and comfort.
- There are no universals, but there are common experiences.





Grief = Sadness	Trauma = Terror
Generalized reaction is SADNESS	Generalized reaction is TERROR
Grief reactions stand ALONE	Trauma reactions generally include grief reactions
Known to the public and professionals	Largely unknown (esp. in children)
Does not disfigure identity	Attacks and distorts identity
Guilt says, I wish I would have	Guilt says, It was my fault
Dreams of person who died, was hurt	Dreams of self dying, being hurt
Pain is related to the loss	Pain is related to tremendous terror and sense of powerlessness, fear and loss of safety
Anger is NOT destructive	Anger is assaultive (even if non-violent trauma)



Approaches of traditional grief counseling:

Narrative approaches: making sense of the loss and loss story

Continuing Bonds: creating an ongoing relationship with the deceased.

Restoration-oriented support: "to find an enduring connection with the deceased while embarking on a new life" (Worden, 2008)

Meaning Making: "making sense" of or coming to understand the situation in a different way, finding benefit or positives that. come from the situation, and changes in identity. (Gillies & Neimeyer, 2006; Janoff- Bulman, 1992; Park, 2008)

Coping vs Adapting

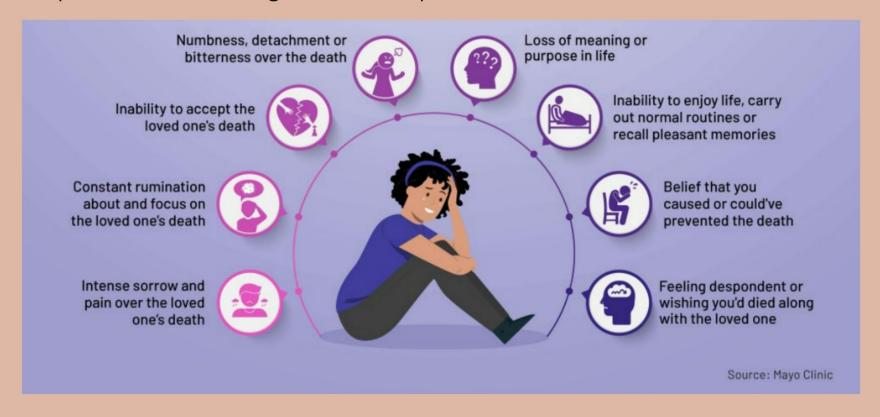
Coping

Reducing the immediate distress caused by the loss in various life dimensions.

Adapting

Integrating the loss in a way that allows one to move forward and live a life in accordance with their values.
(Shear, 2020)

A quick note on Prolonged Grief/Complicated Grief



ICD11: In 2018 the World Health Organization approved a new diagnosis of Prolonged Grief Disorder. Guidelines for this diagnosis include the occurrence of a "persistent and pervasive grief response characterized by longing for the deceased or persistent preoccupation with the deceased accompanied by intense emotional pain (e.g. sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self, an inability to experience positive mood, emotional numbness, difficulty in engaging with social or other activities)".

DSM 5: In 2021 the American Psychiatric Association approved a new diagnosis of Prolonged Grief Disorder to be added to the March 2022 edition of the DSM. DSM 5 PGD requires the occurrence of a persistent and pervasive grief response characterized by persistent longing or yearning and/or preoccupation with the deceased accompanied by at least 3 of 8 additional symptoms that include disbelief, intense emotional pain, feeling of identity confusion, avoidance of reminders of the loss, feelings of numbness, intense loneliness, meaninglessness or difficulty engaging in ongoing life. Must be at least 6 months after the death for children and 12 months for adults with symptoms persisting for at least one month.

Center for Prolonged Grief acronym (Shear, 2015)

D doubting oneself (self-blame)

E engrained misconceptions about grief

R ruminating about imagined alternatives ("if only")

A anger, anxiety, or bitterness that can't be resolved

I insistent belief that the death was unfair or unjust

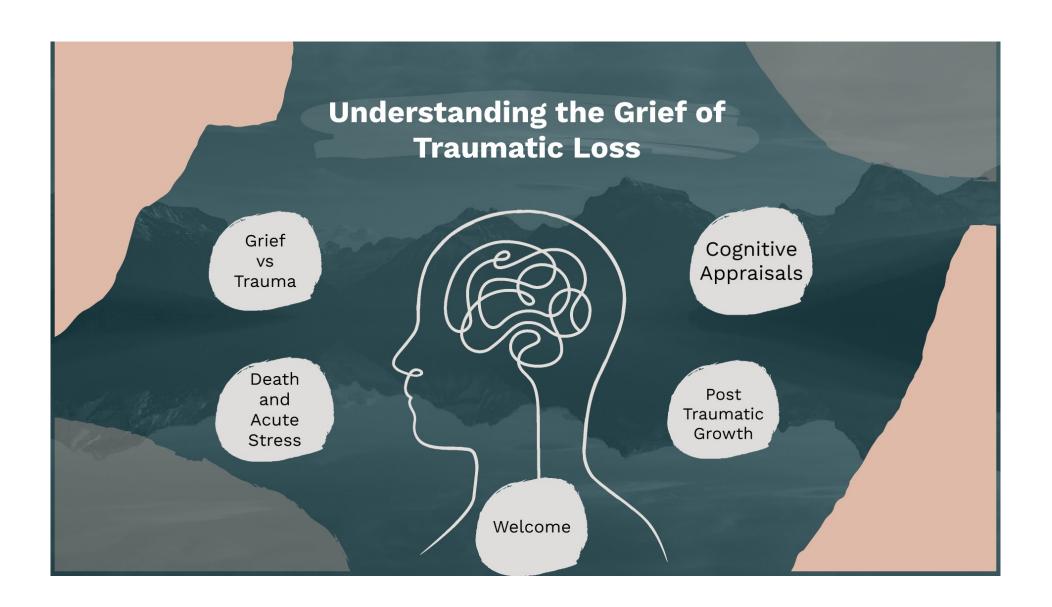
L lack of faith in one's ability to adapt or have a meaningful future.

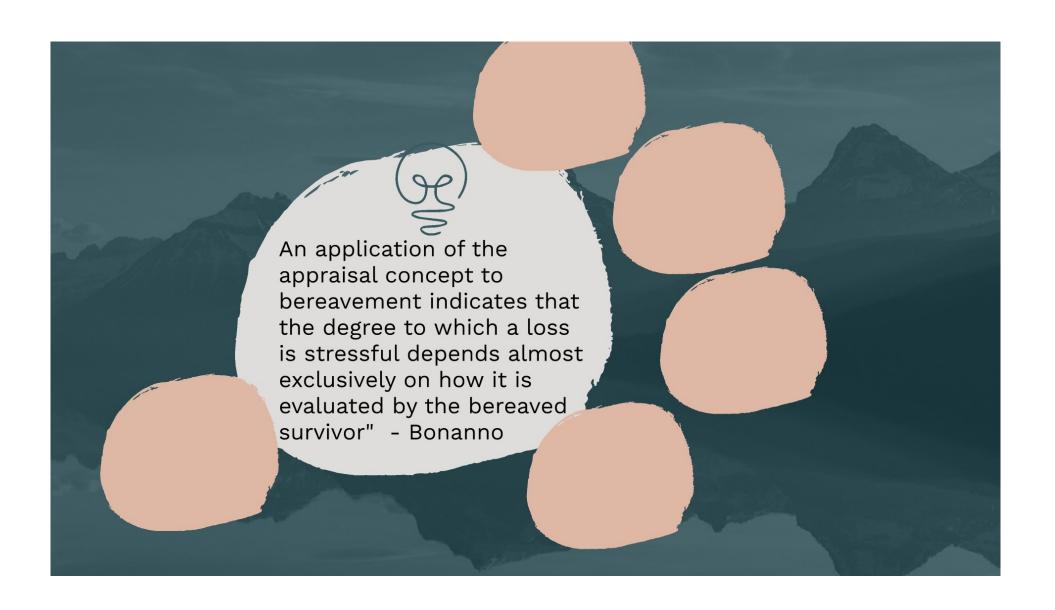
E excessive avoidance of reminders

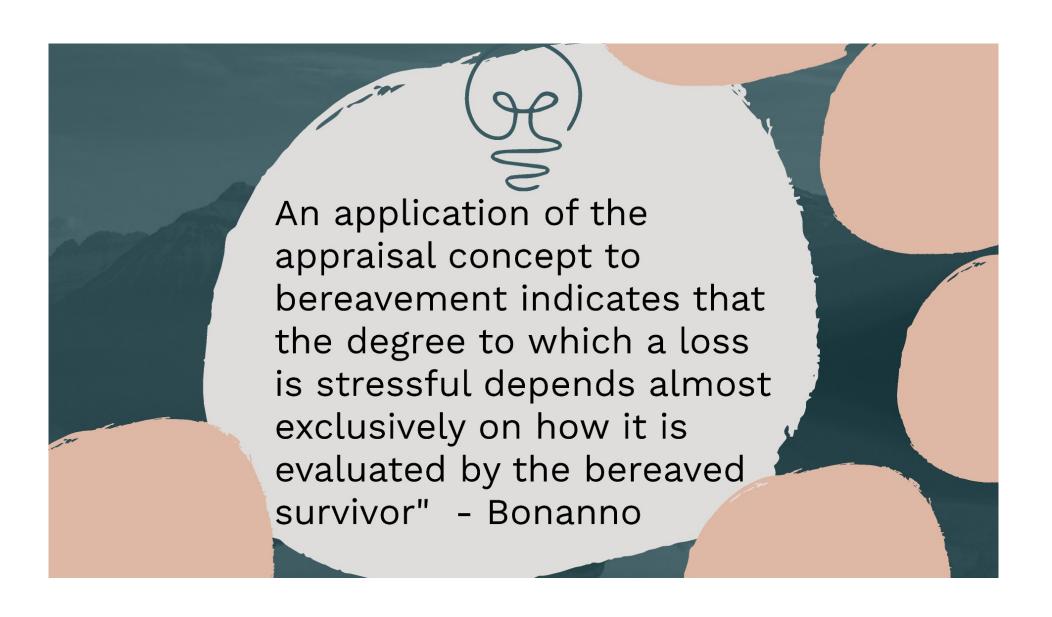
R rejecting support from others

S survivor guilt that prevents seeking joy and satisfaction

But WHY?











benevolence of the world

the world is generally a safe place where more good happens than bad

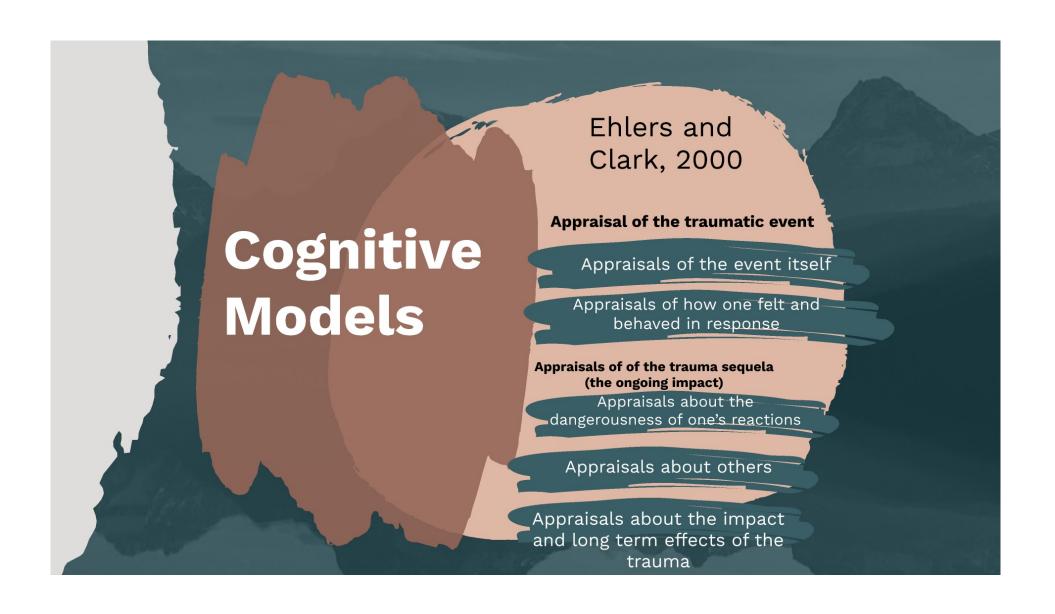
most people have good intentions and can be trusted

the self as worthy

I am a fortunate, lucky, worthy, decent, and capable person

meaningfulness of the world

the world is orderly, just, and logical





Appraisals of the event itself

Appraisals of how one felt and behaved in response

Appraisals of of the trauma sequela

Appraisals of of the trauma sequela (the ongoing impact)

Appraisals about the dangerousness of one's reactions

Appraisals about others

Appraisals about the impact and long term effects of the trauma





Some fail to find the answers they are looking for and continue to struggle with randomness of death

Boelen (2010): Study conducted with 409 bereaved people examining the effects of intolerance of uncertainty (IU)

- IU was a unique correlate with PTSD
- Overall results suggested that negative beliefs about uncertainty are linked with fear-based intrusive images, avoidant responses, and hyperarousal.

the role of volition

For suicide loss survivors, their belief about the deceased's volition often becomes a central feature of their grief—and can have a profound impact on the meaning they attribute to the death (Sands, 2009; Sands, Jordan, & Neimeyer, 2011).

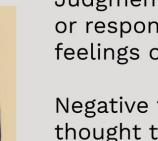
Choice:

rejection abandonment anger

Not a Choice:

comfort, able to conceptualize as an illness Intolerance of uncertainty can lead to a sense of ongoing threat. For example... · We (my loved ones and I) are vulnerable to death · The circumstances of the death are likely to happen again · Things that used to seem safe, now seem dangerous Kristensen et al (2012) • 132 participants who lost a close relative due to cancer · Large percentage of respondents showed the tendency to believe they would get cancer themselves These, and other appraisals related to the event, can lead to a sense of ongoing threat.

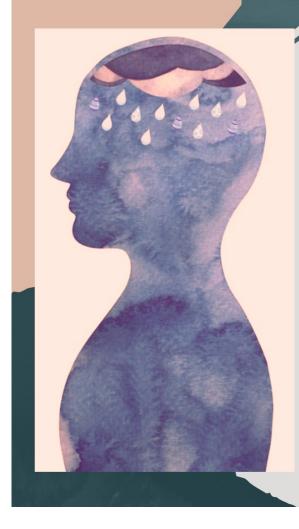
Appraisals of how one felt and behaved



Judgments about how they personally felt or responded to the trauma can impact feelings of self-worth and self-confidence

Negative thoughts about self-blame are thought to play a role in adjustment to bereavement and are associated with feelings of depression and guilt

These might extend beyond the death to rumination about unresolved conflicts of what mourner did wrong in relationship with the deceased

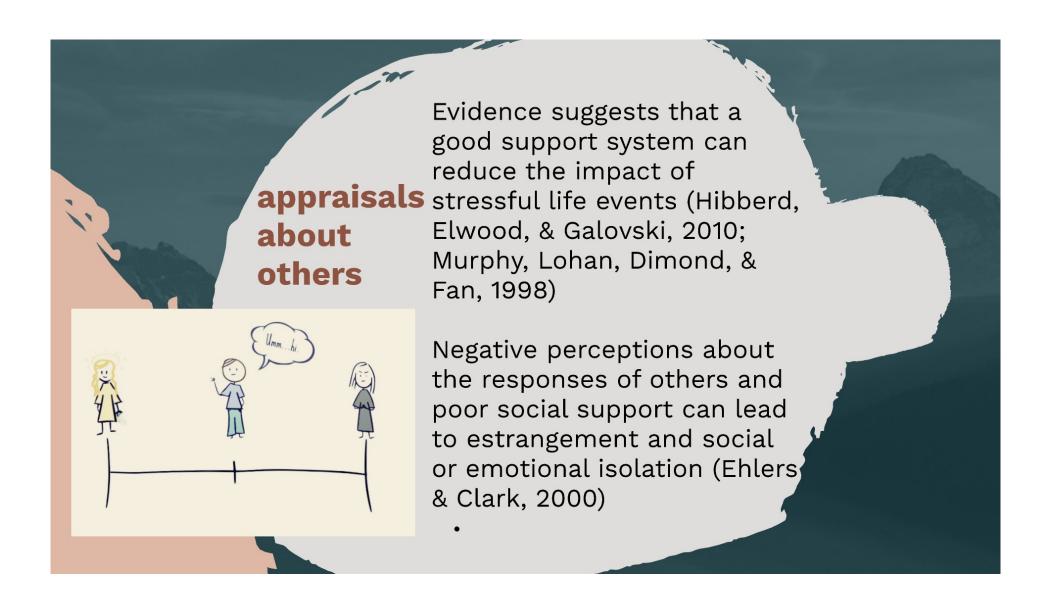


Appraisals about the dangerousness of ones reactions

"If individuals do not see [PTSD] symptoms as a normal part of the recovery process, they may interpret them as indications that they have permanently changed for the worse or as indicators of a threat to their physical or mental well being." (Ehlers & Clark, 2000)

329 bereaved individuals

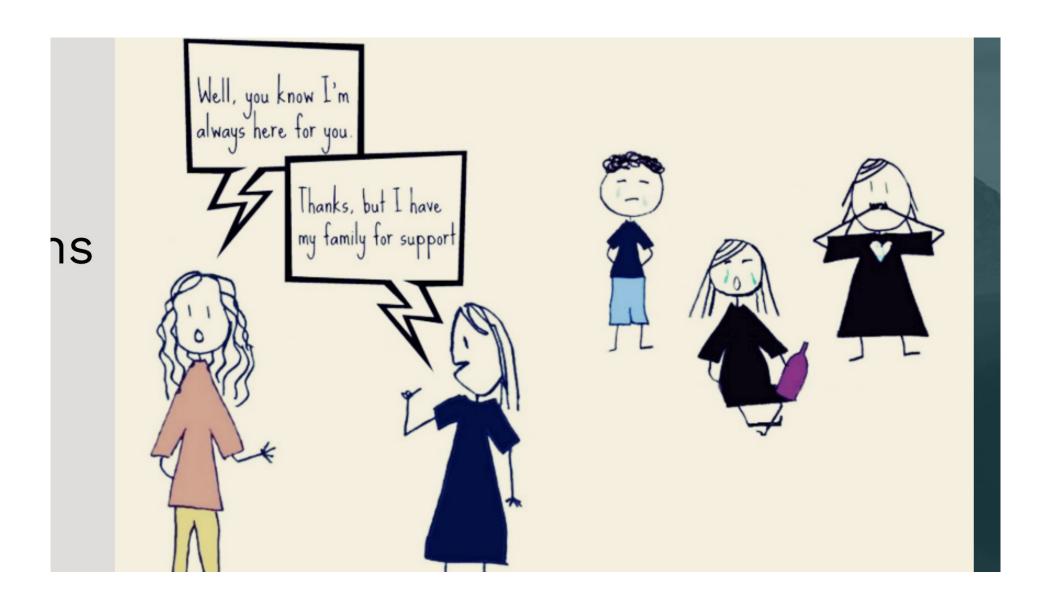
- Threatening interpretations of grief reactions
- Explained most variance in traumatic grief and depression
- Was one of the best predictors of anxiety
- Bolen et al (2003)

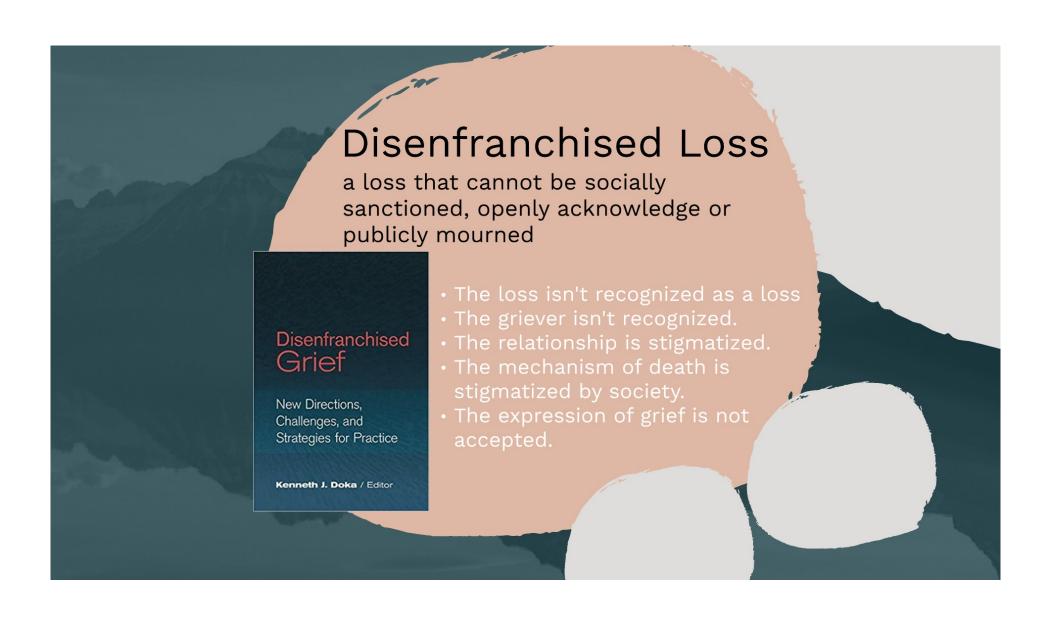


When everyone in the support system is grieving, fractures can occur. When family members struggle with grief, there can be a contagion of negative affect (Rando, 1993)

- Among those grieving the same loss, heightened negative emotions and different grieving styles can negatively impact the support system and cause misunderstanding (Cook & Oltjenbruns, 1998).
- The person who died may have been the mourner's primary support person.

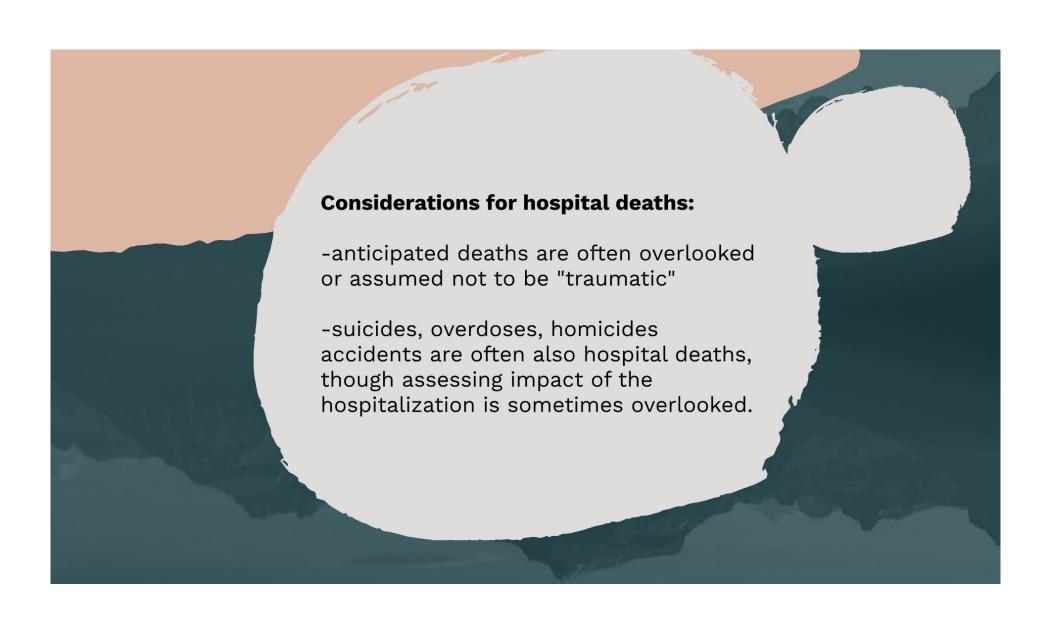


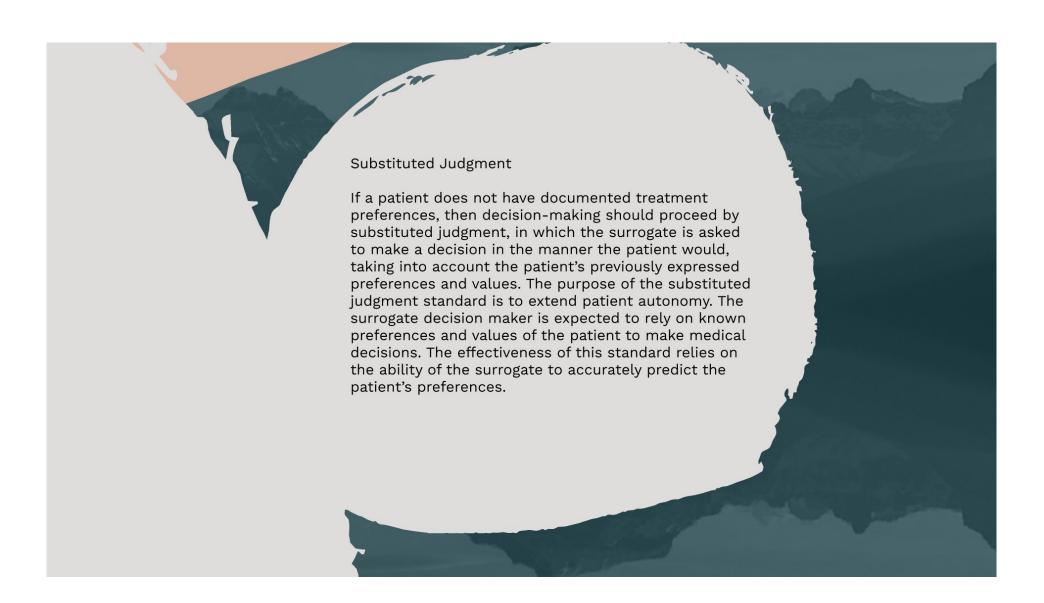






Decisions





Substituted Judgment

If a patient does not have documented treatment preferences, then decision-making should proceed by substituted judgment, in which the surrogate is asked to make a decision in the manner the patient would, taking into account the patient's previously expressed preferences and values. The purpose of the substituted judgment standard is to extend patient autonomy. The surrogate decision maker is expected to rely on known preferences and values of the patient to make medical decisions. The effectiveness of this standard relies on the ability of the surrogate to accurately predict the patient's preferences.

A review of 40 different studies that followed up with end of life surrogates found:

- 30% experienced substantial distress, including ongoing symptoms of anxiety, PTSD and depression
- 30% experienced moderate distress
- 10% had a positive end of life experience

*NIH Unit on Vulnerable Populations EOL Study

Impact of surrogacy on grief

'I felt like I was the jury to sentence to death the person I loved most in the world.'

'I wouldn't wish being a surrogate on my worst enemy'

Surrogacy in the time of COVID

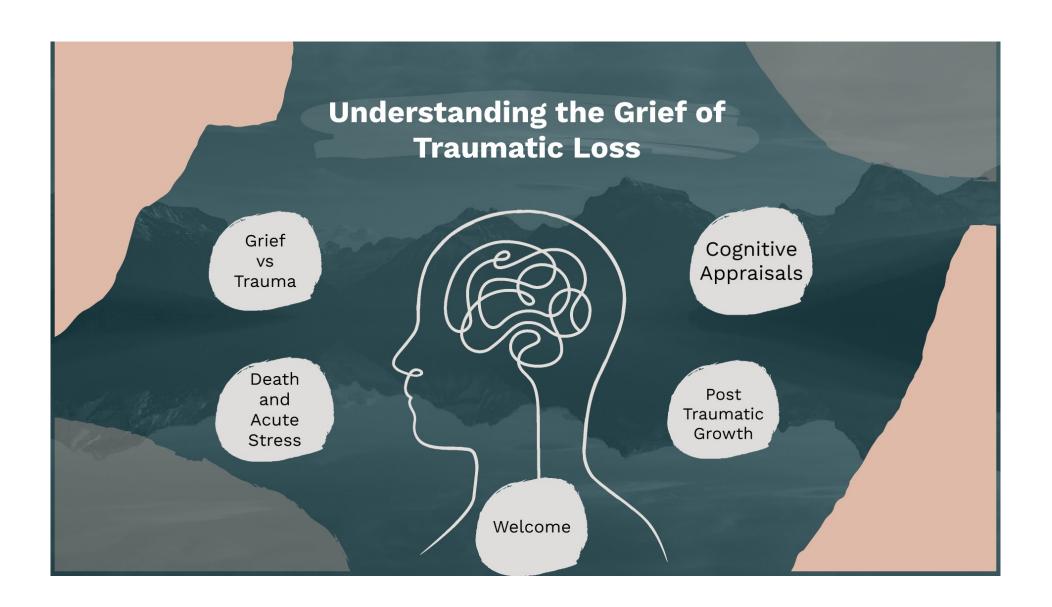
- Communication with hospital staff
- · Confidence in care
- Confidence in best-interest
- · Confidence in decision making

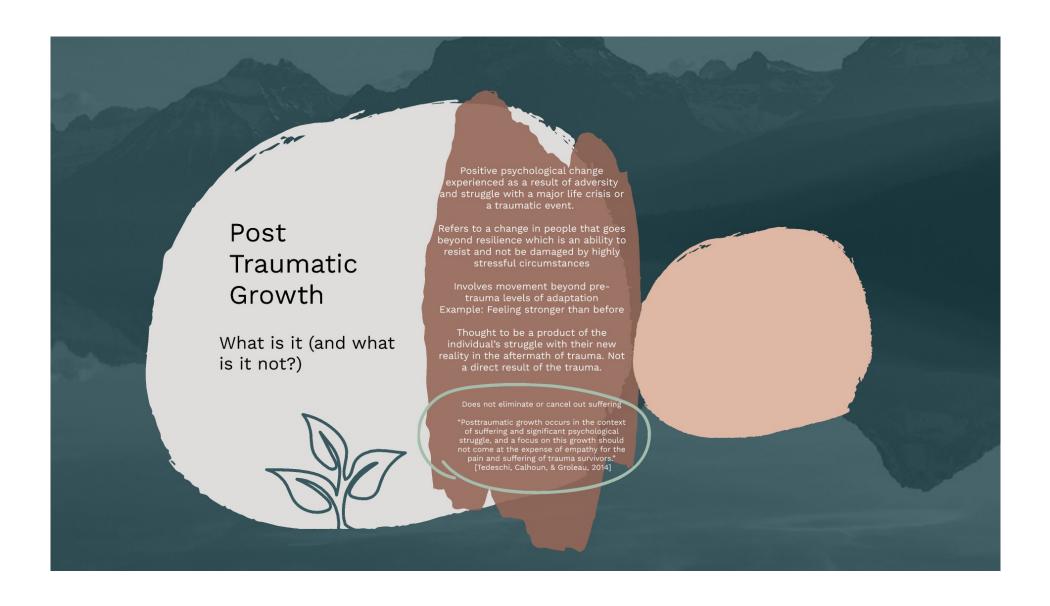
All layered on time of the other challenges



Other hospital death considerations

- Witness CPR or other invasive procedures
- · Perception that continued treatment prolonged suffering
- Lack of understanding of hospital communication
- Regret around decision making and loss of confidence or self-efficacy for future interactions.





Positive psychological change experienced as a result of adversity and struggle with a major life crisis or a traumatic event.

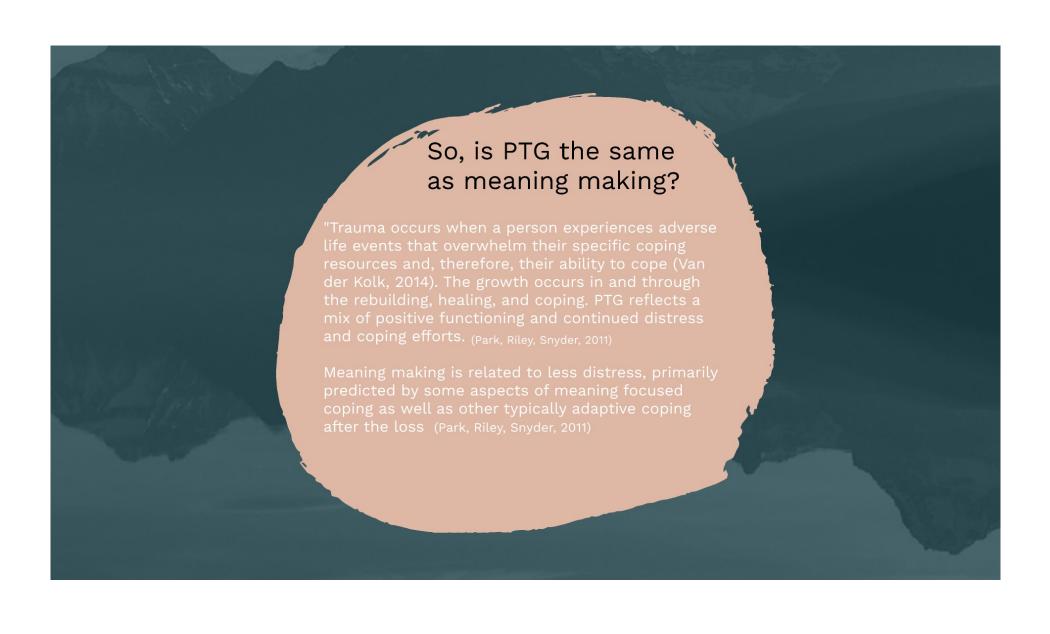
Refers to a change in people that goes beyond resilience which is an ability to resist and not be damaged by highly stressful circumstances

Involves movement beyond pretrauma levels of adaptation Example: Feeling stronger than before

Thought to be a product of the individual's struggle with their new reality in the aftermath of trauma. Not a direct result of the trauma.

tic

nd what



Does not eliminate or cancel out suffering

"Posttraumatic growth occurs in the context of suffering and significant psychological struggle, and a focus on this growth should not come at the expense of empathy for the pain and suffering of trauma survivors."

[Tedeschi, Calhoun, & Groleau, 2014]









In Bereavement

Analysis of 15 studies measuring positive growth following bereavement (Michael & Cooper, 2013):

Positive change commonly reported in around 30-70 percept of survivors of various traumatic events including bereavement Found following themes:

- Positive personal transformation
- Reappraisal of life and priorities
- · Reports of lower "negative symptoms"

Criticism Actual Growth or "Positive Illusion"?

- Some studies cannot correlate perception of growth with evidence of actual growth
- Does it matter?

