Psychiatric Social Work Intervention in Prolonged Grief Disorder; Case study in Indian context

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Loss of a loved one is always painful. When the relationship is deep it is difficult to accept the death of the dear one and it remains unresolved grief. In the West Grief Therapy is widely practiced. In Indian context where the family support system is stronger than the western countries, the incidents of unresolved grief is rare. However of late, the number of unresolved grief is on the increase as per the news reports of increasing suicides among those suffering from unresolved grief. Unfortunately several such cases indicate the symptoms of Affective Disorder or Psychotic Disorders. Only a clear diagnosis could identify the unresolved grief and do proper therapeutic intervention. This study narrates two case studies one of a teenager who lost his father and another is a mother who lost her son. Both showed the symptoms of pathological grief which were falsely diagnosed as Bipolar Affective Disorder and Psychotic symptoms respectively by two different psychiatrists. In the 1st case after two and half years and in the second after one year they were re-diagnosed as pathological grief and proper grief therapy was given by which the affected individuals could come back to normalcy. The need of multidisciplinary assessment and psychiatric social worker's intervention are stressed as suggested.

Introduction

Disasters are unforeseen whether natural or man made. Disaster preparedness helps to reduce casualties and for effective immediate intervention. However in the post disaster phase the survivors' exhibit abnormal reactions which are considered normal in any abnormal situation. But if the abnormality is prolonged it can be a psychotic symptom or a bipolar affective disorder or it is a prolonged grief reaction. Unless careful diagnosis is done, severe damage could be resulted. This study is exploring two cases which were wrongly diagnosed as mental illness by the psychiatrists and later happened to re-diagnose as prolonged grief reaction and consequently given prolonged grief therapy by the psychiatric social worker and by which the symptoms are remitted.

As per the study of Maciejewski et al (2007) Bowlby (1969) was the first to propose a stage theory of grief for adjustment to bereavement that included 4 stages: shock-numbness, yearning searching, disorganization-despair, and reorganization.

Ku¨bler-Ross (1969) adapted Bowlby's (1969) theory to describe a 5-stage response of terminally ill patients to awareness of their impending death: denial-dissociation-isolation, anger, bargaining, depression, and acceptance. In the current study both the clients were fixed upon the denial stage. There was an overlap of depression and manic symptoms in the first case and of psychotic like symptoms in the second.

Lichtenthal et al (2011), studied grief and mental health service use among 86 bereaved caregivers of advanced cancer patients. Sixteen percent of the bereaved sample met criteria for prolonged grief disorder, which was significantly associated with suicidality and poorer health-related quality of life, but not with mental health service use. The majority of bereaved caregivers with prolonged grief disorder did not access mental health services. In multivariable analysis, having discussed psychological concerns with a health care professional when the patient was ill was the only significant predictor of mental health service use during bereavement

The majority of bereavement research is conducted after a loss has occurred. Thus, knowledge of the divergent trajectories of grieving or their antecedent predictors is lacking. In a study Bonanno et al (2002) gathered prospective data on 205 individuals several years prior to the death of their spouse and at 6- and 18-months post loss. Five core bereavement patterns were identified: common grief, chronic grief, chronic depression, improvement during bereavement, and resilience. Common grief was relatively infrequent, and the resilient pattern most frequent. The authors tested key hypotheses in the literature pertaining to chronic grief and resilience by identifying the preloss predictors of each pattern. Chronic grief was associated with preloss dependency and resilience with preloss acceptance of death and belief in a just world.

Only recently have psychotherapeutic interventions for complicated grief been developed and evaluated in randomized controlled trials (Supiano, 2012). These trials have reported significant reductions in complicated grief and related symptoms in response to treatment relative to control groups. However, little is known about the long-term outcomes of these treatments. Wagner et al (2007) present an evaluation of a 1.5-year follow-up of an Internet-based cognitive–behavioral intervention for complicated grief. Treatment group patients (n = 22) were administered various assessments of complicated grief indicators, including the Impact of Event Scale, the anxiety and depression subscales of the Brief Symptom Inventory, and the SF-12. Results indicate that the reduction in symptoms of complicated grief observed at post treatment was maintained at 1.5-year follow-up.

According to Malkinson (2001) the application of cognitive therapy to the acute phase of grief and to prolonged dysfunctional grief are highly effective. He also gives guidelines and specific strategies for assessment and intervention are offered for social work practice with the bereaved. Research studies have set the stage for differentiating complicated grief (obsessional preoccupation with the deceased, crying, persistent yearning, and searching for the lost person) from depression (clinical signs of depression with preoccupation with self) (Prigerson et al., 1995). The implications of these findings lend themselves to differential treatment interventions for grief (psychotherapy with a focus on caring and support) and for depression (combined psychotherapy and psychopharmacology) (Malkinson, 2001).

According to the cognitive approach, psychopathological grief takes the form of distorted thinking, where an excessive emotional reaction (such as depression) is related to negative cognitive evaluations (automatic thoughts) of oneself, the world, and the future. For example, bereaved persons with distorted thinking may interpret loss as an intended rejection (How could he or she have done this to me) (Beck, 1976) or as a confirmation of being worthless (I am guilty and a worthless person for not saving his or her life) (Malkinson & Ellis, 2000). During stressful life events, people often use maladaptive cognitive processes, referred to by Beck (1976, 1989; Beck, Wright, Newman, & Liese, 1993) as cognitive distortions and by Ellis (1962) as irrational beliefs. According to rational-emotive behavior therapy (REBT), overreaction and lack of reaction to the death of a loved one are not in themselves "right" or "wrong," or preferred or undesirable, rather are related to a specific set of beliefs (cognitions) that are functional or dysfunctional (adaptive or maladaptive). In the case of loss through death, negative emotional reactions (e.g., sorrow, sadness) may be regarded as relating to adaptive cognitions (e.g., "Life has changed forever, and it's sad and painful;" "The doctors did all they could do to save my child; I don't blame them;" "I know we did everything to keep him alive, but it didn't help, and he died"). Complicated grief, on the other hand, is seen as a negative emotion related to and maintained by maladaptive cognitions (e.g., "Life is not worth living without my loved one," "I can't stand my life without my loved one"). In the case of the boy narrated in this case study as a result of the death of his father he felt that 'life is meaningless' and therefore he stopped schooling.

Thus, from a cognitive perspective, complicated grief is defined as persistence over time of distorted, irrational beliefs as the dominant set of cognitions affecting the emotional consequences in the form of depression or anxiety (Malkinson & Ellis, 2000).

The REBT perspective distinguishes between healthy and unhealthy consequences of one's belief system in reaction to loss. Grief is a normal and

healthy reaction to a very stressful event. As distinguished from depression, grief is a process of experiencing the pain of the loss and searching for a new meaning to life without the dead person, and it is also a process of restructuring one's irrational thinking into a more rational, realistic mode. Unlike depression, it is a process of searching for alternatives to life without the loved one who is the center of the pain and yearning. It is oscillation between grieving the loss and having to make choices regarding the reality of the loss (Neimeyer, 1999; Neimeyer et al., 2000; Stroebe & Schut, 1999). Grief within the REBT conceptual framework is a process that helps the bereaved person organizes his or her disrupted belief system into a form of healthy acceptance. Grief that has a healing effect and that adapts to the sad reality, which no longer includes the deceased, involves pronounced negative emotions such as sadness, frustration, and pain. Yet, it minimizes unhealthy, self-defeating feelings of depression, despair, horror, and self-deprecation. A detailed assessment of the client's perceptions of the activating event (A) will assist the social worker in identifying the client's loss-related irrational beliefs (B) that underlie specific emotional consequences (C) (Malkinson, 1996) and will also enable the social worker to distinguish between functional and dysfunctional responses (B, C) to the death. This distinction is especially pertinent to sudden, traumatic events, which are characteristically negative and overwhelming. As Ellis (1994) emphasized, dysfunctional thoughts about the adverse event ("How could she have done it to me? I will never forgive her for leaving me," "It shouldn't have happened to me," "This absolutely shouldn't have happened at all," or "I should have prevented it") coexist with functional, healthy thoughts ("It's so painful, but I did all I could to help her"). In addition, exploring the death event in detail may have a cathartic effect because telling the "story" includes one's interpretation of the event and how one feels about it, offering an opportunity to express irrational thoughts the client may have, about the event itself or thoughts about the self, others, or the circumstances surrounding the loss (Malkinson, 1996). It is essential to explore with the client the personal meaning of the loss event (e.g., "She was all my life; my life is worthless without her") and of the lost person (e.g., "He was the only one that cared for me") (Freeman & White, 1989). This includes how the loss is verbalized and what specific words (e.g., "I am tired of life") do or do not mean to the client. These will assist the social worker in proposing alternative interpretation, paying special attention to the person's linguistic style

Malkinson (2001) points out that REBT based for the acute-phase interventions has four aims:

1. Identifying irrational beliefs (demandingness directed to self, others, and the world) and their emotional (e.g., anxiety), behavioral (e.g., avoidance), and physiological (e.g., breathing difficulties, heart palpitations) consequences;

2. Explaining and teaching the connections between beliefs (B) and consequences (C);

3. Identifying and assessing individual specific consequences, (i.e., specific language to describe emotions, behaviors, and specific physiological reactions);

4. Teaching and practicing appropriate, healthier (rational) cognitive, emotional, behavioral, and physiological grief responses (Ellis, 1994; Ellis & Dryden, 1997; Malkinson, 1996).

The above given literature indicates pathological grief needs diagnostic clarity and psychotherapeutic intervention particularly cognitive. In this study two prominent cases are studied which were misdiagnosed as mental health disorders and were unresponsive to treatment until they were correctly diagnosed as pathological grief and psychotherapeutic intervention along with cognitive restructuring and a host of related therapeutic methods were used. Each case with a brief history and treatment modality adopted is narrated.

Tragedy of a teenager

Mr. Ashok(fake name), 17 year old boy was brought to National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, India, as referred by a district mental health practitioner that he had been on treatment for bipolar affective disorder but with no sign of improvement. Taking his detailed history it is understood that the precipitating factors of illness is accidental death of his father when the boy was 14 and half years old. The detailed analysis of the symptoms showed that following the death of his father, the boy had anger outbursts, violent behaviour, and absenteeism in the class, imitating the behaviour of his father, preserving the materials used by his father, loss of sleep and loss of appetite. All these symptoms indicate of grief reaction was falsely diagnosed as bipolar affective disorder. He was on mood stabilizers. They were tapered and stopped. He was observed over a period of two weeks. Psychotherapy for pathological grief was started. There was amazing response. Various therapeutic techniques were used. Directed imagery in empty chair method was much helpful to mourn upon the death of his deceased father.

Use of symbols like photos, the articles used by his father and stories father used to tell him and his brother were helpful in the intervention. Evocative language was used by the psychiatric social worker who was the chief therapist under the guidance of the resident psychiatrist. His mother gave useful information regarding the stories he wrote following the death of the father. If depicted a voyage in which his father was the rower. Deep in the middle of the sea the father disappeared. The boy was left alone… father was his guide….friend….philosopher and all. During the therapy the boy rewrote the story as he himself picks up the row and rowing towards the shore. He was weeping… but a sigh of joy glittered on his face. The grimace that clouded his face disappeared. As the sea is calm his mind too reached serenity.

Cognitive restructuring which was done helped in generating positive and hopeful thoughts about future. All the negative thoughts he entertained previously were rewritten to positive thoughts. A structured ABC analysis was done for assessment as well as intervention. It helped him to emotionally relocate the deceased father. Gradually he recovered. He dreamt a bright future. He wants to lead a responsible life which probably his father would have expected from his son as he grows in age and maturity. Thus the therapeutic intervention was successful. Follow up was done for a period of six months. However the sad part of the story was that the boy fell into drug induced bipolar disorder as a result of wrong diagnosis and medication that lasted for two and half years until we re-diagnose him having pathological grief.

Mother in unresolved grief

Catherine John(fake name), 48 year old married lady having three children, two elder girls and youngest boy, lost the youngest in Thattekkad Boat tragedy, a manmade disaster that took place in Bhoothathankettu Reservoir in Periyar Valley Hydro-electric project, Kerala, India way back in February 2007. The mother could not accept the loss of her beloved son. She lost her sleep, complaint of heaviness of head, having no personal care showed abnormal behaviours by which the family people took her to a psychiatrist. He diagnosed her as having psychotic symptoms as post traumatic and put her on antipsychotic drugs. Her abnormal situation persisted over a period of one year until the psychiatric social worker took up the case. He assessed her history and re-diagnosed it as pathological grief which is unresolved. With the help of her husband she was shifted to a short stay home and started grief therapy. In the initial stages she was not responding.

Complicated grief involves processes that do not move progressively toward assimilation or accommodation but, instead, lead to stereotyped repetitions or extensive interruptions of healing ((Malkinson& Witztum, in press). It was evident with her behaviour that very often she fell into unrealistic preoccupation with her son recalling all happy and sad moments she had with her son. Initially she was made free from the drugs. In the therapeutic intervention imagery of the past life incidents were used. Empty chair technique was highly useful and effective. Cognitive restructuring was done although she was not co operating initially. Gradually she accepted the loss of her dear son and started reinvesting her attention on husband and two other girl children. In a later stage she requested to visit the site of her son's mishap. It gave the result of exposure to the past tragic event. She was taken to Bhoothathankettu to show the site were her son got drowned. Seeing the site she turned into violence and collapsed into unconsciousness. But it was effective to make her believe the truth of the loss of her son. Gradually she got into the awareness of the loss of her son and grieving worked out.

Once she recovered from the abnormality she set out her daily routine and back home happy as she was prior to the loss of her son. She was encouraged to find a job for herself and it helped her to be away from the ruminations of the memories of her lost son. Within three months she recovered fully and was back into normalcy. The follow up was done for a period of six months to one year during which she was trying to reinvest her time and energy upon the education and future plans for the elder daughters.

Future plans for the better world

Primarily in the case one the grief intervention was after two and half years of actual loss. In the second case the intervention was done after one year of the unfortunate loss. However in both the cases the clients were falsely diagnosed by the registered psychiatric practitioners and were on medication. In Indian context the human right issues of these clients were not taken up. The family members were happy that the clients are recovered finally with the psychiatric social work intervention. However in the first case the unfortunate tragedy of the client that he was affected by drug induced bipolar affective disorder is a matter of grave concern that it should be brought to the awareness of psychiatrists' community. A multidisciplinary setting there are feeble chances of false diagnosis.

Secondly if there is an eclectic approach of right therapeutic intervention with psychotherapy along with cognitive and behavioural intervention the chances of recovery are high and fast. Re-grieving and bringing the client back into normalcy should be carefully planned out. In both the cases the medication was tapered and stopped. It helped to find out the importance of non pharmacological modalities of treatment in the redemption of pathological grief. In a few cases medication may be necessary. Careful diagnosis will help to plan proper intervention that includes psychiatric and psycho social intervention methods.

Thirdly ignorance of the medical community along with the ignorance of the general public upon complicated grief and pathological grief made the situation bad to worse. Hence public awareness as well as professional community awareness of the grief and its treatment is urgent need of the time. Media should take up such cases to highlight the fact that the complicated grief could be intervened and resolved. It also helps in generating public awareness to save the mental health of several unfortunate persons who fell into unresolved grief.

Fourthly social workers have a major role in the intervention in terms of assessment, therapeutic intervention, rehabilitation and generating community awareness on how to deal with complicated grief. Social work

education institutions are recommended to conduct symposiums and workshops to prepare the budding social workers to learn the skills of handling the grief cases particularly complicated grief cases.

Finally more research is to be done in the area of grief and its therapeutic intervention particular to Indian cultural context. It should be a part of the curriculum in psychiatry, clinical psychology and psychiatric social work. The psychiatric nurses should be given adequate awareness on how grief cases are different from other forms of psychiatric disorders in patient management.

Conclusion

The goal of grief therapy is to resolve the conflicts of separation and to facilitate the completion of the grief tasks. The resolution of these conflicts necessitates experiencing thoughts and feelings that the patient has been avoiding. The therapist provides the social support system necessary for all successful grief work and essentially gives the patient permission to grieve.

In any unresolved grief diagnostic clarity is important. Detailed history of the death of the near one and history of the type of relationship between the deceased and the survivor should be collected to plan out the intervention in more scientific and accurate manner. Although, it is difficult to get diagnostic clarity in pathological grief, there is higher chances of success in intervention, when the diagnosis is more accurate and detailed. In the Indian context family ties and kin support system should be effectively made use of secondary to therapeutic intervention. Effective grief management should be part of the curriculum in medical and paramedical training services.

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