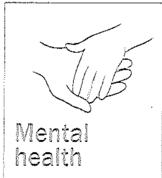
Dangers of grief – watch quiet ones

Key points

- Some people will cope with the Christchurch tragedy but watch for those who aren't coping.
- The angry and distressed are easy to spot – the Kiwi stoics hiding away at home need more help.
- Medications can help with immediate symptoms. However, being able to de-stress is much more important in the long run.

Useful links

- http://tinyurl.com/4jkrody (RANZCP Guide to managing post disaster stress response)
- www.moh.govt.nz/moh.nsf/indexmh/coping-with-stress-factsheets
- www.psid.org.au/response



Malcolm Falconer

The Christchurch earthquake and the chaos and loss of life it has caused will have a continuing impact on mental health that health practitioners will need to recognise.

As prime minister John Key said: "People will cope, or not cope, in their own way." It is the "not coping" group that will be the challenge in the coming weeks and months.

These will be the people who will become distressed, angry and frustrated at the unfairness of the tragedy, and act out in ways unhelpful to themselves, their partners, and their families.

The angry and obviously distressed is one group and they can be easily identified. However, of more concern are those who don't display any overt behaviours – they just go to ground. These people will need to be coaxed out of their shock, but will only be noticeable by their absence. Hence, John Key's other request: reach out to your neighbours in these hard times.

Recognise the symptoms

The symptoms of stress and the disorders that can accompany them include the following.

Grief

Those who have lost family, friends and colleagues will go through the grief process. The Kübler-Ross model describes five stages of grief: denial, anger, bargaining, depression and acceptance.[1] But the processes are neither linear, nor sequential, and are never really "done".

It's not how much stress we have – and that people are better or worse at handling stress than others – it's simply that some people are better at de-stressing

However, the phrase "time will heal" is not helpful. This is like saying the wound you feel so intensely now will grow a scab, form a scar and in another year it won't be visible. People who've lost someone they love never want to forget that person.

Simon Rubin, an Israeli psychologist who works with families who've lost relatives in suicide bombings offers a far more useful analogy of people dealing with grief.[2] He likens the heart to a dining table, and the empty chair where their loved one sat is now vacant. No one else can replace that person; no matter how much time passes, that seat will always be empty. He says this is an appropriate response and a mark of respect. However, he reminds the grieving person that there are other people sitting in the other seats who also need love and respect. He suggests the grieving person lean the empty chair against the table – so it stands as a symbol of their loss – then attends to the other people at the table.

Trauma

Some people experience post-traumatic stress disorder (PTSD) as a result of their experiences. The symptoms of PTSD, which include re-experiencing/nightmares, hypervigilance, dissociation, depersonalisation and avoidance, will be obvious in those who present for help. However, avoidance or hypervigilance will be the main reasons those who don't seek help choose to stay hidden in their homes and avoid getting help.

PTSD is an anxiety condition and can be helped by the same medications used to treat general anxiety disorder. The physiological aspects of nightmares and sleep issues also respond to the treatments used to manage such symptoms. Relaxation-skills training, breathing, meditation and distraction techniques can also be helpful.

Avoidance and dissociation require grounding exercises to modify behaviour. For example, systematic exposure, such as driving to the GP by a route that bypasses the place that causes distress. Cognitive strategies involve developing a realistic view of worst case scenarios and the person's vulnerability to these.

The fear that drives the emotional aspects of dissociation and depersonalisation in PTSD is extinguished by a combination of cognitive and behavioural strategies. The aim is to allow the person space and safety to talk about what happened – but not in the third person, as if describing a movie, or with a 50-yard stare so as to disconnect from the emotions or the experience described. The aim is to gradually remember the thoughts and the events, and to re-experience the emotional state of the event at the same time.

Depression

Sleep problems, loss of appetite, loss of libido, poor problem solving and concentration, memory issues, loss of motivation and pleasure, thoughts of hopelessness and helplessness, and sometimes suicidal ideation are all symptoms of depression.

In times like these, most people will have some of these symptoms, and some people show them more overtly than others. When asked how you can help, they shrug or cry because they know you can't bring back a lost loved one, house or workplace, or the city. But others will hide their symptoms with stoicism. They will say others have it worse, and so feel reluctant to talk about their loss.

But suffering is not a comparative phenomenon. Frankl, the psychiatrist who had the misfortune to be a Jew in Poland in 1936 and endured the Nazi labour camps, said suffering was like a gas. It is not a matter of who has more gas, because the gas you smell is the gas that fills your room. The important thing is to acknowledge your own gas and how it is affecting you.[3]

Behavioural activation is the best way to reduce the severity of depression. Learned helplessness was defined by Seligman as the most disabling aspect of depression. When a person starts to think "what's the point?" and can't deal with problems any more, depression turns to suffering, and suicide becomes an option.

I was with call centre staff handling calls from distressed people in the recent crisis. A man who had lost his grand-daughter needed sleeping pills. His GP's office wasn't functioning, so his call was to the contact centre. He wanted to talk about his loss but it was too big, so the contact centre person asked him why he'd called his GP. He was so distraught he couldn't sleep and wanted help with sleeping. So began problem solving: he had to get in his car, find an open petrol station, drive 45 minutes around destroyed roads, sit for four hours in an emergency clinic, but he got his sleeping pills. What else was he going to do? The alternative was to stare at a wall all day and not sleep yet another night. His actions took time and effort; the next challenge won't seem quite so impossible. In this way people get through.

Stress and vulnerability

How many people will suffer disorders, and how badly, depends on many factors. Those with previous conditions or a genetic predisposition to conditions will be the most vulnerable.

The late Professor Ian Falloon, of Auckland Medical School, outlined the stress vulnerability model (see figure). This states that stress and adverse life events combine to raise levels, from a previous baseline, and, when these reach a threshold, those with pre-existing or predisposing conditions become vulnerable. Medication raises the threshold and offers a quicker recovery and relief from symptoms, but it doesn't prevent the threshold being reached if the stress and life events are significant.[4]

The big five life events are: loss of someone close, loss of employment, relationship break-up, serious illness or injury, and loss of home. Many people caught up in the recent events in Christchurch have had a full house of these major life changes. Life events must be dealt with on a "life on life's terms basis". Stress is a separate issue and the management of this is directly proportional to the capacity of a person to de-stress. It's not how much stress we have – or that some people are better or worse at handling stress – it's simply that some people are better at de-stressing.

Resilience

Resilience is the capacity to bounce back from adverse life events. In outlining their cognitive behaviour therapy, Padesky and Mooney described what makes people resilient. They see resilience as being comprised of our values, our beliefs and our ultimate concerns: the non-negotiables of our heroes, the maxims we were raised with and the stories or myths that inspire us.[5] But during times of extreme crisis these can elude us. The temptation is to give advice, but this can reduce problem-solving abilities and increase dependence and helplessness. Socrates said, if one asks the right question, people access their own wisdom. So, giving advice to people stuck in crisis is often not as helpful as asking if they have had crises before, and, if so, what they did and what worked. This allows people to access what made them resilient when facing previous – if lesser – crises. What worked before will work again. It's great to help people, but it's better to help people to help themselves.

References

1. Kübler E. *On Death and Dying*, Routledge; 1969.
2. Rubin S. Two-Track Model of Bereavement: Theory and research, *American Journal of Orthopsychiatry* 1999; 51(1),101–09.
3. Frankl V. *Man's Search for Meaning*. Hodder & Stoughton;1959.
4. Falloon I, Fadden G. *Integrated Mental Health Care: A Comprehensive, Community-Based Approach*, Cambridge University Press; 1993
5. Padesky C, Mooney K. Uncover Strengths and Build Resilience Using CBT: Auckland workshop, 27–28 March 2006.

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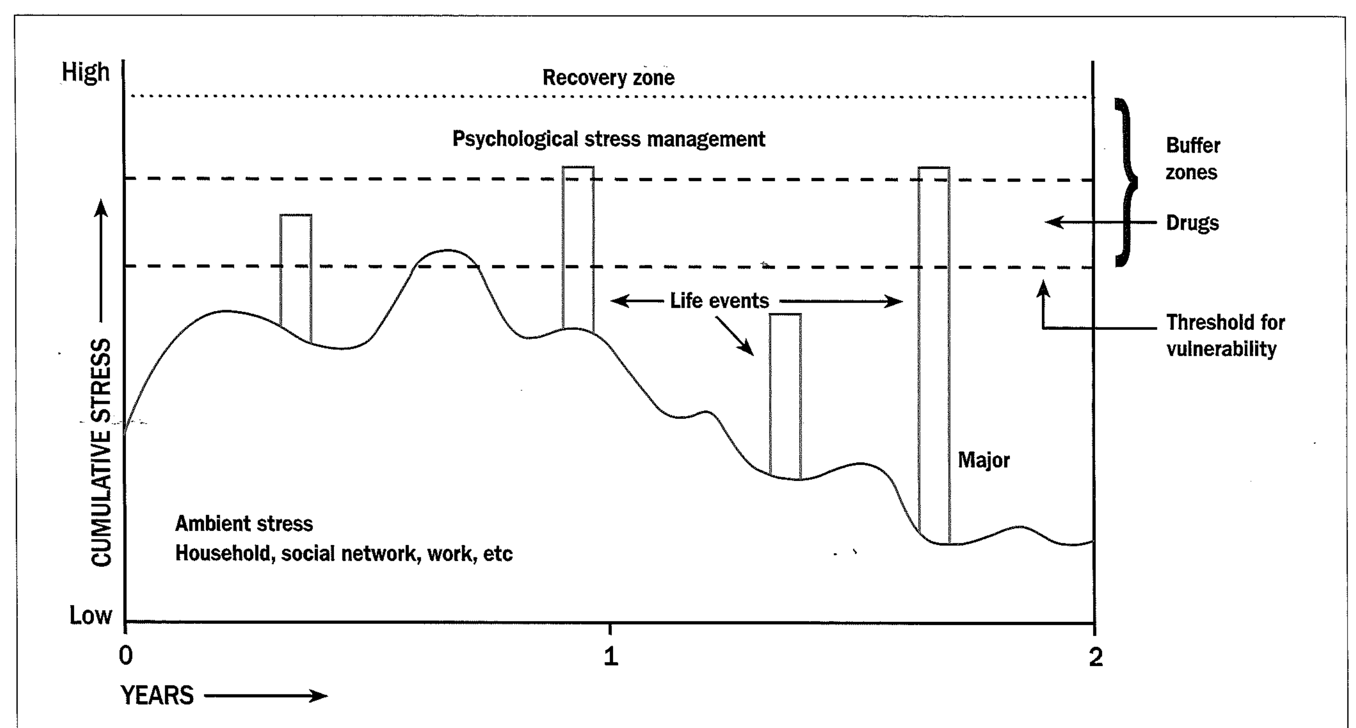

Stress and life events can combine to raise stress levels to a point where people become vulnerable. Diagram courtesy of Cambridge University Press. Integrated Mental Health Care: A Community-Based Approach, *by Falloon I and Fadden G*