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ADULT GRIEF GUIDE

For socio-healthcare professionals

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FMLC
Fundación Mario Losantos del Campo

INDEX

INTRODUCTION

Three years after the launch of the first edition of the Adult Grief Guide, we felt the need to review and modify a substantial amount of its contents. When we decided to write this guide back in 2015, our focus was set on the socio-healthcare professional. At that time, we perceived that there was a knowledge gap in this area that was important to fill. Our aim was to enable Primary Care workers to identify patients with complicated grief from those with a healthy grief who, therefore, did not require therapy. That was our main motivation.

In this new edition, we wish to incorporate the main questions that grievers ask when they assist the Mario Losantos del Campo Foundation's psychotherapy service, aiming for the professionals themselves to be the ones who answer these questions. Only when in direct contact with grieving fathers, mothers, children, and siblings can we identify the questions that resonate in the heart of a person who has just suffered a loss.

Throughout this guide we want to reply to all those questions that we have been asked about in therapy. Answering these questions has been proven to ease the pain of the bereaved, so it could be argued that the ultimate goal of this book is to exponentially increase the number of people we can help. It is thus a tool aimed to guide and help.

It is an enormous responsibility for us to develop a guide that provides guidance and brings comfort and relief to people who have recently suffered a loss. In writing this guide we have tried to express everything we know about grief with the aim of making it more accessible. The conclusions we reach in this guide are not intended to be rigid, nor do we pretend to lecture, we only seek to shed some light on such a complex process.

Grief is a universal experience that affects all of us. The fact that death is universal makes this an issue with which we are all very sensitised and one we tend to discuss with a certain levity. Hence, when a death occurs, frequently people from the bereaved's sphere tend to offer their opinion over what is right or wrong regarding grief. This happens because each individual has their own subjective idea on grief: on how long it should last, what the most common reactions are, which ones are adaptive and which ones are not.

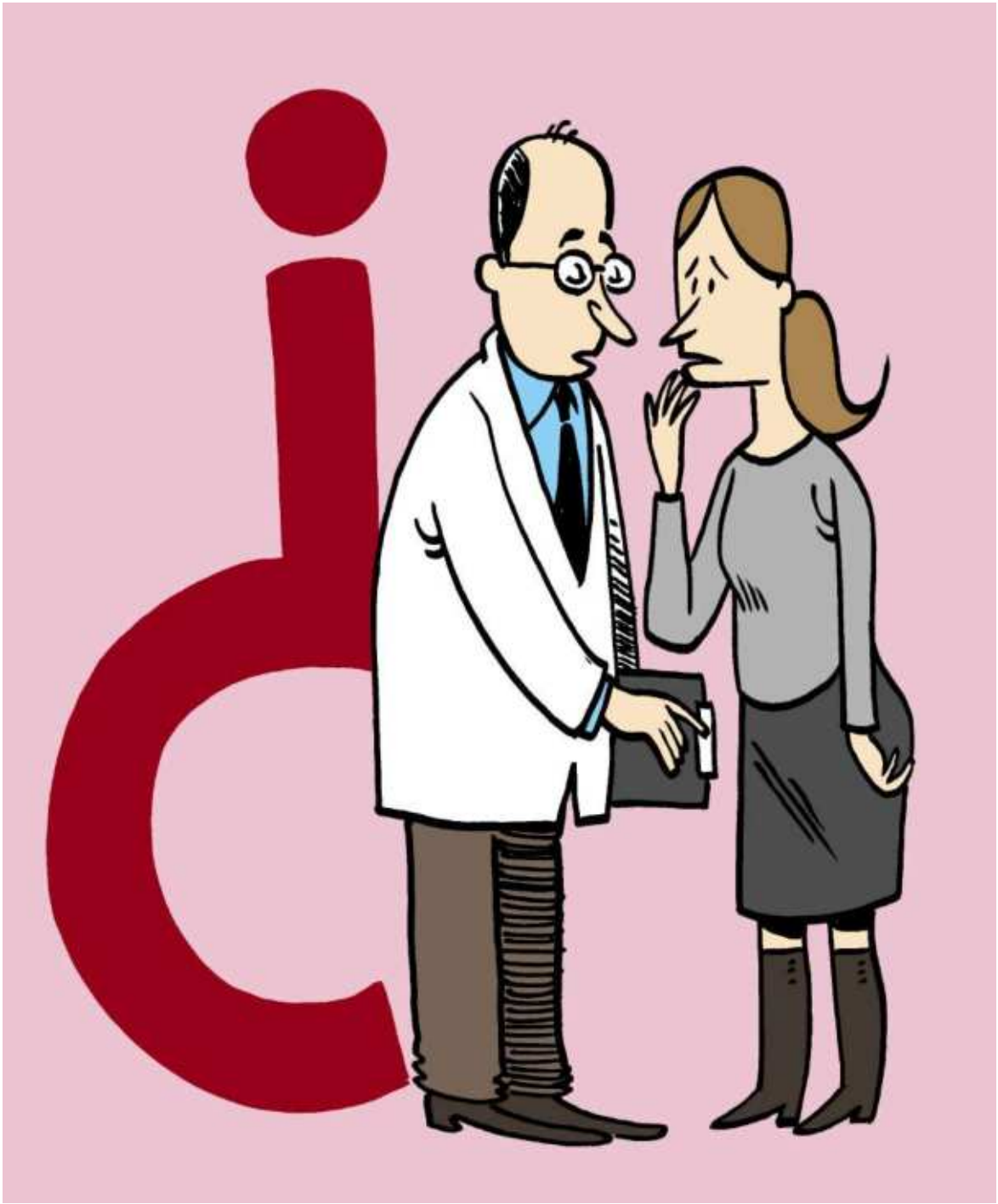
In my experience, these "ideas" based on our own beliefs, on general culture or on the experiences of close relatives do not usually adjust to each person's real experience. When a person goes through grief, they discover that everything they theoretically believed they knew about this process is insufficient to explain and manage it, especially concerning the idea that there are rights and wrongs. During an experience as intense as that of grief, all these beliefs are challenged and have thus to be questioned and adapted to the reality that each individual goes through.

During the first moments that follow a loss and those that come after, each person acts as best they can in order to adapt to what is happening; hence, it is not fair to establish Manichean categories that classify these reactions as good or bad. Each bereaver does what they consider appropriate to respond to the demands of the situation. Therefore, when someone - in good faith – offers advice regarding our grief, it is worth placing them on a standstill and bearing in mind that these comments do not innate from a technical or objective knowledge of that reality, but rather from a subjective experience. And since in grief there are no universally valid answers, neither is there any universally valid advice

It is important to distinguish a professional opinion from a personal one. A technician's advice is not the same as the advice coming from a friend. In these circumstances, a technician's advice is always more reliable and, in fact, there are grief "technicians"; that is to say, psychologists who are experts in grief therapy who, although they are not infallible, do have a more founded and intricate opinion on the process and its approach.

CHAPTER 1

WHY A GUIDE ON GRIEF?



Generally, a person going through a grieving process visits the social-health professional feeling vulnerable, disorientated, hurt... with many doubts about the process, about the pain and, sometimes, with a blocked or masked grief. How can we act correctly, from the vocation of wanting to help, in the face of this increasingly frequent demand?

It is an increasingly generalized perception that in our society death is not well seen: it is hidden, medicalized and transformed into a technical process. This technification becomes a defence, a buffer of pain and reality. In advanced industrialized societies, it is ever more difficult to accept or live with the mere idea of death (Gala, Lupiani, Raja, Guillén, González, Villaverde et al., 2002). However, death is the most absolute of all certainties. And, even if we avoid thinking about it, the patient's relative, the palliative patient, the bereaved... all continue to need help, support, understanding and space to grieve.

In the past, family and community networks, which used to be more extensive, used to cover this basic need and offer the bereaved the necessary support. However, currently, society tends to distract, avoid or deny this space; that is to say, it tends to "protect itself" from pain, so it is increasingly common for the bereaved to choose to resort to health professionals (Gil-Juliá, Bellver & Ballester, 2008). Presumably, this trend will continue to grow naturally, hence, social-health professionals in contact with grievers will need to know the grieving path in order to offer them adequate help.

1.1 Reflections regarding grief

Talking about grief necessarily implies talking about loss. This may seem obvious, but it is not. Only those who suffer a loss will grieve, those who have nothing, lose nothing. Grief takes place when we lose something or someone whom we have greatly loved. Losing it implies having had it, having enjoyed it. Some find comfort in the idea that grief is the price we pay for having loved.

In order to discuss grief, it is essential to reflect on the human being's need to bond and connect. The bond is the starting point of any grieving process. Frequently, the way in which we have vitally bonded ourselves to a person and the type of attachment we have developed with that particular loved one can predict the type of response we will endure during the grieving process when they pass away.

Another almost philosophical issue to reflect upon is the tolerance level that each person has towards absence. Even whilst being in a relationship, there are "spaces" that seem unconquerable and that are not susceptible to merging with the "other". Even in the closest of relationships there is a space that still only belongs to the individual, beyond the couple's or the friendship's sphere.

In that sense, there are moments or experiences in which we find ourselves alone. We all have to face that feeling of emptiness at some point. There are those who welcome that space, and even conquer and defend it, and there are those who are greatly afraid of it. Those of us who are committed to accompanying people in grief must have previously gone through this experience successfully in order to be able to reflect on it with our patients.

"Void" is not an easy term to explain or manage. Irving Yalom, an existentialist psychologist, addresses it in a masterly way in the film "Yalom's Cure" (2014): in it, he raises the need to expose oneself to that "void" or that intimate space that is only accessible to each individual person. It can be a place where we can cultivate our talents or our hobbies -something similar to our private niche-, or it can be a space in which we feel, with all its rawness, the abyss of loneliness with which every human being is born and dies.

Overcoming this void in order to transform it into a space for recreation and enjoyment is a challenge. That is the goal all therapies should aim towards. However, this will not be possible if the therapy conductor has not succeeded in doing so first. The therapeutic space thus becomes the rehearsal for this reality. This is the reason as to why grief therapy sessions need to be on a weekly basis (in order to conquer the gap formed between sessions).

With the revision of the Adult Grief Guide, we wish to answer those questions that our patients have been asking us over the last few years. They are real questions that arise from experience, from close contact with grief as an experience, as absence or emptiness. The Greek philosopher Socrates considered knowledge as a form of birth and conceived the idea of learning from dialogues through questions and answers. This new edition aims to formulate the right questions in order to find the meaning to the most common answers, because grieving is full of unsolved questions and because, both for the bereaved and for those around them, it is essential to put those unknows into words.

Sometimes, the answers are universally valid and, on other occasions, each person will find their own answers. These questions come from those raised by the people we have seen during evaluations, throughout individual or group therapies; the professionals we have trained; or simply those who have approached us with their doubts via Internet, by phone or in person. This is the reason as to why this guide was conceived as fundamentally a practical one.

We have gathered all the thoughts that have arisen over the almost fifteen years that we have been working as grief experts. Our sessions consist of accompanying people who are grieving, by listening to their questions and concerns. Together we establish a dialogue in which we reflect on everything that is happening to them and the meaning this has. Thus, we try to make them understand what they are experiencing, but at the same time, we manage and approach a reality that is painful, giving it a space that releases the force of all those emotions that grief contains.

There are grievers who are relieved by dialogue because of its intellectual side, as they require working with the most rational part of the process. There are also those who use therapy to verify that there is a space where their grief does not generate rejection or produce more pain, but one where it rather dissolves or evaporates. Grief requires for us to give it a space, that we give it a name, and we do so through dialogue. It is in the course of our conversations that these questions and their answers arise.

1.2 Why is a guide on grief necessary for socio-healthcare professionals?

Recent studies have revealed that a third of the cases seen in Primary Care consultations have a psychological origin. Out of all these cases, a quarter are identified as the result of some type of loss (Bayes, 2001).

On another hand, bereavement is considered as a cause of morbidity and mortality and hyperfrequency in Primary Care (Lacasta and De Luis, 2002) and it is thought that the average annual rate of visits to the healthcare centre is 80% higher among grievers (García, Landa, Trigueros and Gaminde, 2005). Various studies, many of which have already become classics, confirm these data (Prigerson, 1997), (Martikainen and Walkonene, 1996) and (Parkes, 1964). All these statistics expose, on one hand, that the bereaved turn to the

socio-health professional for help and, on the other hand, that grief can have complications on a psychological, physical and social level.

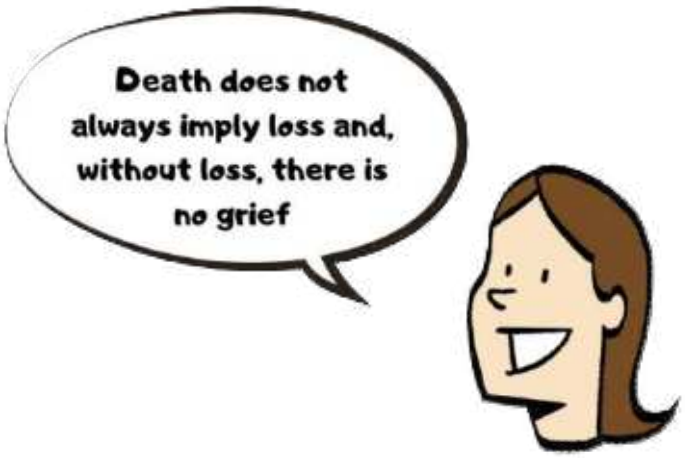
Among the possible physical complications compiled in multiple studies, we found that the risk of depression in widows is multiplied by four during the first year (Zisook and Shuchter, 1991), while almost half of them present generalized anxiety or panic attacks (Jacobs, Hansen, Kasl, Ostfeld, Berkman et al., 1990); alcohol abuse increases (Madison and Viola, 1968) and 50% of widows use a psychoactive drug during the first 18 months (Parkes, 1964). Furthermore, between 10-34% of grievers develop pathological grief (Jacobs, 1999) and the risk of death increases (mainly due to cardiac events and suicide). In fact, widowers are 50% more prone to die prematurely during the first year of widowhood (Kaprio, Koskenvuo, and Rita, 1987).

These are some of the possible complexities grief can have on a physical level, perhaps the most serious ones, but in my experience it is also common for the bereaved to express various somatic complaints: physical sensations similar to those experienced by the deceased, fear of illness, or feelings of exhaustion and shortness of breath.

Grief is a social process and as such, feeling support, as well as being able to verbalize and share the experience, is essential for its resolution. However, today's society can exert its influence in the opposite direction, (Tizón, JL. Loss, grief, bereavement. Paidós, Barcelona 2004) that is, by forcing the bereaved to recover immediately, to be distracted, to avoid contact with pain or tears, thus causing the process to be inhibited, as well as complicating it.

In summary, a correct elaboration of grief is essential for an individual's good physical and mental health (Portillo, Martin and Alberto, 2002).

As we have already mentioned, our society feels more and more blocked in the face of disease, pain and death. Socio-health professionals, as participants in society, are not alien to this trend. Various studies reveal certain attitudes that occur within the hospital professional environment: not wanting to name death, incongruities and dissonances between verbal and non-verbal communication or an increase in technological attention to the detriment of empathic-affective communication (Gala et al., 2002). Behind these attitudes lies the socio-health professionals fear, the reflection of their own worries and their concern in avoid causing the patient a harmful emotional.



Socio-healthcare professionals who assist people in situations of pain, grief or illness, face greatly emotionally intense experiences, which can involve a high degree of stress and uncertainty, (Rothschild, 2009). In an attempt to briefly relieve the bereaved person of this searing pain, the health professional can easily fall into the error of prompting attitudes that avoid pain (e.g., over-medication, etc.). Frequently, they tend to seek a solution that magically alleviates and resolves the patient's pain, becoming frustrated if they perceive that it does not improve from one encounter to another, or after a "reasonable" period of time. A professional's lack of knowledge on the path of grief can lead them to demand practically unattainable goals from themself and from the bereaved.

While the socio-health professional deals in their interior with these confusing and contradictory tendencies, this attitude can lead the bereaved to endure -as seen in my clinical experience- a feeling of abandonment, as well as greater loneliness and confusion.

On another hand, data from recent studies have shown how effective therapeutic intervention reduces hopelessness, depression and anxiety. Likewise, there is

evidence of the importance psychological support from healthcare professionals has on patients during the last moments of the disease and its effect in the subsequent evolution of the family's grief. The intervention made by the socio-health professional in any of the phases of the death process will directly influence the subsequent evolution of grief.

By providing the socio-health professional with training on how to cope with grief and how to handle pain and death, we will provide them with the tools to cope -arising from their vocation to help- with these situations of great emotional intensity. In addition, these resources constitute a fundamental support for the professionals, since they often help to prevent healthcare stress by improving treatment with the patient and the family.

Although the use of technology or protocols is essential (in the case of other professions within the healthcare field), this is insufficient if we intend to offer an effective, beneficial and efficient response to crisis situations. In this context, Chochinov (2009) coined the term "Patient-centred care", in which communication and emotional approach in helping relationships are enhanced.

All these aspects support the need to provide greater training around grief, both at an accompaniment level as well as regarding therapy. With this guide we aim to respond to a need present both in society and within the socio-healthcare field of professionals, who must face situations involving death, pain and illness in their day-to-day lives. The more prepared the professional is, the more capable they will be in accompanying the patient and the patient's family throughout the process of illness, loss and grief (Gómez, 2000).

Throughout this book we are going to embark on the path of grief; a very personal process wich involves many curves, obstacles and slopes. Therefore, the professional who approaches this world needs to have a few certainties about what grieving is like in order to be able to accompany the bereaved in a satisfactory way, giving them freedom of movement so that they can choose to resolve the process in their own way.

We aim for this guide to be useful at any level of intervention: whether it is during accompaniment, counselling or therapy (Worden, 2013). The differences between each level are as follows:

- **Therapy:** Therapy's goal is to identify and resolve the conflicts that prevent those whose grief does not appear, is delayed, excessive, or prolonged from completing the tasks of grief. That is to say: they suffer what we refer to as complicated grief. Therapy will be carried out by an experienced grief psychologist.

- **Counselling:** The purpose of counselling is to aid the person in the resolution of the tasks of a recent grief, so that the process is successfully fulfilled. It is carried out by socio-healthcare professionals trained in grief, although there are also places where this function can be performed by volunteers who have gone through similar circumstances.

- **Accompaniment:** The aim of accompaniment is to be by the side of a person who experiences pain due the recent loss of a loved one, listen to their pain and validate it: give them time for emotional expression. This is accomplished by professionals who are in ongoing contact with people who are experiencing acute grief situations, such as funeral service workers or emergency room professionals.

Whatever stage of the intervention level the professional is in, the appropriate general intervention framework for the experience of grief is counselling (Gómez, 2000). The professional who works following this framework undertakes the responsibility of knowing how to listen to themselves -their behaviour reflects their inner state-, of understanding others without judging them, of opening up to another person's experience, accepting them and enabling them to communicate with themselves. Counselling offers a very favourable framework of openness, understanding and acceptance that allows the bereaved to freely embark on their own path of grief.

According to William Worden (1997), the general grief intervention objectives are:

- Aid the person to come to terms with the reality of the loss.

- Aid the person address the emotions and the pain that loss entails.

- Aid the bereaved to adapt to the world now that the deceased is gone.

- And, finally, help them to psycho-emotionally relocate the deceased.

To achieve these objectives, we suggest a series of general principles that can guide the intervention:

- Talking about death (and everything related to it) helps and relieves.
- Each grief is unique, not one is the same as another. Only our conscientious listening will help us to discover the keys to each process.
- Encourage the expression of emotions and pain.
- Explaining, in general terms, what the grieving process consists of makes it easier for the person to get involved in it and for them to not feel so lost.
- Help them in answering the questions they may have.
- Encourage the reconstruction of the personal world of meanings after the loss (values, beliefs, one's own identity, etc.). Grief provides us with the opportunity to update or rebuild our inner world.

All these principles have the purpose of updating certain concepts, modifying others and incorporating some new ones. And experience has taught us that those who approach FMLC seeking help are, fundamentally, searching for answers to rational and not so rational questions.

We aim for the Primary Care physician, the nurse, the social worker -all those professionals who detect grief at the first level- to be able to provide them with a correct and sufficient response, which initially serves as a comfort to their patients. This may dramatically reduce the need for clinical grief care. And, in case that is not enough, we hope that you will find in this guide useful tools to identify those cases that need specific attention and, thus, be able to adeuqately refer them.

This new edition of the Adult Grief Guide has the novelty that it is more concrete and practical, because each of the words it contains are aimed at relieving the pain of those enduring grief, taking our clinical experience as the only starting point.

This guide does not end on the last page, but rather continues through the reflections that we hope to sow in all its readers. It is a living guide. Certainly, the questions it contains do not exert all knowledge of grief, but neither does it purport to do so. Hopefully the answers and reflections that we propose in this guide will be of use as a relief and a guide.

REMEMBER:

- **Grief is the natural process that occurs when we lose something or someone we have deeply loved.**
- **A third of the cases that are attended in the Primary Care consults have a psychological origin.**
- **In order to be able to address and accompany the griever in a satisfactory way, the healthcare professional needs to have several certainties about this process that we will try to answer in this guide.**

CHAPTER 2

THE MOST FREQUENT QUESTIONS MADE BY GRIEVERS AND THEIR SOCIAL CIRCLE

A well-known Mario Benedetti quote reads: "When we thought we had all the answers, suddenly, all the questions changed". This is the phenomenon that takes place whilst we are grieving.

Answers do not exhaust the need human beings have to understand, but rather help produce the inertia that propels us into reflection and introspection. Each question generates a new one, in a succession that leads to a deeper understanding of grief and of oneself.

Below, we have tried to enumerate the main questions that we have had to answer throughout all these years:

2.1 What certainties do we have regarding grief?

There are few certainties regarding the grieving process. One of them is that it involves pain. The Spanish word for grieving "duelo", comes from the Latin "dolus", which means pain. This is significant, as pain is an essential aspect in this process. If it does not involve pain, we know it is not grief. Almost all reactions towards pain are adaptive, and the shape this pain adopts in each person can vary considerably.

Another certainty that we have is that there are no universalities surrounding grief. There are some generalities that can guide us, but there is not one given factor that is universally valid. Consequently, it is necessary to analyse grief case by case, given that what is valid for one person may not be so for another one. Knowing that there are no universalities in grief is tremendously liberating for the bereaved, as this means that they do not have to adjust to a particular experience or specific reaction that others consider to be valid, but rather leaves space for nearly any reaction.

2.2 Is what is happening to me normal?

If the questions raised by grievers had to be ordered in terms of importance, this would be the first one. The main concern of a person going through grief is knowing if what is happening to them is normal. Pain in the face of loss is so intense that sometimes the bereaved may come to think that they are going crazy. Part of the therapeutic work will consist in validating and legitimizing the reactions that a grieving person may go through as they confront the

death of a loved one. In my experience, the range of reactions that are normal in the face of pain is very ample.

Deep down, this concern is linked to the perception of "doing it right or wrong". We begin with the false belief that there is a right or wrong approach towards the elaboration of grief. However, the truth is that each person does as best as they can, each individual reacts with the resources they have available. Patients who reach out to us show a great interest in addressing the process correctly, in not adding more distress or a pathology to the pain they already feel. Therefore, knowing that what is happening to them is normal is a source of reassurance and comfort for them.

However, normality is a purely statistical matter. There is no normality in objective terms, but only in relation to a society or an environment, always in comparison with something. This piece of information is important in therapy, as well as in this type of consultations that make us redefine the concept of normality. The reason behind this is that if we stick to the statistical criteria, some grief reactions that seem atypical or strident are normal if we explain them or place them in a specific context. For example: a person suffering from foot pain, in abstract, this may be strange or pathological, but if they have previously banged their foot or something has fallen on top of it, the pain is perfectly normal. This does not imply that this pain has to be neglected, but it does normalise it.

If we take the experience of grief as an example, the reactions of each person must be analysed taking into account their context. That is to say: if a person is extremely shy, they will undergo a shy grief process and this will be normal; whereas, if they are a tremendously melancholic person, they will endure a particularly melancholic grief process. The characteristics and reactions of grief cannot be analysed separately from the individual. Grief is an added part of what a person already is, in such a way that previous experiences or the personality of the bereaved will mark and define the "normal" way in which each one faces grief. Our job is to depathologize the reactions to grief: firstly, because almost all of them are normal and, secondly, because many of those that are not statistically normal are normal when framed in their own context. The first task of the grief "companion" must be to soothe and normalize. In order to do this, it is essential to believe it. We cannot say something if we do not believe it ourselves. Additionally, we also have to distinguish between

normal and non-normal reactions and be able to explain and understand each reaction in a given context.

The first task of the grief "companion" must be to soothe and normalize. In order to do this, it is essential to believe it. We cannot say something if we do not believe it ourselves. Additionally, we also have to distinguish between normal and non-normal reactions and be able to explain and understand each reaction in a given context.

If the context allows the reaction to be explained, then the reaction is normal. If the context does not make any sense of it, then it is not normal.

2.3 How long does grief last?

This is one of the questions that causes most concern among grievers. There is a widespread belief, according to which grieving lasts a year and any process that lasts longer than that is considered to have pathological overtones. But, in reality, there is no specific deadline in which to elaborate grief, each person requires a different time span, thus by trying to frame grief in an exact period of time only serves to add pressure to the process.

Most probably, this ingrained belief that establishes that the duration of grief lasts for one year is connected to a period of time when widowed women mourned their loved ones at the beginning of the 20th century. Once the obligation of mourning disappears, the process is left without rules that establish a framework or a time limit.

Time is one of the fundamental components of grief. However, this is not the equation's essential ingredient, but rather only part of it. Actually, what determines whether grief is overcome or not is what each person does with their time.

Throughout the entire grieving process there are numerous micro-decisions that the grieving person must make:

- Go to therapy?
- Try to allow the grief process to flow or encapsulate it?

- Ask their social circle for help?

- Request a medical leave?

Grief is an active process. For this reason, placing pain at the mercy of the passing of time unprotects the bereaved and leaves them without resources or options to manage the process, as they merely limit themselves to wait for time to go by. If grief resolution were that simple, psychiatrists would prescribe time instead of medication. But the only thing that time does is set distance between a pain. If the bereaved simply awaits, grief will remain unresolved and the pain will not disappear.

When a loved one dies, we frequently hear those around the bereaved say the phrase: "Time heals everything", but this is utterly false. Time serves as a buffer, but it does not cure anything. The passage of time only makes us older.

One of the basic concepts that we know about grief is that, when portrayed graphically, the process depicts a Gaussian Bell Curve. This is a graph that contains two axes: one represents the level of pain and the other, the passage of time (Parkes, 1964).

Generally, the pain level is lower during the first moments of grief -coinciding with the need to reduce the impact produced by death- and it grows as time passes and the person begins to realise everything that the loss of their loved one implies. Usually, peak level occurs around six or seven months after the death and this is what we call, acute grief (Parkes, 1964).

2.4 Why am I not hopeful?

Many grievers become afraid when they perceive that they do not feel hopeful about anything, they are apathetic. However, this is completely normal, as pain is incompatible with hope. As long as the grieving process lasts, it will be normal for hope not to exist and any attempt at it from the griever's part of will cause a lot of frustration.

Pain and hope have an inversely proportional relationship (Emilio Duró, 1998): the more pain, the less hope and vice versa. Frequently, the griever's social circle seeks to alleviate their pain by encouraging them to carry out enjoyable activities, but more often these will not bring about an authentic connection with hope, as they are incompatible.

What we can do is offer relief in order to try to reduce the level of pain.

2.5 When is it necessary to go to grief therapy?

For me, one of the keys that signal the need for therapy is the fact that the process is not progressing, that the sensations have not varied in duration or intensity for four or five months. The changes indicate that the process is

alive, while the absence of these indicates that there is a blockage that must be addressed in therapy.

Sometimes therapy serves the griever to mitigate or alleviate unbearable anguish, or to vent and empty out when he cannot talk about his emotions with his family and surroundings. It is also useful when you want to look for a deep meaning to the loss, give meaning to life or when the beliefs on which it was based have been devastated by the death of the loved one.

Even under these circumstances, the decision to go to therapy is something subjective that each griever must find within themselves. You do not have to go to therapy based on the "recommendation of" someone, but because you feel you require it. The recognition of that need, real or false, marks the beginning of the process.

When one attends therapy without being convinced, recommended by a doctor or a friend, the motivation to continue going is minor and, in the face of any setback, the patient will abandon the therapy, misemploying a resource that in other circumstances could have been useful.

The start of therapy has to occur at the right time, once the bereaved feels ready, since each person requires their own moment to begin a therapeutic process.

2.6 Who can provide grief therapy?

Grief therapy as such should only be practised by a grief expert, be it a clinical psychologist or a medical therapist.

Other than this, there are certain levels of assistance that can be provided in a timely manner. For example, a Primary Care physician may offer treatment to control "flowery" symptoms during the grieving process; or a psychiatrist can offer pharmacological support when the process becomes complicated.

The latter is usually used as a temporary assistance, in order to reduce anxiety levels and prompt sleep and rest.

2.7 What types of therapies are there?

There are many valid therapeutic offers to help to manage grief. On one hand, we have the medical-psychiatric option, which controls the most physical part of the process and can be complemented with conventional therapy. Also, within conventional therapy, therapy can be carried out individually or in group format.

Group therapy is very powerful, since all the group's energy is attached to the power of the therapy itself. In turn, individual therapy is aimed at people who do not want to participate in group sessions, either because of shyness, modesty, or because the person feels quite invaded and needs to work on some personal aspects or grief itself before being able to continue with group therapy, among other reasons. An example would be traumatic grief, which is easier to work on in individual therapy rather than in group therapy.

Each of the different psychological orientations offer the griever something different and all of them promote the elaboration of grief. Each professional or patient must choose the one who best suits their needs. In my opinion, the most appropriate one is a person-centred therapy, the efficacy of which is supported by numerous studies.

I believe that the desire to help is in the human being's DNA and each individual does so from where their point of expertise. What I have discovered is that non-scientific techniques such as yoga, meditation, acupuncture, homeopathy or hypnosis, to which many grievers resort to and which I do not dare to downplay since they seem to work. Each person will find their path.

2.8 When and where to refer?

It is important to have a list of professionals to whom to refer a patient when necessary. Each socio-healthcare professional is responsible for "generating" that list, in order to refer cases to other professionals they trust and with whom they can establish collaborations and work in a network.

2.9 Why is it necessary to know the grieving process?

According to statistics, each death can affect up to ten people and it is estimated that around 10% of grievers will endure a complicated grief, with severe implications for their physical and psychological health (Prigerson, Vanderwerker & Maciejewski, 2007).

In 2017, a total of 424,053 inhabitants died in Spain. Out of this number, it is estimated that in 2017 alone there were around four million people grieving, of which around 420,000 would be going through a complicated grief process. This places before us a substantial number of people in need of help.

Recent studies have revealed that a third of the cases seen in Primary Care consultations have a psychological origin. Of these cases, a quarter are identified as the result of some type of loss (Bayes, 2001). Bereavement is considered a cause of morbidity and mortality and hyperfrequency in Primary Care (Lacasta and De Luis, 2002) and it has been calculated that the average annual rate of health care visits is 80% higher in grievers (García, Landa, Trigueros and Gaminde, 2005). Various studies, many of them already considered as classics, confirm these statistics (Prigerson, 1997); (Martikainen and Walkonene, 1996) and (Parkes, 1964).

All these data prove that the bereaved reach out to social-health professionals for help and, furthermore, that grief can have complications on a psychological, physical and social level.

Among the possible physical complications collected in multiple studies, we found that the risk of depression in widows multiplies by four during the first year (Zisook and Shuchter, 1991), while almost half of them present generalized anxiety or panic attacks (Jacobs, Hansen, Kasl, Ostfeld, Berkman et al., 1990); alcohol abuse increases (Madison and Viola, 1968) and 50% of widows use a psychoactive drug during the first eighteen months (Parkes, 1964). Furthermore, between 10% and 34% of grievers develop pathological grief (Jacobs, 1999) and the risk of death increases (mainly due to cardiac events and suicide). In fact, widowers are 50% more likely to die prematurely in the first year (Kaprio, Koskenvuo, and Rita, 1987).

These are some of the possible complications on a physical level, perhaps the most serious, but it is also common for the griever to express various somatic complaints: physical sensations similar to those experienced by the deceased, fear of illness, feelings of exhaustion and suffocation.

Although grief is a normal adaptive process, it is sometimes psychologically complicated, causing pain to be delayed, inhibited, or masked (Rando T.A., Treatment of complicated mourning, Champaign, IL, Research Press, 1993). In these cases, normal reactions such as feeling depressed or feeling anxious can transform into despair, a feeling of helplessness in life, clinical depression and disorders derived from anxiety, such as phobic attitudes and obsessive thoughts.

Grief is a social process and, as such, the fact of feeling support and being able to verbalize and share the experience will be essential for its resolution. However, today's society can exert its influence in the opposite direction, that is, forcing the bereaved to be well right away, to be distracted, to avoid contact with pain or tears, causing the process to be inhibited and complicated.

In summary, a correct elaboration of grief is essential for the good physical and mental health of the individual (Portillo, Martín and Alberto, 2002).

We have already justified the importance of the grieving process. But to elaborate this process properly it is very useful to have a theory that provides the professional with a deeper understanding of the process that the patient is going through and, at the same time, provides the bereaved with a greater sense of control over what is happening to them, as well as a hanger on which to organise their feelings and give them meaning.

2.10 Questions without answers

One of the great concerns of human beings is to answer the questions about death. However, there are answers that no one has, so these questions are also an invitation to begin a deeper understanding of loss, its meaning, of love...

The attempt to give a concrete answer to that search will not be able to quench the thirst for knowledge, because there are questions for which there is no answer.

For this exact reason, when a patient formulates one of these questions, we must carefully accompany the need behind the posed question and let the patient themself find their own answer.

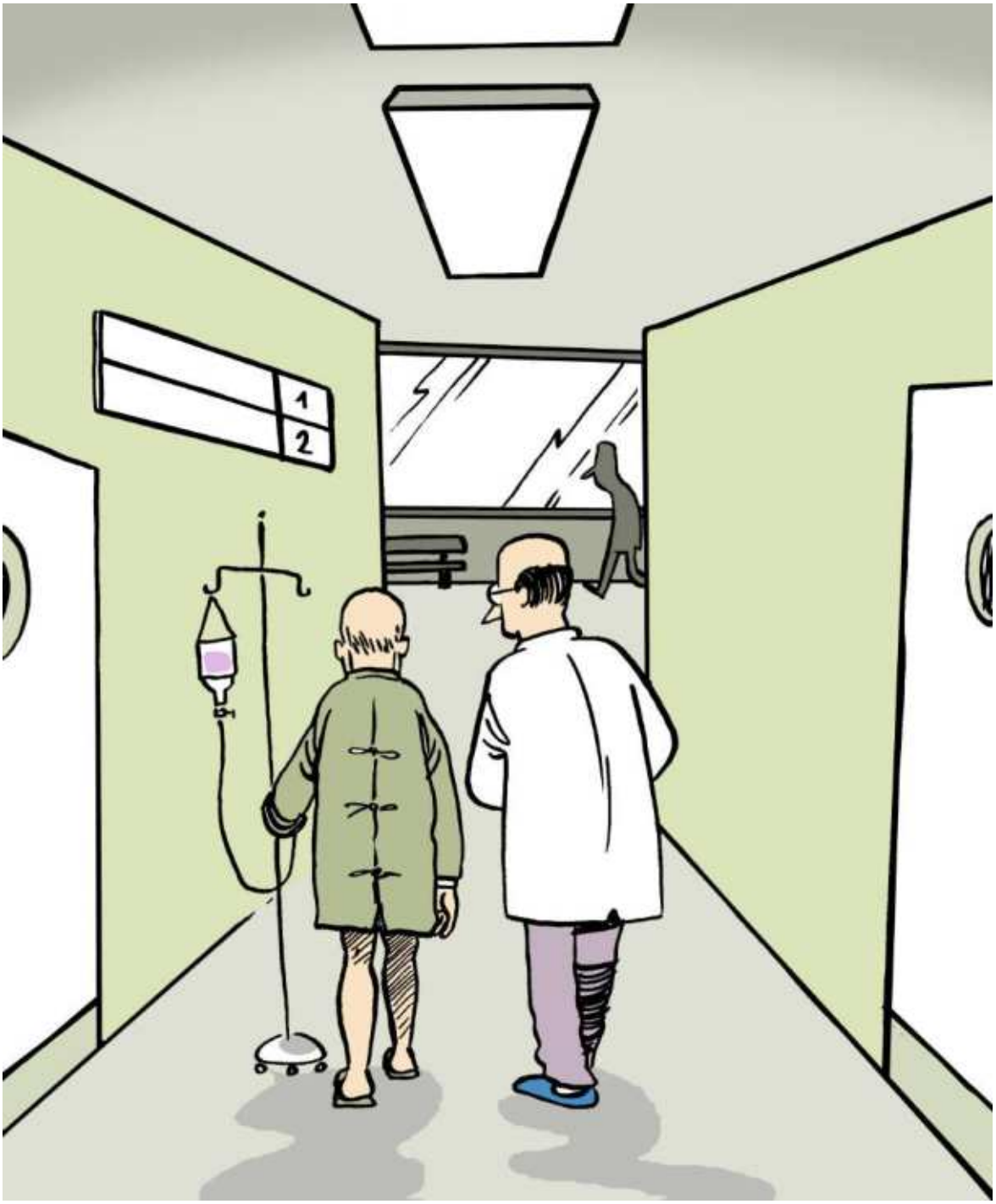
We have to be conscious that neither ourselves nor anyone else has the answers to all questions. On the contrary, the desire of been seen by the rest as infallible experts can break the intuitions born from these concerns.

REMEMBER:

- **Pain is a fundamental aspect of grief and the form it adopts on each person can vary greatly.**
- **There is no "correct" or "normal" way of elaborating grief, the range of reactions towards this process is immense.**
- **Grief does not have a determined duration; each griever requires different periods of time. The fundamental issue is what each individual does with their time.**
- **Therapy is necessary when a stagnation of the process is perceived and we see that it does not progress, being able to help the bereaved in multiple ways.**

CHAPTER 3

GRIEF INTERVENTION **LEVELS**



The most powerful tools against pain are the love and compassion that come from other human beings, whilst there are essentially two main reactions towards pain: withdrawal or approach. This is an almost obvious statement, as only these two possibilities exist.

These positions are maintained according to the attitude that each person keeps towards this reality. When the pain of others frightens, a withdrawal occurs: people who adopt this position change the subject so as not to talk about death in front of the bereaved, they avoid delving into the meaning of the emotions and sensations of the other, they do not know how to comfort or how to accompany the pain and feel overwhelmed by reactions that are usually normal and even healthy in this process. On the opposite side are those who are not so afraid of the pain of others and want to help.

The most common outtake is that both a group as the other side have good intentions, but few resources to face such complex situations. Pain can only be approached by those who do not fear their reactions and firmly believe that it can be overcome. Those who do not have this conviction will approach grief from paternalistic and overprotective attitudes, transmitting the idea that this process is something that must be protected and moved away, because it is difficult to overcome.

3.1 How can I provide basic psychological aid?

There is no single way to help someone who has suffered a recent loss. Everyone reacts as best they can to a situation that is often disconcerting and very intense. Hence, when a person with a recent or immediate grief comes before us, it is useful to have a series of general guidelines that we can adjust to the needs of each suffering person, since knowing them allows us to provide support and comfort with a greater sense of security.

There are at least three ingredients that are essential in that "shaker" to relieve pain:

Symptom control and attention to the more physical aspects of grief

This point relates to the most common symptoms or reactions to the grief of loss. We refer to reactions such as headaches, dizziness, fatigue, difficulty falling asleep or lack of appetite, among others.

Grief is a process that has a huge impact on the human being and requires a large number of resources to achieve the balance that is lost with the death of the loved one. This emotional impact has a physical correlation (Gendlin, 1967) with a great diversity of different sensations that accompany the process.

Grief is a first-rate stressor for the individual. This stress maintained continuously over time is what explains, at least in part, the physical correlation. In a first instance, taking care of the more biological part calms the bereaver and restores a certain sense of control over the grief.

The best prepared person to address these symptoms during the first moments is the family doctor. He/she is the one who will be able to supervise and, where appropriate, prescribe any medication that allows adjusting the sleep and rest cycles if necessary, as well as regulating previous medications or, for example, illnesses that have been neglected during the deceased's illness. or during much of the grieving process.

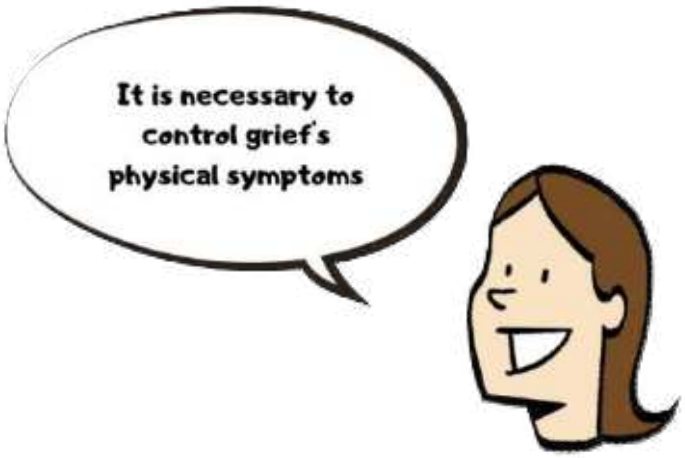
It is essential to properly regulate the diet and rest of the bereaver. Grief requires a lot of energy and, to be able to go through it, it is important to properly monitor these two aspects.

Any type of help aimed at meeting these needs will help to mitigate the most visible physical symptoms.

Closeness

In general, grief is a process that you go through alone, without a clear guide or instructions. In this sense, the loss of a loved one sometimes brings with it other losses: the loss of contact with friends or acquaintances, with neighbours, with the social circle. This occurs because the social environment is usually not prepared to meet the needs of a bereaved person, nor to "bear" the pain of others, since pain can produce fear and even rejection.

The isolation caused by not feeling understood or validated can intensify the bereaved's grief over the loss of a loved one. Usually, people tend to move away from what causes pain or suffering and closer to what gives them pleasure. During grieving this paradigm is fulfilled. The social circle is often frightened by the bereaved's reactions and does not have the capacity to take charge of the griever's pain.



When this happens, the help offered to the bereaved by their closest circle may be inadequate, by prescribing what they really need themselves: that there is no pain, something that is impossible throughout grieving, because its mere name means pain and withdrawal to this emotion is impossible.

Other times, although the environment is prepared to deal with the suffering of the bereaved, the perception that he has of the help is that it is insufficient or does not suit his most pressing needs. In this context, it may happen that the bereaved is perceived as a burden or as inadequate, causing a distancing from his or her closest circle.

In the end, this detachment is prompted by two situations:

- The bereaved feels misunderstood and does not know how to make their social sphere understand what they need.

- The social sphere does not know how to manage their pain or how to help them.

These two situations have a meeting point in communication: open communication between both parties can help to put on the table what each one is willing to do and what the other needs. This direct and honest communication will help the sufferer to get closer to the people around them and to release his pain, because what each person needs is different.

In these disconcerting moments of grieving, one of the things most valued by the bereaved is the closeness of another person: without invading, without overprotecting, simply being available, making concrete offers, validating and normalising the feeling that loss produces in each one. Only another human being can calm the pain of a person who hurts, because we are social beings.

It is also important to handle the closeness / distance duality, because when the closeness is excessive, it can become pernicious. We all need a space to assimilate what has happened, to feel without pressure. When closeness becomes suffocating, it is no longer useful. This is why it is essential to pay attention to the rhythm of each suffering person without pressuring them: to allow and encourage them to take care of what they can. The difficult balance involved in this dance makes it sometimes difficult to meet the needs of a grieving person, largely due to the limitations that each one carries.

An aspect that is not often considered within the grieve accompaniment is the perception that each subject has of the help they are receiving. This is fundamental, because what matters is what the bereaved perceives and not so much the real situation. It may be the case of people who, being very accompanied, feel alone and others who, despite having little or no support, feel that they have received more than enough. That is the difference between the real support received and the perceived, you have to attend to the second, not the first.

Hope

It is extremely difficult to cope with pain if what we have in mind is that it will last forever. For this reason, it is absolutely essential to instil hope in the grieving patient: a real hope that the grieving will be overcome, that the pain will be undone. You have to support that message with objective data. The reason is that you cannot live without hope, since pain wears down a lot and we cannot ask a grieving person in any other way to live with their pain, to leave space or not to reject it.

In my clinical experience, there are at least three arguments that allow us to affirm that the human being is biologically prepared to overcome pain:

1. Throughout our history, we have lived and endured millions of losses and we have overcome them. In spite of everything, we are still on earth as a species and we have not become extinct.

2. According to the World Health Organization (WHO), 90% of people who suffer the death of a loved one go through a healthy grief. Healthy grief, logically, hurts. But the pain lasts for a shorter period of time and, moreover, it remits almost spontaneously, without making any effort. It is a type of grief that does not require therapeutic, psychological or medical attention. There are those who need more time to get over it and those who need less, but the vast majority of people get through grief. The percentage of people who require help to overcome it is very small compared to the number of people who do not.

3. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) includes a novelty in the annex relating to conditions that require further study: resistant complex grief disorder. This describes in a fairly detailed way a type of disorder that globally affects the individual in his life and that therefore requires psychological and / or medical attention. It is important to note that the prevalence of this disorder is between 2.4 and 4.8%, which implies that the vast majority of people who experience a loss will be able to overcome it almost spontaneously and a "small" percentage of Cases will require therapeutic help, but both will overcome it. There is a percentage - barely close to 1% - where unfortunately and for different reasons we have to speak of therapeutic failure. For these cases there is not purely "curative" therapy, but there would be the possibility of making an emotional accompaniment to relieve the sufferer and combine it with a pharmacological therapy to control the most intense symptoms of anxiety or anguish. For all these reasons, based on statistical criteria and facts, we can categorically affirm that grief can be overcome, with or without help and / or more time.

Messages that can offer hope:

- *"Pain does not last forever".*

- *"No matter how long or dark your night, a new dawn will break".*
- *"This too shall go away".*
- *"You are doing everything in your power, now just trust".*
- *"You are not alone with your pain, you can ask for help for whatever you may need. Wherever you may not be able to reach, I will".*
- *"Others prior to you got over this, and so will you".*
- *"Be kind and compassionate to yourself, and the rest will come by itself".*

What not to do:

When faced with a person's grief, we should not take anything for granted, as if all griefs were the same. This, in addition to being false, diminishes the importance of the experience itself. Each experience is unique and each pain is different.

Do not minimize the pain of others, or say lightly that "it will pass." Nor should we downplay the death of the loved one to reduce the drama of the tragedy, with phrases such as: *"At least he no longer suffers", "It is the best thing that could have happened to him/her", "Nothing could be done for him anymore. "," You are young, you can fall in love again "," You can still have another child* "... These phrases so widespread and heard at funerals often produce discomfort, a sense of incomprehension and anger in most of the grievers.

Do not use topical phrases (from movies, customs, social milestones) such as:

- *"I share your feelings".*
- *"I'm here for whatever you may need".*
- *"Don't worry, time heals everything".*
- *"Only the good guys die".*

It is difficult to avoid topics, because they are comfortable and allow you not to think much. They are social conventions that seek to alleviate the pain when a loved one dies, whatever the circumstances. However, the final effect of the topics is that they convey indifference, they equate all experiences. They do not express a specific real feeling (what this specific death generates for me, in relation to this specific person) but they are set phrases that, by dint of repeating them, have lost their meaning. What a griever values most at this time is the proximity of a specific message, one that is born from the heart and that seeks to shelter, comfort or at least have an honest and real communication in the face of the pain and tragedy that death has caused.

3.2 Who can provide help during grief?

We could say that almost anyone can accompany or bring comfort to a person who suffers: pain needs witnesses. But it is important to distinguish help from quackery and not to abandon oneself to the "*siren song*" that is sometimes offered with good intentions.

With this term we do not refer to homeopathy, acupuncture or reiki, but to techniques that produce iatrogenic effects, that normalize or enhance signs of grief that are not healthy, for example, groups that seek unorthodox spiritual contacts or in the beyond.

Intervention Levels

The fact that grief is a universal experience also contributes to the existence of different levels of intervention. From the most basic to the most professional, the levels would be:

- **Unprofessional help**. It is the one that can provide the closest social circle: friends, family, neighbours... supporting, accompanying, taking care of the well-being of the grieving person at specific levels, such as providing food, housework, etc.

- **Non-specialized professional help**. We talk about the help that the Primary Care doctor can provide to the sufferer. It is not a specific aid to attend to grief, but it can attend to certain common symptoms of the process, such as anguish, insomnia or anxiety. At this level, the social worker or the nurse is also relevant, as they may have knowledge about the approach to grief due to their more frequent contact with patients and closer follow-up.

- **Specialized professional help**. We speak of specialized help when a person goes to a service in order to receive specific help for the discomfort caused by grief and receives it from professionals who have been trained to attend this process. At this level we can already speak of grief therapy taught by expert psychologists. They will be the ones who deliver the therapy, either individually or in groups, depending on the needs of each patient.

3.3 How can we measure grief?

The grieving process is difficult to measure. It cannot be evaluated exactly - as if it were an X-ray - in order to see where the process is, that is: if it is progressing or blocked, how much and what is left to finish. But it is important that a part of the therapy be devoted to evaluating it, because this information acts as an external motivator.

If we do not give the bereaver an estimate of their evolution, the process may seem infinite in time. However, there is no standard method that allows the professional to accurately discern where a person is at during the process. Part of this difficulty has to do with what the fact of ending the grieving process implies for each subject and, above all, when to end it.

In the previous edition of this guide, we incorporated the Revised Texas Inventory, (Faschinbaguer et al, 1977, 1981) better known by its acronym ITRD. This inventory consists of twenty-one items and is self-administered. The average administration time is ten minutes. However, in this new edition, we have not included the questionnaire, because we consider that it overdiagnosed complicated grief. Furthermore, grievers are usually not motivated to fill in the scales and Primary Care physicians do not have time in consultation to address this issue in depth.

Even so, there are subjective measures that make it possible to roughly estimate where each bereaver is in the process, what they have achieved and what they are lacking. Normally in my professional practice I use what I call "the measuring table", which is nothing more than my worktable. At a point in therapy, I ask the patient to imagine that one end of the table is the beginning of the grieving process and the other end is the end. Next, I ask them to pick a point between the two that represents how far they have come and how far they have to go. Clinical experience has shown me that patients almost always agree with my own assessment of their condition.

Another way to appreciate the progress of grief is to observe the patient's changes in therapy: from one week to another things change, what is verbalised is different, the sensations are different... this tells us that the process is not blocked, because pain varies in intensity, duration and frequency. If the pain begins to manifest itself in waves that last less, or that are less frequent or less intense, that speaks of a positive change.

Other positive signs are that the person talks more about themself than the deceased, that they worry about everyday things, that they talk more as compraed to if they barely talked before, that they more focused compared to before, that they are more aware of what occurs and name their emotions ... even the patient's own perception of reality. Sometimes it's the subtle details that show us progress in the course of grief.

At other intervals it seems that the patient is not moving forward and that the process has stalled. In those cases, what happens is that perhaps we have gone very deep into the process and it is moving towards greater awareness, towards greater introspection, "inward" rather than "forward". But that should also be recorded as progress: the ability to tolerate pain or to speak openly about what happened.

3.4 What role do the different social agents play?

The human being lives in society and elaborates grief in society. Thus, each of us has a role and a way of influencing the grieving process of the people around us. The griever is not alone, they live immersed in a specific culture and time. Our culture is hedonistic and seeks immediate pleasure - perhaps that is why it is difficult for it to meet the demands of the bereaved who need care and time to grieve - but we all play a role in it.

For this reason, it is not society in the abstract that must change to favour contact with the reality of grieving and suffering, but each one of us, with small gestures, being receptive, informing ourselves about grieving, by speaking openly about death and pain… Each person has their own "niche" from which to influence and improve their knowledge of grief or the care of pain.

The role of the media

The media have a key role in facilitating this process and their power of influence is expressed in many different ways:

- Giving spaces in written and audiovisual media that make it possible to speak normally about grief, death or suffering.

- Disseminating rigorous information about grief and giving voice to well-known experts on issues of loss, trauma and grief.

- Following the guidelines recommended by mental health experts when transmitting news likely to impact the population, such as attacks, accidents, natural disasters...

When a major media disaster or tragedy occurs, the guidelines that trauma experts advise are:

- Avoid the dissemination of traumatic or potentially traumatic images.

- Offer objective data, but avoid speculation.

- Intersperse other information and do not focus only on the tragedy.

- Launch messages of hope and flee from "devastating prophecies".

- Find out about what can benefit and what can harm listeners.

- Provide information about the process that is being lived, caring towards the emotional needs of those affected and where help can be received.

The role of doctors and healthcare workers

Doctors and health workers have a priority role, because they are often the ones who detect whether a grief is complicated or pathological. Many people go to the doctor, nurse or social worker with complaints, or with a discomfort that hides a neglected grieving process. Therefore, this primary care is essential.

Socio-healthcare professionals have to know how to identify when they are facing a complicated case of grief and when it is a healthy grief. Faced with the latter, they must normalise the reactions, validate them, provide support and closeness. Faced with complicated grief, they should refer each case to the psychiatrist, if medication is required, or to the grief expert if no pharmacological regimen is required.

From this it can be deduced the essential need for social and health professionals to know a theory of grief that allows them to answer the main questions of a bereaved, in addition to facilitating the differentiation of one case from another. It is essential that they do not "prescribe" a specific period of time to elaborate grief, that they do not pressure the patient or transmit topics such as: "What you have to do is not think about it", "Get to work so as not to have so much free time", etc.

3.5 What does the grieving patient seek in a doctor?

In today's society, the institutionalisation of death and grieving has brought complications for grievers. Faced with the way in which mourning was lived as in the past - more natural, with rituals in which the neighbourhood, the social sphere and the entire society participated - a more solitary or individual way of living this process has been imposed.

These factors have contributed towards the limits of grief becoming more diffuse, pushing patients to look towards the health professional for the "rule" that distinguishes normal from pathological. By stripping grieving from the "official" rites that give it meaning, and appointing a beginning and an end, the need arises to institutionalise the treatment of this same process.

The healthcare professional in grief

1. The grieving process involves enormous stress for the body, causing physical wear and tear that sometimes leads to the development of various symptoms that add anxiety and suffering to the bereaved.

2. Sometimes, during the period of illness prior to the death of the loved one, the bereaved may abandon the medical treatments or processes that he or she was following before the loss. This loss generates in the bereaved a real awareness of physical death and it is then that fear and the need to take care of and check themselves arises.

3. The difficulty of the social environment to contain the pain of the bereaver and respond to the unknowns generated by death and grief lead them to consider the socio-health professional as the only valid speaker.

• What does the griever seek in a doctor

The griever seeks different things from the Primary Care professional:

- To check their physical condition after grieving the loss of a family member.

- A review of their medications and medical processes that have been interrupted by the illness or death of their loved one.

- Advice and guidance regarding whether or not their grief is being a healthy process.

- Advice on practical issues, such as medication in case of anxiety, or receiveing guidelines to help them feel better.

- Consolation. The griever seeks words of encouragement, as well as another person who acts as a witness and accompanies them in their pain.

- Something different from what their social environment already offers them. If what they need (understanding, affection and guidance) is found in their social environment, they probably do not have as much need to go to the doctor. They look for something different from what their close ones offer them in the hope of finding themself better.

- Hope. The griever trusts that the professional knows how to manage and reduce the discomfort and pain of grief.

Ultimately, what the griever is looking for in the doctor is an answer to the questions that he/she must face after the loss. They require guidance in a generally quite confusing process, where there are no clear boundaries between what can be considered as normal and what is not.

The demands of the griever will require the doctor has a greater training in grief and specific training in listening skills, as ultimately what a griever is lsearching for is another human being to comfort them.

REMEMBER:

- **Grief is a major stressor and can cause physical symptoms that need to be addressed. Self-care is vital during the first moments of this process.**
- **An open and close communication between the bereaved and their social circle is crucial to prevent them from feeling misunderstood and in order to avoid their tendency of isolating themselves.**
- **It is essential to convey hope to the bereaved in the notion that they will get over the loss, as well as confidence in that they are capable of achieving so.**
- **There are different levels of intervention in grief, going from no professional intervention to that of a specialised professional.**
- **Doctors and health workers play an important role, as they are often the ones to detect if a grief process is complicated or pathological.**

CHAPTER 4

DEFINITION OF GRIEF

We live in a society in which talking about grief, pain or death is uncommon. We live keeping our backs turned away from this reality for as long as we can and only turn to face it once it is inevitable. Ignorance causes us to react towards grief in an intuitive way, which quite often is not the most appropriate one.

Comprehending the keys of the grieving process is essential if we intend to help people who are going through one: not only in order to differentiate normal reactions from pathological ones, but also because bereavers need to know a theory that helps them understand in a simple way what is happening to them. This in itself is already therapeutic.

If we thoroughly review the literature that exists surrounding this topic, we will discover that there is not merely one, but rather many definitions of grief. Each of them constitutes an attempt to understand it as a phenomenon, as well as a step forward in its description. The truth is that there is no single way to define grief, just as there is no single way to explain or experience grief.

4.1 Grief: Definition

We know that in Spanish, the word "dolor" (grief) comes from the Latin term "dolus" and it means "pain". Therefore, based on its etymology, we should not be surprised that bereavers feel pain and have a hard time. As Doug Manning used to say, "*Grief is as natural as crying when you're hurt, sleeping when you're tired, eating when you're hungry, and sneezing when your nose itches. It is Nature's way of healing a broken heart*".

One of the most widely accepted definitions of grief is that "*it is the normal process that follows the loss of a loved one*". This definition is heir to the different nuances that different authors such as Bowlby, Tizon, Parkes or Freud have incorporated into this definition.

The grieving process has been detected in numerous animal species, not only in humans. An example can be the case of oysters. When one of the members in an oyster pair dies, the surviving partner secretes a substance which is chemically very similar to human tears.

Thus, grief is a behaviour that is installed in the human being at an almost biological level and one which takes place after any loss in general: ie., the loss of a job, a relationship, an object to which we were especially linked, a loved one, or the expectations of having a healthy child. **Throughout this**

guide, we will focus on grief as the normal process that takes place after losing a loved one who has passed away.

Although we accept this definition as the one that comes closest to our understanding or explanation of grief, it could be said **that not a single grief is the same as another one.** This is because grief is an addition to everything else that a person is and, since there is no single person equal to another, there cannot be two equal grief processes. It is as if grief were a transparency that is superimposed on the personal characteristics of each human being: each of these peculiarities will modulate grief, making it unique. Or which is the same as saying: it would be necessary to subtract from grief that which a person already is, in order to adjust the treatment to the expectations. This means that grief must be evaluated in its own context, taking into account the individual characteristics of each person.

The death of a loved one will not turn someone into a more active, sweeter, more sensitive, or more responsible person. If a person is very sensitive, they will remain as such during grief, and if thye are very rigid, they will handle their grief in a rigid style. It should not be assumed that everyone will behave in the same way during grief, nor can it be presumed that the expectations regarding its resolution will be the same.

4.2 What is grief and what is not grief?

It is essential to differentiate grief from other similar processes. Grief can frequently be mixed up with other mood disorders, such as major depressive disorder. The DSM-V guide, (*Diagnostic and Statistical Manual of Mental Disorders,* 5th Edition, APA, 2013) is not of great help when carrying out a differential diagnosis, as it centres all the responsibility in the clinician's opinion, who thus has to use their own experience in order to reach one decision or another.

Often, the FMLC psychotherapy service is referred to by a psychiatric service in the area regarding cases that have been diagnosed as recurrent depression or as persistent grief. What I have found is that:

- Major depressive disorder and grief share most of the same symptoms, especially if we are facing a complicated or pathological grief.
- When it comes to a grieving process, no significant improvements are reported with the use of antidepressant medication, while in the case of depressive disorder, the improvement is evident.
- Usually depressive disorder causes the loss of self-esteem, while in grief this does not necessarily occur.
- A major depressive disorder and grief can coexist, but one of the processes is almost always more urgent than the other and work on both cannot be undertaken at the same time.

However, this distinction, which simplifies and clarifies a lot at a pedagogical level, is not so simple to carry out at a practical level. Therefore, it is up to the clinician to determine what decision to make in each specific case. We usually establish a hypothesis and test it. And, if it does not work, we conceive another one.

Likewise, we can establish differences between a healthy grief and a complicated or pathological one. One of these differences involves the intensity of the symptoms: at first, it is normal to have intense feelings of pain, sadness, anger or others, but when that intensity persists over time we are talking about to a pathological grief.

Another aspect that allows us to differentiate normal grief from a pathological one, is the moment when symptoms first appear: if they come out when the loved one dies, or after a few days, we are talking about normal grief. However, if the symptoms crop up weeks or months later, or do not emerge, we are talking about a pathological grief. This makes sense in that, when

death occurs, the social support the bereaved recieves is prolongued for some time, weeks, or even months. Yet, when it comes to a time-delayed grief, social support is no longer present.

Finally, there are characteristics that allow us to differentiate a complicated grief from a normal one: denial of death is one of the main signs of pathological grief. Denial is a very primitive and typically psychotic defense mechanism, as well as complex and structured hallucinations in which the griever can see or even hear the deceased person.

Above all, we see a cultural perspective and, in that sense, what is considered "normal" within one culture may not be so in another: culturally normal behaviours related to the deceased are part of a healthy grieving; while those that are not, are part of a complicated grief. Denial that is upheld over time is part of a complicated grief, while if it only occurs during the first moments, it is solely a protective mechanism.

In general, we can say that sadness in grief is associated with the loss of a loved one and not with life in general. Through the grieving process, the world is what seems amiss, not oneself or one's own image. Moreover, through a healthy grief, sadness emerges in the form of waves, it is not constant and often coexists with moments of joy and feelings of gratitude or admiration for the loved one who is no longer there, this is something that does not occur throughout a complicated grief process.

There is no single criterion when it comes to correctly identifying whether or not a person is going through a complicated grief. Hence, it could be useful to use an inventory or scale that allows us to define the needs of the person who asks us for help, as well as to determine which treatment is the most appropriate one for them.

In order to accurately identify complicated grief, there are two inventories. The first one, is the Inventory of Grief Experiences, created by Katherine Sanders in 1977, which consists of 135 dichotomous items and is divided into 18 scales. This inventory is adapted into Spanish and is self-administered. The average administration time is an estimated twenty minutes.

The second inventory we have is the Texas Revised Grief Inventory. Better known by its acronym TRIG, this questionnaire was prepared by Faschinbaguer in 1981 and consists of 21 items, divided into two scales. It has also been adapted into Spanish and is self-administered. Its average administration time is approximately ten minutes.

The importance of achieving a correct diagnosis lies in the fact that normal grief does not require therapy, whilst pathological grief does. Avoiding the psychological treatment of people undergoing a healthy grief process would provide important expense savings to the Spanish Public Healthcare System. Health problems derived from bereavement could also be prevented, as shown by the abundant medical studies on the matter, which indicate a higher mortality rate arising from cardiac events and suicides, as well as a greater use of healthcare resources by those undergoing complicated griefs.

As we have already pointed out, it is especially important to measure the degree of grief intensity, as this element makes the difference between a normal process and a pathological one. In the first edition of this guide, we included the Texas Revised Inventory of Grief, as it is an objective measuring instrument. However, we consider that this instrument overdiagnoses complicated grief and, furthermore, cannot be applied in Primary Care consultations due to the limited time professionals have available to tend for their patients. Additionally, we find that patients lack motivation to fill out these forms and grievers, quite often, get tired of answering it and abandon self-administration.

In order to replace it, we have included a series of questions that professionals can ask their patients and can help in guiding them in their diagnosis:

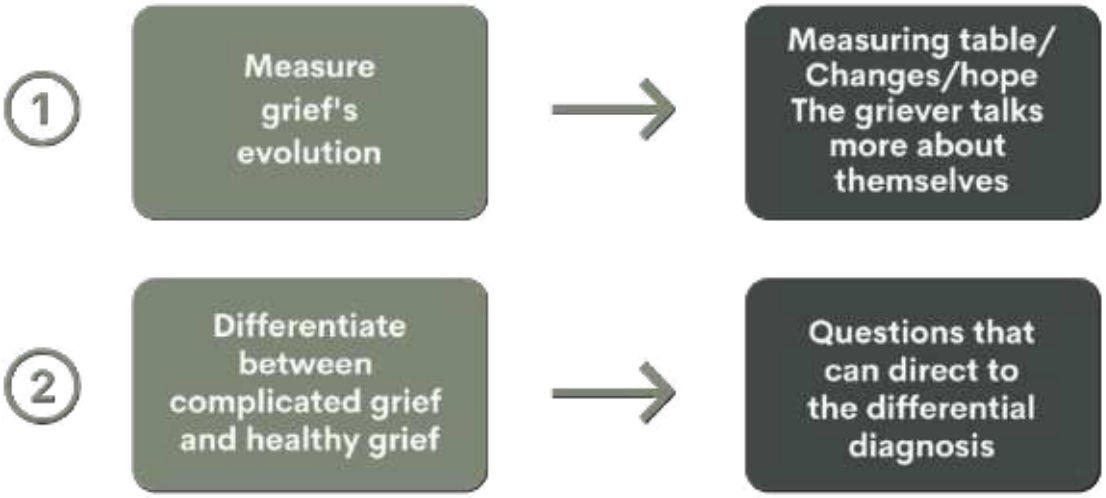
1. Does the patient have physical symptoms that are not organically based?
2. Does the patient have depressive disorder symptoms (such as dysthymia, lack of enthusiasm for activities that they previously enjoyed...) - that do not subside with medication?
3. Are there any unresolved grieving experiences in the patient's history?
4. Does the patient have the feeling that the world has become a dark or dangerous place since the death of their loved one?

These questions should serve as a guide for healthcare professionals. If the answer to these questions is affirmative, it would be appropiate to refer the patient to a specialised grief treatment service that allows them to delve into this possibility.

4.3 How does grief work

Grief is a normal process that most people resolve without the need for therapeutic intervention. Nonetheless, what are the keys that solve the grief of those who require psychological attention or need guidelines?

Two types of measurements:



In this epigraph, we will address how grief works in general, respecting the fact that each grief is unique, as not one is the same as another. There are many things that can be done to relieve or sooth the pain caused by grief:

- **Medication**, to which we can turn to in order to treat the most acute symptoms, reduce anxiety levels, bolster sleep or any other disorder related to the damage and emotional wear that this process implies.

- **Time**. It is imperative that time goes by to be able to work on the loss. However, we are not talking about a specific period of time, three months or a year, as each person will need a different amount of time. Also, time is not the only component involved in this process. Time only sets distance away from a painful event and, in that sense, can appease it. Yet by itself, the course of time does not cure anything.

- **Pain treatment**. Pain caused by grief requires for it to be seen, recognised in all its nuances, legitimised and normalised. That calms the pain. Therapy can help us in doing so, but if someone does so by themselves they will achieve the same effect. The therapist conveys the assurance that grief can be overcome, offers hope and normalises grief's reactions, inviting the patient to confront these reactions, whatever they may be, in order to be able to live with them. And they do so by speaking about these feelings from their own core: by

accompanying them, acknowleging them, allowing them to unravel, thus rewriting what happened and what is happening to them since then.

When we pay attention to pain, it dissolves, not immediately, but it does in the medium or long term. If, instead, we distract it, the pain is postponed, it freezes and accumulates.

On another hand, grief is a process that is perfectly regulated. It manifests itself as a diffuse discomfort concentrated in the centre of the chest and it thus, greatly distorts the diagnosis. If it is addressed, sorrow or a feeling of emptiness or absence emerges, which is why crying frequently appears. When we cry out long enough, it generates a kind of sedation, as tears have a chemical component very similar to the main ingredient present in any benzodiazepine.

SUGGESTIONS:

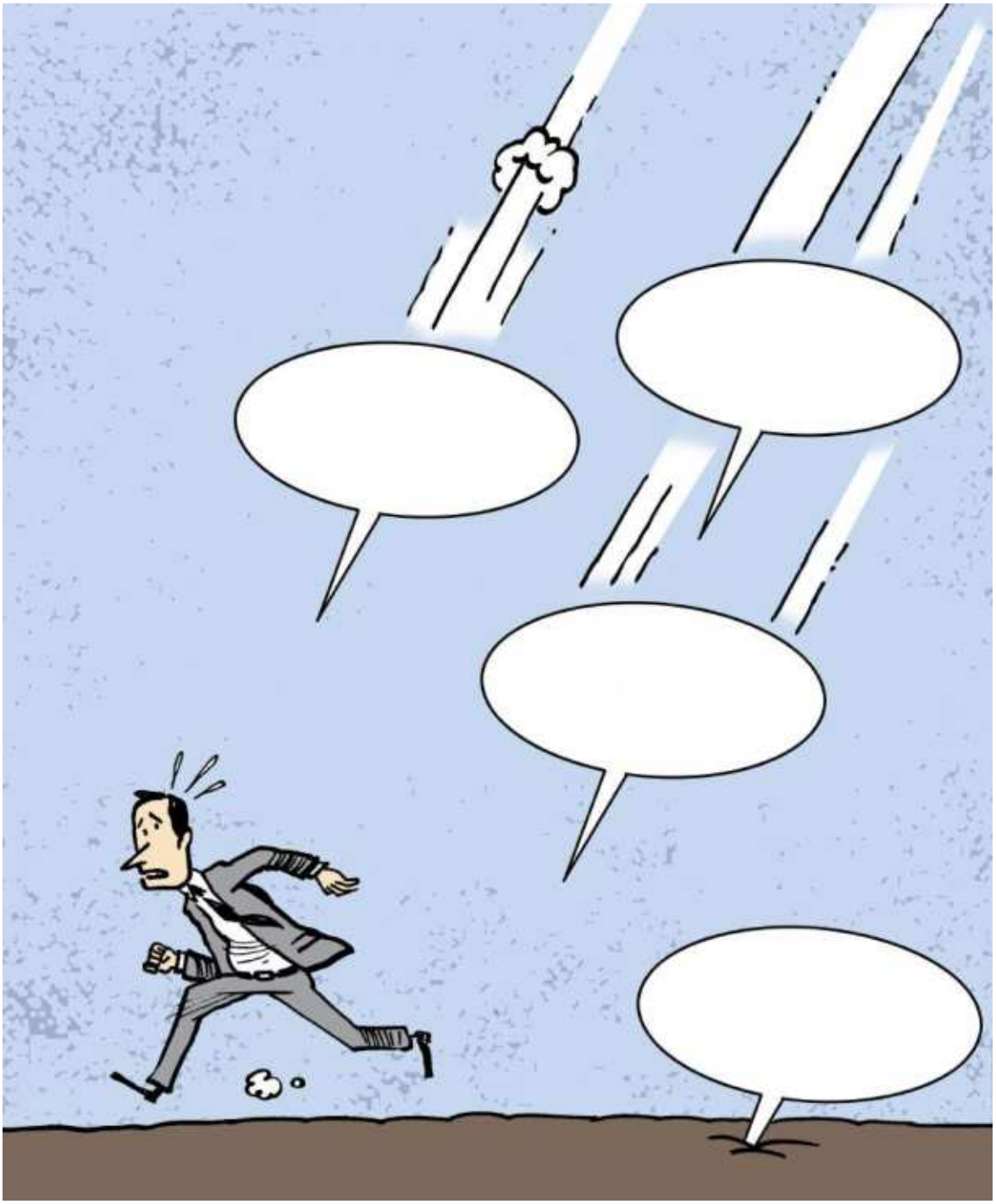
- Stay calm.
- Normalise reactions, always within common sense.
- Do not strive too hard.
- Do not try to force or organise the grieving process.
- Be compassionate towards yourself.
- Follow your intuition.
- Get plenty of rest.
- Keep up the hope that grief can be resolved.
- Do not pretend, do not rely solely on the course of time and, above all, do not return to life as if nothing had happened.
- Do not fight against grief's reality and emotions, because there is a lot of suffering in denial: what you resist, persists and what you allow yourself to feel, flows.

REMEMBER:

- **Grief is the normal process that takes place after any loss. There is no grief without loss.**
- **Each grief is unique from the rest.**
- **Anyone can accompany or bring comfort to a grieving person: pain needs witnesses.**
- **Some keys in offering basic help: pay close attention to the physical aspects of grief, provide hope and closeness.**
- **Grief differs from depression in that it is not a disorder and that it is solved without medication.**

CHAPTER 5

IRRATIONAL OR ERRONEOUS IDEAS REGARDING GRIEF: INADEQUATE FEEDBACK



The expectations around how grief works, how long it lasts, whether it comes to an end or not and how this occurs… This is to say, the theories that each individual person establishes regarding this process, decisively influence their evolution. In our society, there are many irrational ideas about grief which people consider to be valid. Learning to demystify grief and offering an alternative theory is a key factor in its resolution.

We have all heard, at some point or another -either through a relative or an acquaintance- inadequate phrases that make us uncomfortable. Many people find it difficult to remain silent when a death occurs in their social circle. In their attempt to fill the void of silence caused by the pain and sorrow for the loss, they may make comments that may seem inadequate or awkward. However, sometimes during these situations, the most appropriate phrase is: *"I do not know what to say, I doubt there are any words that can relieve your pain"*.

Below, we shall elaborate on the most common and widespread misconceptions regarding grief:

"Time heals everything"

This statement speaks of a passive person, one who expects things to occur as if they had no control over what happens around them. This generates a significant sense of loss of control and presents a panorama whereby one can only wait for the pain to disappear, almost as if by magic. But, in reality, time actually sets real distance with the death of our loved one, allowing us to look at it with another perspective. In any case, we can strongly affirm that what leads to the resolution of the grieving process is not time, but rather what one does with their time.

"He/she would not want you to suffer"

This idea induces us into thinking that the deceased person were still alive, an assumption that can block the bereaver's acceptance of the death and, at the same time, propel them to censor certain reactions for fear of being seen from the afterlife and disregard their loved one. This idea must be counteracted with the reasoning that when people die, they stop thinking and feeling. Hence, if a person suffers or does not complete their grief process, the only thing that occurs is that they do not get over the death of their loved one.

"It's worst if you think about it"

Sometimes, when we do not know what to say to a grieving person, we try to avoid the subject, as we consider it to be "delicate" or "thorny". However, when a person tries to solve their grief, they need to assimilate and think about it in order to find some sense to it. Everything we resist, persists and what we let be, dissolves.

"What you ought to do is to distract yourself"

This idea is especially widespread and refers to the need to hide or distract pain, as it considers that suffering in itself is something pathological. Out of all the irrational ideas we can come across, this is one of the most harmful ones, because it blocks an emotional flow that is in itself a natural healing source. Blocking, distracting or disguising pain only contributes to complicate grief.

"You have to be strong"

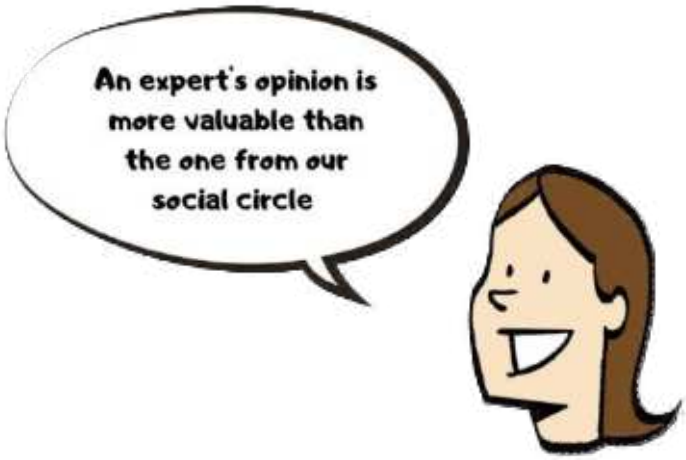
This idea is often repeated and refers to two erroneous approaches: the impossibility that expressing pain is a sign of strength and that the expression of emotions is bad for one's health. In general, these ideas are deeply rooted in an individual's personality, and are very difficult to confront and change. Applied in a rigorous manner, the assumption that "you have to be strong", inevitably leads to an emotional blockage that can end up pathologising grief.

"If you do not overcome it, you are not allowing the deceased to rest"

This idea follows the same principal as the previous: *"He would not want you to suffer"*. Dying implies to stop seeing, thinking and feeling. A person who is dead -by definition- does not rest, as their vital functions and senses no longer exist. If a person does not overcome grief, they will have a hard time and may suffer more than necessary, but that does not imply that they have to bear the guilt of preventing the deceased from resting.

"Those of us who are here, need you to be well"

Those closest to the bereaved express all these ideas with a single intention: to relieve, comfort and avoid pain. The only problem is that pain cannot always be averted. In the words of Jorge Bucay: *"Grieving hurts and nothing can be done to avoid it"*. Therefore, although our



social sphere says this with the best of intentions, these ideas only push the bereaved to encapsulate, prolong or defer their pain over time.

We live with our backs turned, denying the truth about death for as long as we can. Hence, when death strikes us closely, we feel frail and defeated, not knowing how to reposition ourselves. We do not know how to handle pain, so we resort to those strategies that we have always used and found helpful. The problem with this is that, when circumstances change, the strategies that are to be used must also change. What was once of use to us, now no longer works, so we must implement new tools in our daily lives.

Our social circle may not be very capable in comforting or accompanying us in the face of loss. Quite often, the loss of a loved one brings with it other losses, in this case, those of social relationships that we once enjoyed. An explanation to this phenomenon could be the distance that originates between the circle and the bereaved, a detachment that is bidirectional and based on fear: the distress the social circle has of harming the bereaved or of being infected by their pain; and the concern the bereaved has of

exhausting the patience of their social sphere or the dread of being hurt by them.

Inadequate expressions that hinder authentic communication and can be upsetting:

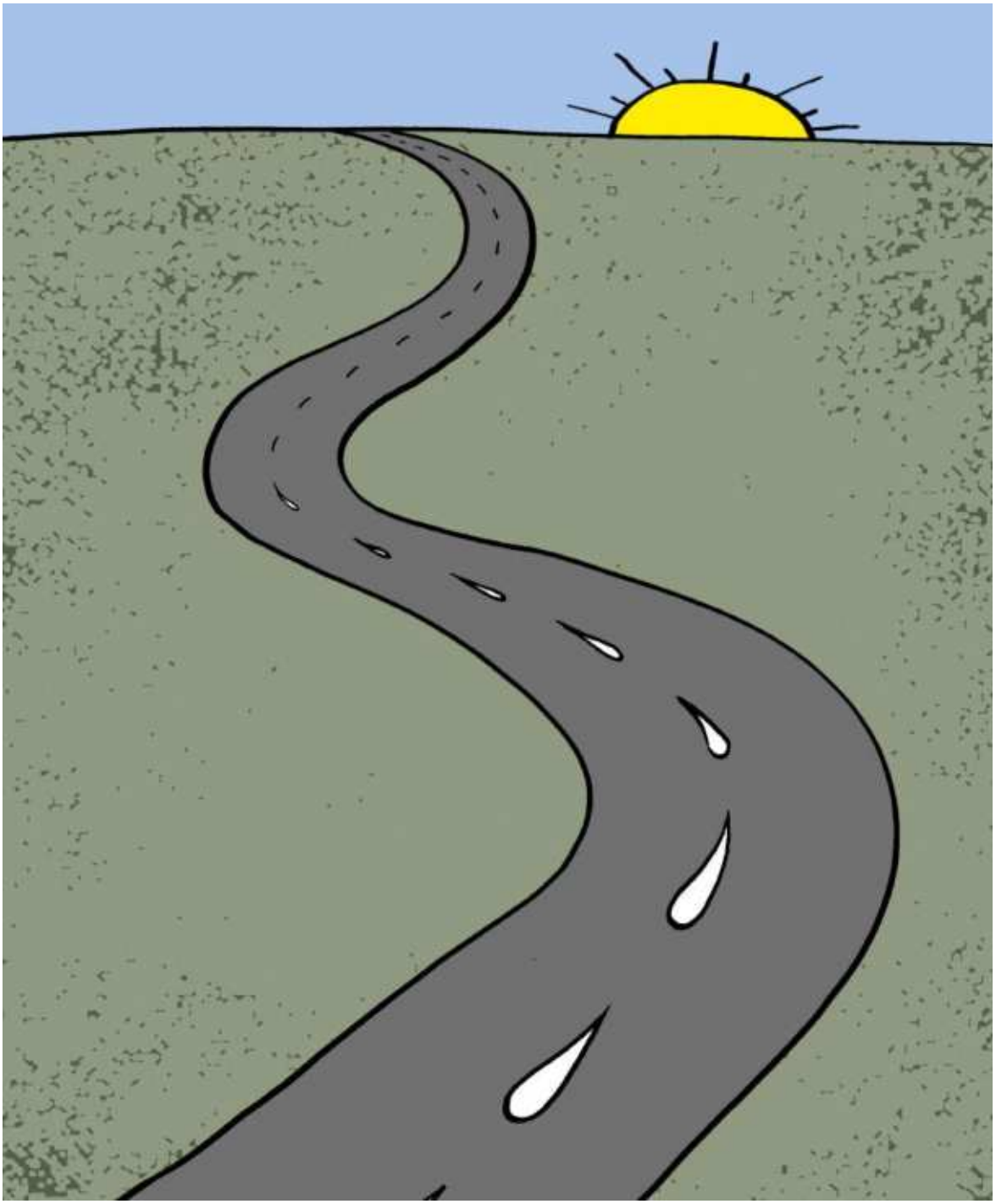
- *"This way he/she no longer suffers..."*
- *"It must have been a relief..."*
- *"At least you have more children..."*
- *"You can still have more children".* (In the case of early losses).
- *"How old was he/she?". (As though if the deceased was an elderly person, the death could be justified or, in the case of children, as if the pain would be greater based on the years they had lived).*
- *"A partner can be replaced, a child cannot".*

REMEMBER:

- **In our society there are many irrational ideas about grief that people consider to be valid, however they are actually only harmful to the bereaved.**
- **Idioms such as "You have to be strong", "He/She would not want you to suffer" or "We need you to be well" are inappropriate or awkward.**
- **In these cases, the most appropriate phrase to say is: "I don't know what to say, I don't think there are any words that can relieve your pain".**
- **It is more useful to be present and limit yourself to listen, than speaking: a look, a gesture may be considerably more helpful than any word.**

CHAPTER 6

WHAT DOES THE GRIEVING **PROCESS** CONSIST OF AND HOW DO WE UNDERSTAND IT?



Occasionally, grief -acknowledged as the normal process that takes place after the loss of a loved one and as an adaptive period in which the person uses all of their resources to overcome it- can get blocked, come to a halt or become complex.

There are at least two social factors capable of hindering the smooth running of this process, which could be resolved in a natural way without complications. One of them is the act of turning one's back on grief: it is omitted, hidden and is often avoided by society, as if wanting to avoid pain or prevent suffering. An attitude that constitutes one of the biggest traps in this process.

The second factor that can hamper grief is trying to regulate pain, ie. by classifying it. Pain is different for each person, regardless of the loss they have suffered: there is no single way to experience affliction. The stages or phases are ways of apprehending a reality in order to be able to work and understand it. However, certain realities -such as grief- are difficult to transfer to a clinical aspect, as each individual has their own pace, their own strategies and their own way of processing grief.

Beyond any theory, the main key to grief is that any attempt to stop or resist pain will increase and perpetuate it; while keeping a confident attitude, allowing pain to flow, will gradually dissolve it. This explanation is easy to understand and difficult to put into practise. A professional's job is to build trust in order to allow the patient to be in contact with their own pain. It is a delicate task, one that is undertaken gradually, by trying to progressively amplify the pain tolerance threshold.

The psychologist and researcher William Worden defines the tasks of grief as those which the bereaver has to solve in order to be able to properly process their grief. In so doing, he offers a simple and pedagogical explanation to understand this process. He uses the term tasks instead of phases (according to the theory of Colin Murray Parkes) or stages (according to the theories of Elizabeth Kübler-Ross, 1973). The explanation is quite simple: when talking about tasks, we give the subject the possibility of carrying out an action in an active way, thus helping to relieve that feeling of helplessness, of *"What can I do for myself to be better?"*. On the other hand, it places the subject in an active place of grief, not a passive one (ie. suffering).

Specifically, Worden refers to four tasks of grieving:

- **Accept the reality of the loss**. Intrinsically related to this task is the question of what to do with the deceased's belongings. Both the decision to get rid of them immediately and to keep them as if the

deceased were to return, speak of a total or partial blockage of the bereaved on this first task.

- **Process the emotions associated with grief**. As we have already pointed out, Bucay says: *"Grief hurts and there is nothing you can do to avoid this"*. Family members who try to "distract" the bereaved, or people who "occupy" all of their time in trying not to feel, interfere or interrupt this second task.

- **Learn to live in a world in which the deceased is no longer present**. This is related to our own identity: I am no longer the husband or wife of the deceased, but his widow or her widower. This task refers to the roles that each one played, with accepting assignments and different tasks from those that we previously performed, but it also has to do with making the decision of what you want to do with your life now, what do you need, what can they offer you and what can you offer yourself.

- **Emotionally relocate the deceased and continue living**. This is connected to the idea of "keeping" the deceased in a place that is only ours, without constructing a shrine or denying their memories. It consists of establishing new relationships, regaining hope, living and not merely surviving.

These four tasks do not have to be carried out in a specific order, nor are they successive; that is to say, completing each of the tasks is not required before proceeding to move on to the next.

REMEMBER:

- **The theory of the tasks of grieving helps the bereaved to have an active attitude towards this process, granting them a certain sense of control.**
- **There are four tasks and they are not successive, nor is it necessary to finish one to begin another. Sometimes they run simultaneously.**

6.1 First task: Accept the reality of the loss

The first task, "Accepting the reality of death", is quite complex because it not only consists of being aware at a rational level that the loved one has died, but also requires assimilating all that this implies on an emotional level: what it means to be dead, specifically defining what has been lost. This invites the griver to walk a path that leads them to define who they were to that person and who that person was to them. In doing so, we delve into the meaning of loss.

Today we live with our backs turned to death for as long as we can. Therefore, when we face the death of a loved one directly, it becomes an unreal situation for us. We live with the false feeling that only the elderly die or that only "others" have accidents. This is why, processing this task is sometimes so difficult that it gets blocked or, at least, it gets complicated.

Sometimes the loss is so painful and so difficult to bear for the bereaved, that the organism rations out the pain, causing an oscillation between acceptance - in which the bereaved feels all the pain that it entails - and non-acceptance, which causes the bereaver to have the "strange" feeling that the deceased person has not died, but is on vacation or working, despite rationally knowing that it has happened. In these cases, acceptance should not be forced upon: one must wait until the bereaved is ready and refrain from contradicting or confronting them. Each person requires their own set time.

- **How can this task become blocked or complicated?**

We can detect that a person has partially or totally blocked the first task of grief when, for example, they talk about their deceased loved one in the present tense and not in the past tense.

Another way to detect if this task is blocked is to enquire after what the griever has done with the deceased's belongings. In the event that they have kept all of their things (*"I keep his /her room as he/she left it"*) they may be denying death through a mummification process (Worden, 1991) as if the deceased person were to return. On the contrary, if you remove everything that belonged to the deceased as if it never existed, you are denying death through a process of minimisation.

Sometimes, denial acts in the form of a question, the bereaved ask themselves: *"What would have happened if...?"* in an attempt to imagine

different outcomes and, while they are imagining them, the person is alive, if only in their mind and for a fleeting moment. This mechanism, which is usually an unconscious one, causes the process to start all over again several times a day, which is a huge waste of energy for the bereaved.

The death of a loved one pushes us to accept that death is a reality, that we all die. That is a certainty that governs the world and the sooner we accept it the better, since it is an immovable rule that works the same way for everyone. In general, the idea of our own death or that of others generates so much anguish that we need to deny it at least for some time, until we are able to accept it.

Another extreme form of denial occurs in people who claim to see, hear or feel in some way the loved one who has died, in a kind of "hallucination." It is a very primitive way of denying the loss and, if maintained over time, these perceptions - which can be normal in the first moments or weeks after the death of the loved one - can turn into something pathological.

In this context, everything that has to do with clairvoyance or paranormal resources poses a special problem, as it maintains the idea that the deceased person is "alive". Since there is no scientific evidence to confirm whether there is life beyond death, we cannot categorically state that it does not exist. But it is clear that parapsychology can generate a lot of confusion in the first moments after a loss and, furthermore, it is not scientific, while psychology is.

In recent decades, the popularisation of clairvoyance, tarot and parapsychology in general through certain television programmes has favoured many people placing great hopes in a séance, which is why it is increasingly urgent to unify positions in regards to this topic. When a person dies we do not know if their spirit remains alive in the form of energy or another type of matter, but it is evident that that person no longer exists in the same way as they did before, that is, they no longer have corporeity. Therefore, as we are unable to imagine how a spirit lives or exists, we imagine it as it was when it lived physically.

In principle, our recommendation is to be cautious. Each person must make their own decisions and the temptation to communicate with the loved one in this way is understandable. However, this can be tremendously expensive, being able to find a huge scam at the end of the road, or favour the induction of hallucinations in cases of psychotic vulnerability.

The theme of the afterlife links to another important element in the grieving process: faith. It is a very powerful resource for those who are believers and can turn to it. However, it is necessary to watch out for some harmful messages that occur within the framework of religion, such as:

- ***"He/she would not like to see you suffer"***. This message is inappropriate for several reasons: First, because it blocks the pain, which can end up complicating grief. As we have explained previously, grief involves affliction and a fundamental part of overcoming it is working through and draining that pain. Secondly, the message is incorrect because the deceased person can no longer see us. That is precisely what physical death implies: that the senses no longer function. If a person suffers from grief, that is the only thing that occurs: he/she is afflicted by grief. But this does not affect anyone else, nor does it harm the deceased, because - for better or for worse - that person no longer feels, suffers, or enjoys life.

- ***"God took him/her because he/she was good, only the best die"***. This message is often repeated a lot in therapy sessions, as an expression of feeling of profound injustice caused by the death of a loved one. Faced with this kind of message, the answer we usually offer our patients is that we all die, but only the deaths of good people, who are honoured and remembered more, hurt. However, we do not publicly mourn the deaths of people we consider "bad" and, perhaps because of this, we feel that the best people are the only ones who die.

How can you help to process this task?

In order to work on this task, the bereaved person is gently asked to tell bit by bit what happened, how their loved one died, describing in great detail what occured at each given moment and reviewing what he/she was doing at each instant. It is about collecting real data that allows the bereaver to assimilate what happened and, at the same time, counteract the fantasy that their loved one has not died.

Always respecting the faith and beliefs of each individual, it must be clear that when a loved one dies their life - as we conceive life - is over: their vital functions stop, their senses (hearing, sight, touch, smell and taste) no longer work. In short, that is what it means to be dead. If there is another way of living, whether it be in the form of a spirit or soul, that is up to each

one of us, but without a doubt, it is an existence different from the one we know and one hard to imagine.

REMEMBER:

The first task in grief is to ACCEPT THE REALITY OF THE DEATH, both emotionlly and rationally.

Blocks during this task can come about in different ways:

o Talking about the deceased using the present tense.

o Keeping the room as they left it, as if the deceased were going to return.

o Removing everything from the room as if it had never existed.

o Trying to communicate with the deceased through mediums, spiritism, etc.

o Imagining different endings by asking questions like "*What would have happened if...?*".

The way to work around the first task is by asking the bereaver to tell us how their loved one died, so that they collect real data related to the loss.

6.2 Second task: elaborate the emotions related to grief

The second task in grief is to work out the emotions and pain of the loss. Not all of us feel pain in the same way, or with the same intensity. In Worden's words: *"It is impossible to lose someone with whom we have been closely linked without feeling a certain level of pain".* What we feel and how we feel it will be part of each person's individual process.

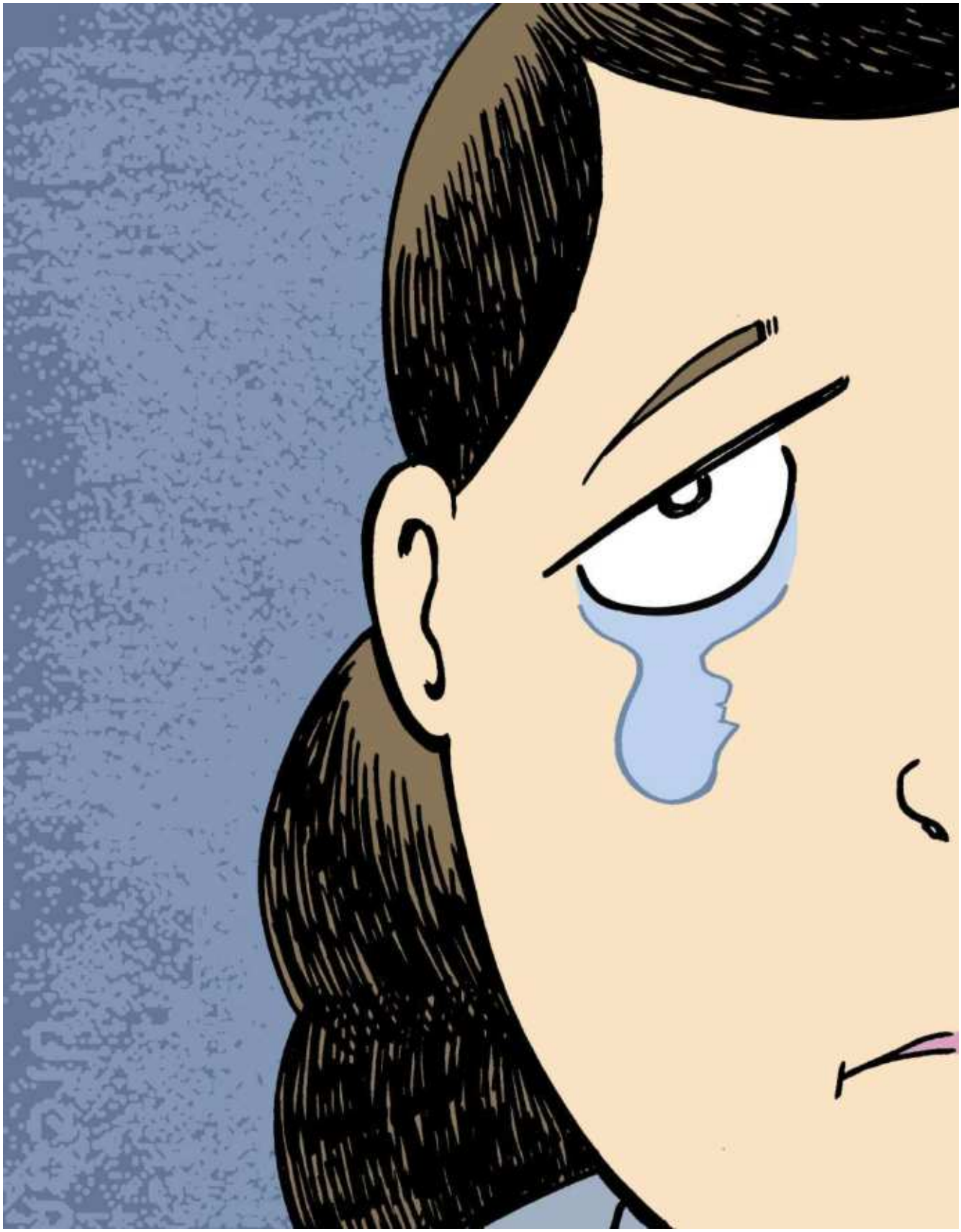
Encouraging emotional expression is one of the fundamental principles of both accompaniment and grief therapy. It is equally important to know the nuances of that expression: what those tears are made of, who is that anger aimed at or what lies behind that guilt. It is not only important to place emotions in words, but we must help the bereaved to elaborate the particular and deep meaning.

One of the few certainties we have regarding grief is that it hurts, so the way to overcome it is through feeling and facing that pain. We know that the emotions regarding grief struggle to come out and that, sooner or later, they surface in order to be addressed. Knowing these emotions and naming them stops them from being perceived as threatening or potentially destructive. Welcoming them helps the bereaved make sense out of the experience, as well as knowing the information they provide about their own needs. Only by expressing them will we know their meaning and can will be able to satisfy them.

A key aspect of grieving is meeting the needs that are generated throughout the process. When a need appears at the forefront - for example, being heard - it remains activated until we attend it. Once taken care of, it disappears and is replaced by another need that was previously in the background. As we address these needs, the process moves forward.

We can often identify the needs that are hidden behind an emotion. Emotions function like needs, as they are taken care of and legitimised they are undone, but, if they are repressed, they are perpetuated over time. As with needs, when an emotion is taken care of, it dissolves and another appears, advancing the grief process.

The range of emotions, thoughts, and behaviours that occur in grief is very wide. It is normal to feel sad, empty, sad, or angry after a loss. However, in caring for grief, it is essential to listen and payimg attention to the particular nuances of each person's emotions.



Modern conceptions regarding bereaving define it as a unique process in which the bereaver builds their way. It is not conceived as a passive agent whereby emotions pass, but as an active agent that decides and gives its particular meaning to the experience. Understanding bereaving from this conception turns the healthcare agent into a companion alongside the griever's path.

The healthcare worker knows some certainties regarding this path, but knows that the nuances are different in each person and accompanies the debtor always keeping this distinction in mind:

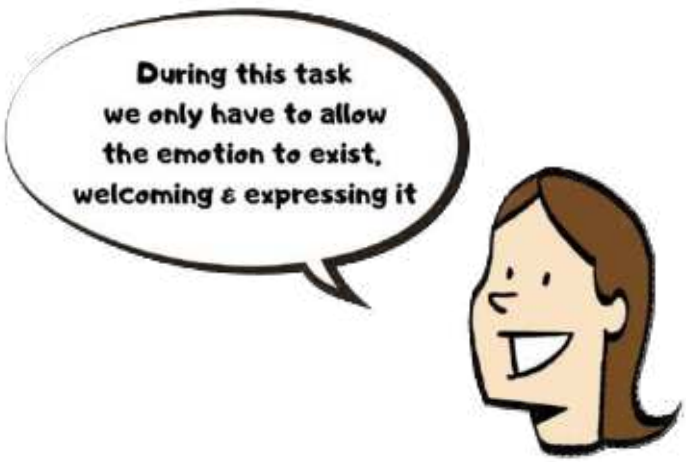
• **Pain** defines the emotional experience after injury and is defining grief. It is a complex experience, made up of a multitude of feelings and personal meanings. Pain is not only felt on an emotional level, but also on a physical and cognitive level. It is a global experience. It is hardly definable in their experience. Therefore, to be able to name it, set limits and locate it, it is very helpful to use metaphors, images, colours and even pinpoint where we feel it in our body.

• **All emotions are adaptive and necessary**. Thus, sadness and grief invite one to be with oneself, to review memories and the experience of death, crying or encountering different emotions, favouring both the assimilation of loss and emotional processing. That is the hidden need behind the emotion. For this reason, pain and what comes with it, is necessary at first. Later, when emotions are more conscious and processed, finding the balance between doing and feeling will help adaptation on the day to day life without the deceased. It often happens that, following some time after death, the bereaved feels worse than at first, sadder. The fact that he/she feels this way is a sign of progress, as that sadness indicates that the bereaver really realises what he/she has lost. Noting that it is progress in grief and explaining the meaning of this sadness can be of great help to clarify the process. It also helps the bereaver to feel more comfortable with their feeling and not try to avoid it.

• **Feeling of emptiness**. Generally the emptiness is felt when the grieving person is working out the first task, related to the acceptance of death. It is the physical sensation that implies the certainty of the absence of the loved one.

• **Anger**. Worden (1997) states that if anger is not properly recognised it can lead to a complicated grief. Anger can be directed against the deceased (*"Why have you left me alone?"*); be a means of expressing rebellion in the face of the feeling of injustice caused by loss (interpreting death as a

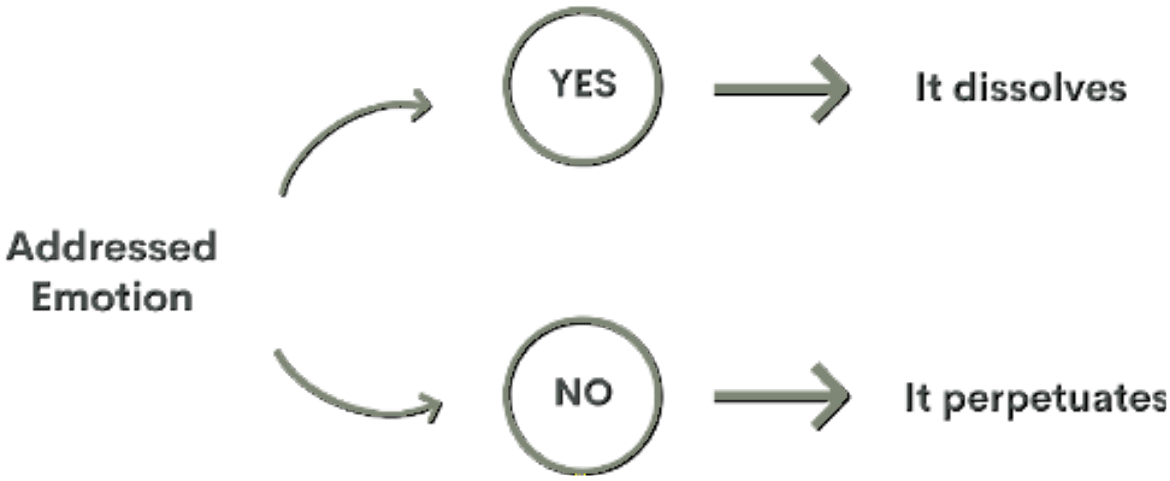
punishment); or as an emotional expression of the denial of the reality of death. The blockage of this emotion can show itself in retroflexion, that



is, when the bereaver directs anger towards themself. Helping the grieving person to control this anger and express it in an adequate manner will contribute in advancing with this task.

• **Guilt**. After loss, bereavers often experience a sense of guilt, with ideas such as: *"I could have done more"* or *"What we did was not enough"*. The unreal guilt –that is, the one that has no real foundation- ends up being blurred with the dialogue and the contrast with reality. However, although as psychologists we detect that this guilt may have an unreal basis, we must allow the bereaver to express it, because probably the people around them will already be trying to prevent them from thinking about it, or be telling them that *"that is nonsense".* That is why it is necessary to offer them a space where they can express and cry their guilt. We will take care of the unreal part of it later through dialogue.

Guilt can also be used by the bereaved as a control mechanism. It is a way of making life predictable and controllable. Ideas such as *"He died because of me"* contain a painful message, but one that allows the bereaver to answer a question that often does not have an answer."*Why has he died?"* or



"Why him?" are questions that are difficult to answer, as they place us before a reality full of uncertainty. But the truth is that death is not under our control: the fact that the bereaver feels guilty without being guilty is a mechanism that offers them a sense of control over death and, in addition, allows them to answer those questions with tangible realities.

We may face cases where the guilt is real. To work with this kind of guilt, tools such as the empty chair, letters that are not sent, etc., are helpful, that is, techniques that allow the bereaved to express their guilt both to the deceased and to themself. It is also useful to ask the griever some questions to help them place into context the decisions they made: *"Why did you decide to make that choice or say such a thing?"; "How were you during that vital moment?"; "What was your relationship with him/her like at that time?".*

• **Anxiety**. This emotion is related to the feeling of abandonment, of being lost, of helplessness and fear of life. It is linked to the inability of the bereaved to adapt again to life without the deceased. When someone close to you dies, death becomes a reality and the fact of living it so closely makes the bereaver aware of their own death, a feeling that can cause anxiety.

• **Desire to die**. When working with the bereaved it is important to assess the suicidal ideation and whether or there is a plan. It may be that their wish to die is linked to the need to reunite or see the deceased again, and that it is a distant wish that the bereaver recognises as a fantasy, but it must always be explored.

In therapeutic practice with the bereaved, it is common to observe how many experiences of loss have been set as traumatic. The fact that the experience is fixed in this way may be due, on one hand, to physiology: there are high levels of neuronal activations associated with the moment of the death experience. The cause may also be that such experience has invalidated the basic schemes with which the bereaver understands and "arranges" the world. These schemes are the axioms that, within our thought system, help us to simplify reality.

In this case, the experience of the reality of near death collides with the sense of security, justice, prediction or optimism that the bereaver had (Neimeyer, 2002). Helping the bereaved to make sense of the loss and to reconstruct these schemes by integrating death into them will help them to adapt to the loss, as well as allow them to work on the traumatic component of death.

In other cases, it occurs that the bereaver is afraid of their own emotions: fear that these will overwhelm them, that they will invade them. Accompanying the bereaver in these feelings allows them to understand that sometimes one ends up exploding due to repressing an emotion for a long time. When it is repressed, the emotion grows and thus, when it comes out, it does so in an explosive way and that is what really scares them. It is an essential job to teach them how the cycle of emotions works.

The factor that may block this task is not allowing yourself to feel, or hindering exclusively in one of the emotions. Other possible ways for the griever to block this task are:

- Focusing only on the positive memories of the deceased, which leads the bereaver to idealise them and, therefore, not allow all emotions and cognitions to be expressed, only the positive part, leaving another part of the experience hidden and unexplored.

- Focusing only on the negative memories of the deceased. This causes the bereaver to be impregnated with the emotion that these memories produce and cannot move forward. Sometimes it has to be treated as post-traumatic stress disorder.

- Avoiding all contact with emotion, memories or thoughts about the person who has died, in an attempt to distract the pain and all experiences related to the loss through continuous activity.

In addition to the emotional coping of the bereaver, blocking the second task is also influenced by the concept of how grief should be lived in the society to which the patient belongs. We are social beings, we live as a family, in a community and, therefore, the influence we receive from it is decisive. Western society tends to push the bereaved towards distraction from pain, pressures them to stop crying or thinking about the deceased, interfering in the elaboration of grief.

All the sensations and feelings described are normal and frequent within the grieving process. Some authors argue that what happens on an emotional level during the first three months after the death of a loved one falls within normalcy. Blocking the second task, as well as the grieving process, can cause normal feelings of sadness, anxiety or emptiness to escalate into more serious emotions such as despair, isolation, major depression or complications related to anxiety (phobias, fear of illness, etc.)

It is advisable to take into account the reactions of the griever regarding certain calendar dates, such as anniversaries. Calendar dates are important: both those that are meaningful to the family (birthdays, wedding anniversaries, death anniversaries) and the holidays (Christmas, All Saints' Day). It is normal for emotional reactions like sadness or pain to appear as these significant dates approach. Studies indicate that reactions to anniversaries are normal even up to ten years after the loss.

Sometimes, exploring the proximity of significant dates on the calendar can shed light on the emotional experience of the bereaved, discovering what lies behind surprising reactions of pain or sadness or ones whose origin are not understood. Preparing for important dates in advance can be helpful, planning how and with whom you want to spend those days.

The assistance in elaborating this task begins with the observation of the bereaver: how they express the emotion, how they cope with it, if they identify what is happening to them, if they are aware of the sensations that appear and accept them, how they express it... All these data is important, because it will let us kmow how the bereaver is managing their feelings and if they have blocked any emotions.

Based on this observation, the help will be aimed at solving the needs of the bereaver: helping them to identify the emotions, name them and express them; or legitimise by listening to what they are feeling and offer a space for this.

Physical sensations are also a great emotional indicator: how the body expresses the emotion, if there is pain, a suffocating feeling... It is convenient to make a stop at these feelings and see how the bereaver experiences them. Approaching them will also help clarification.

As a tool for developing this task, it may be helpful to ask the following questions:

What do you miss the most and what do you miss the least:
This question allows us to encourage the exploration of all the feelings connected to the deceased.

- Empty chair: This technique is used to work on emotions and issues that may have been incomplete.

- **Working with photos and memories:** Talking about the relationship that existed between the bereaved and the deceased, through photos

and objects that symbolise special memories, brings us closer to the emotions of the bereaved and helps us to explore the totality of the experience with them.

- **Drawing**. We ask the griever how they would draw their grief, pain, anger... This is a way of approaching intense emotions.

- **'Focusing'** can greatly help the griever to stay close to their feelings and to approach them in another way.

In the end, it is about helping the bereaver stay with their feelings -whatever they may be- so that they dissolve, so that they trust that grief can be overcome and they can "live" with those emotions. When this is put into practice, the emotion dissolves. Of course, it must be borne in mind that in order to "be" with those uncomfortable emotions, one must keep a certain distance away with those same feelings.

REMEMBER:

The second task is TO ELABORATE THE EMOTIONS RELATED TO GRIEF, such as pain, sadness, anger, anxiety or guilt.

This task can be blocked if the griever does not allow themselves to feel the emotions or is excessively blocked in one of them by excess or by default. Other forms of blockage are:

- **Focus only on the positive memories of the deceased.**
- **Avoid all contact with emotions, memories or thoughts related to the deceased.**

The conception that may exist regarding grief is a key element in this task's blocakage, as well as how the bereaved's society considers it should be experienced.

The aid to carry out this task out will start by observing the bereaved, after which we will resolve their needs, helping them to identify their emotions and legitimise them by listening to them.

6.3 Third task: Learn to live in a world in which the deceased is no longer present

The third task of grief refers to the adaptation that the bereaver needs to undertake with regards to all the changes that the death of their loved one implies.

In order to begin this task, the bereaved person needs to be aware of the roles that the deceased played. This is where the first problem occurs: normally, people are not aware of the role that the other person played until sometime after their loss, since we live naturally assuming the functioning of our lives.

For this very reason, it is necessary to carry out a first phase which involves identifying the tasks that the bereaved will have to carry out, either in the present or in the future, as well as those changes that the death implies in terms of the roles they played and day-to-day activities.

A problem related to the identification of roles is that, while some are obvious, others are not. This can happen either because they are exceptional -that is, they do not occur regularly-, or because other family members willing to help assume that burden and prevent the bereaved from becoming aware that these roles exist, since at no time do they feel the need to respond to the demand that these imply.

Some examples of these roles could be: the economic administration of the home and banking procedures, the completion and presentation of the income statement, procedures related to home insurance, the enrolment of children in school or their extracurricular activities, relationship with school tutors, etc. These are roles that are often assumed in a timely manner, and therefore many of the people who come to therapy are not aware of these roles until they are imminent.

When referring to this issue, among the bereavers it is common to hear complaints such as:

"Never in my life have I made the income statement; I don't even know where all the papers are".

"My wife was in charge of that kind of thing, I don't know how to do it".

In order to be able to identify the roles that the deceased assumed, we can ask the bereaved what new tasks they have learned to do, what things the other person was in charge of, or in what practical aspects of their life the deceased person is missing. From there we can help them to incorporate new roles or tasks.

These roles not only refer to the execution of practical tasks, but also to the need to acquire certain identities or even to reformulate personal identity. Work with the bereaved on their new status or role. Here are some examples of role / identity change that take place after the death of a loved one:

- A widow ceases to be the X's wife and becomes the X's widow, or she will only use her name.
- A father or a mother who loses their child can stop being even a father, to be an accomplice with their deceased child.
- A daughter who loses her father is no longer daddy's little girl.
- A child who loses a sibling can become the oldest child, or stop being the middle child, or become an only child.
- When one of the parents dies, they go from being a child to an orphan.
- You can stop being a large family due to the loss of a child.
- You stop having a best friend.
- You go from being accompanied at home to being alone.

It must be clarified that the bereavers have great problems to overcome this task, since it requires them to redefine all the core elements on which they rely to define themselves. This is especially common in women who base their role on caring and relationships with others.

There are many grievers who experience an inmense feeling of helplessness and inability, believing that due to their life history they will not know how to carry out these tasks successfully. This causes a deterioration in their self-esteem and generates in great feelings of disappointment. These people think that changes are due to chance and that they have no power to change or take charge of such situations. If we do manage to do a good

job during this task, the image of the bereaved can be strengthened and their self-esteem will greatly improve.

From what has been explained above, it can be deduced that, even if the grieving person feels powerless, they will often have to assume many functions that they did not perform before, but not for pleasure, but rather because they have no other choice. Here are some of the simpler tasks they **Objects** may have to tackle:

- Pay certain bank receipts that were previously not their responsibility.
- Make adjustments in the family economy.
- Cook, when you had not done so before.
- Take charge of the care of young children.
- Change a flat registry and place it under their name.
- Get their driving license in order to use the family car.
- Make home repairs.
- Enroll in college or any other type of education.
- Go on the school bus route or by bus to school because they do not have someone to take them.
- Pick up the clothes up and arrange them in the wardrove.
- Study alone.
- Get up using an alarm clock.

Although at the beginning the fact of carrying out these activities can cause problems and feelings of inability or failure, later on the achievement of objectives - no matter how small - provides great satisfaction to the bereaved and also, bit by bit, a feeling of ability and control. As they advance with this task, many patients comment on how surprised they are to be able to take on activities that were previously unthinkable.

People who block this third task of grief do not adapt to life: they are immersed in a world that has been paralysed, without evolving. The bereaver is not able to develop coping skills, or else misses opportunities to incorporate new learnings, isolates themself and avoids answering the demands of life in many ways. These people tend to become dependent, given their inability to cope with the simplest and most everyday obligations. However, it should be noted that some (albeit small) changes always occur during this task. But this only happens because they are forced to cover their most immediate needs.

Solving the third task allows the bereaved to grow and even gain autonomy. On the contrary, if they decide to not solve the task, they will be trapped in a life that they can hardly fully enjoy. Part of our work as psychologists will be to analyse the aspects that the grieving person must take care of and the roles that they must assume.

In order to return those things that you must take care of, we can analyse and plan the procedures in a more concrete way with the patient who is in therapy. We can also plan and arrange pending activities from the simplest to the most complex. As the griever progresses with this task, they will gain confidence and it will no longer be necessary to plan the steps to follow with them.

As the patient tells us about small changes, we must reinforce the fact that they realised they are necessary, as well as any approach towards the task or tasks that they have carried out by themselves and that they did not use to do before.

In short, it is about caring for the needs that appear almost spontaneously. When each of them is addressed or resolved, it dissolves and another one appears. Both the fact of detecting the needs of each one and of satisfying them is a journey that guides the individual process of each griever in a unique way. If the needs are blocked, either because we do not detect them or because they are not satisfied, this can cause a lot of dissatisfaction in the bereaved. Therefore, it is positive to promote a connection with each patient and their demands, as well as the possibility of asking for help.

REMEMBER:

- **Grief's third task consists of ADAPTING TO AN ENVIRONMENT IN WHICH THE DECEASED IS ABSENT, with all the role changes that this implies.**
- **Grievers often have several problems in overcoming this task, as it requires them to redefine all the core elements on which they rely to define themselves, it also involves assuming responsibilities that the absent person was previously in charge of and for which the bereaved are not usually prepared for.**
- **This task can be blocked if the person is not able to develop coping skills, or misses opportunities to incorporate new skills, isolating themselves and becoming dependent.**
- **The help in preparing for this task can be directed towards identifying the new roles that the bereaved must assume, gradually planning the tasks that must be carried out and reinforcing the small advances and changes in the role that they are assuming.**

6.4 Fourth task: To emotionally relocate the deceased and continue living

The fourth task of grief involves emotionally relocating in our inner world our loved one who has died.

After the death, the memories and memory of the lost person are very present, becoming almost the protagonists of the life of the bereaved. Elaborating the tasks of grieving, assimilating the death and facing the emotions and the day to day imply that the relationship with the deceased and their memory are very present in the mind of the bereaved.

As the tasks are elaborated, the memory of the deceased - even the bond with them - takes on another form. In this period, the grief would be like a large revolving shelf that the bereaver is rearrenging as he/she faces, accepts and assimilates reality. Thus, with the elaboration of the fourth task, leave room to place new things.

Elaborating the fourth task of grief does not mean forgetting the deceased. It is common for the griever to think about this idea and it causes them a lot of anxiety. However, relocating the deceased does not consist in denying their memory, but in living with the past in order to live in the present.

Experience with the bereaved has shown that, in order to carry out this task, it is necessary that the previous tasks have been well resolved. It would be very difficult to elaborate it if death is not really assimilated, if emotions and pain have not been faced, or if the bereaver has not begun to adapt to the routine and to a world without the deceased. If there is not enough road travelled in the other tasks, facing the fourth will be a somewhat fruitless effort for the bereaved.

The fourth task of grief has to do with hope, with living and taking risks again, getting involved again in activities and planning for the future. Everything that is linked to the idea of not wanting to live will be blocking this task, for example: the fact that a widower promises herself not to fall in love again is a blocking indicator, not because it is mandatory to fall in love again, but for living it as a prohibition.

This fourth task of grief sometimes remains unsolved. We often hear that grief over the death of a loved one never goes away. It almost seems that the general expectations and what is socially accepted is that the bereaver is in pain eternally. We accept it as normal that the grieving person lives

without hope, so that both the bereaved and their social sphere as well as the psychologist stop making the necessary effort for that to change or evolve.

We refer to this state as the "shadow of grieving" and it is defined as a form of chronic grieving that bereavers sometimes carry for the rest of their lives, comparable to a shadowy pain that underlies the feelings of the person.

The path of grief is hard, painful and requires effort, determination and perseverance, but it can have an end. Devising the fourth task leads certain people to make a deep review of their identity, to the point of initiating a process of personal growth. A defining feature of any personal crisis is that the foundations that sustain the deep values of the individual -that is, the general explanatory schemes that have been forged around their conception of the world and their own identity- falter and crack.

Personal growth occurs when the individual affected by this crisis takes advantage of that moment to turn on themself and concentrate their efforts and perseverance in the re-elaboration of these schemes, as well as the deep internal meanings that give coherence to their vision of the world and of themself.

Frequently, clinical experience shows us how the bereaver, after elaborating the grieving process, perceive themself to be more human, more sensitive and more understanding in regards to other people's problems. After suffering the loss of a loved one, priorities and the arrengement of values often change. This can be confirmed by any professional who works in grief therapy, as contact with the most spiritual part of the patient is very close. I can affirm emphatically and in the first person that after having faced a grief and having overcome it, many of the patients grow personally and feel fuller, more compassionate, more sensitive, or more generous.

However, not everyone who suffers a loss solves it by embarking on a path of personal growth and positive learning. Those who do, are resilient people and those who have elaborated post-traumatic growth or flourishing.

The fact that the bereaved faces and solves the four tasks of grieving places us in front of the following questions: *"Does grieving ever end?", "When can we say that it is over?"*

Grief is a process with a beginning and an end. Various authors consider an indication of completion the fact that the loved one can be remembered without pain and emotions and enthusiasm for living can be re-experienced. But even when the bereaver has already finished the grieving process, it

can expected form they to continue to go through ups and downs, especially when it coincides with certain important dates.

It is necessary to emphasise that the process and the duration of grief are alligned to a personal decision. Along this path, the bereaver makes a multitude of decisions and, at a certain point, must also decide whether or not to continue grieving. The result of all these decisions will be the development and end of grief or, on the contrary, its blockage. Hence, as a conclusion, the duration of this process is very personal.

In the fourth task of grieving, the professional's help should be aimed at making the bereaved decide whether they want to remain in mourning or reencounter life. To work on the possible blockages of this task and help the bereaver through their process, these techniques may be useful (only for clinical therapists):

- The vital footprint: This concept is based on the various ways in which the people in our lives influence us. We are all permeable to the people we love and with whom we live, so that we absorb their influence in different ways: gestures, ways of thinking, expressions, shared values, tastes, etc. The fact that the bereaver is aware of the mark that the deceased has left on them can be a way of paying homage to them and rebuilding the bond with the loved one who is no longer there. Of course, not all traces are positive, the bereaver may discover traces of the deceased's influence on conflicting personality traits (eg. insecurity, obsessive character, etc.). Working on these traces will also help them to review the image of the deceased and, therefore, to relocate them emotionally. What footprint would I like to give up and what footprint do I want to endure? It can be a good way for the bereaved to become aware of the "legacy" and take responsibility for it, choosing what they want for themselves.

- Unsent letter: This tool is one of the most useful and powerful in working through the grieving process. It consists of the bereaver writing a letter (or letters, if we see that it is convenient during the process) where they express everything they want, all that remained unsaid, what they need to explain. It is an open letter, without an established script. The only essential element is that at the end of the letter there is a farewell. It is a very difficult process for the bereaver, so it is advisable to alternate it with other lighter activities. The letter should be read by the bereaved in the

context of an individual or group session. Meanwhile, the therapist or other members of the group can write down what they hear, what has been more emotional or significant, etc. This tool helps the griever to put to words the words - of their grief experience - and to find a place for the deceased in their mind and heart.

- Connection objects: Among the belongings of the deceased, there is often an object of special importance for the bereaved, either because of what it meant for the deceased, or because of what it represents regarding them. The fact that the bereaver keeps this object in mind, keeps it in a special place, or works on it in the therapeutic context, can greatly help to address the relationship with the deceased and to rebuild the bond.

- Measure grief: This technique consists of using an object that we have at the office (for example, a table), so that one of its ends symbolises the death of the loved one and the other, the overcoming of the bereavement. The bereaver must pinpoint where they feel they are between the two points. This retrieves the patient to the moment of the path they are on, allowing them to gain a perspective of the work they are doing and to specify what they still have to face.

- Useful questions: What are your strengths? Who am I now? What are your values, your vision of the world and of yourself? Asking these questions helps the bereaver to reconstruct their meanings, as well as to reflect and rework their value system and self-concept.

Throughout the work with the bereaved, it is important to clarify what it means for them to elaborate grief and to work on this specific task. If they do not understand what is involved in grieving, it may mean that there is a block in resolving it. It is also helpful to work with the bereaved on what their fantasy is about ending the bereavement, with questions such as: "What would you lose at the end of the bereavement?" Working on the answers to this question with them can help, on one hand, to correct possible false beliefs regarding the end of grief and, on the other, to expose possible blockages that are interfering with the completion of the process.

William Worden's Four Task Theory sheds light on the process and is very proactive. If we combine this theory with the one that Alba Payás enunciates in her book *"The tasks of grief. Grief psychology from an*

integrative-relational model" (2010), the understanding of the process is further broadened.

The model that she suggests sets before the bereaver the four tasks of grieving but, at the same time, they are also experiencing four different phases:

1. Stun and shock.

2. Avoidance and denial.

3. Growth.

4. Transformation.

Payás states that the task she suggests the bereaver need to carry out must be consistent with the phase in which they are in. That is to say: if the person is in the avoidance and denial phase, we cannot suggest a task that has to do with accepting death, because then they will fail.

Each of the grief tasks brings light to the process as a universal phenomenon. None are complete and none are perfect, but each represents an effort to increase an understanding of the process.

REMEMBER:

- **The fourth task of grief is to EMOTIONALLY REMOVE THE DECEASED AND CONTINUE LIVING, without forgetting about the loved one, but learning to live with their memory in order to live in the present.**

- **This task involves recovering the hope of living. Sometimes it remains unresolved, so the grief becomes chronic. Any personal attitude from the bereaver that is connected to the idea of not enjoying life again is an indicator of blockage.**

- **The elaboration of this task leads many people to re-examine their identity in a profound way, starting a process of personal growth in which the schemes and values that until then configured their vision of the world and of themselves are remade.**

- **The elaboration and length of the grieving process is intrinsically related to the bereaver's personal choice, who at some point along the way will have to decide whether or not to continue grieving. The result will be either overcoming the process or blocking it.**

- **In this task, professional help will be aimed at helping the bereaved in this choice, working out the possible blockages with tools such as the vital trace, letters to the deceased, objects of connection or questions aimed at reworking the value system of the bereaved.**

CHAPTER 7

ANTICIPATORY GRIEF VERSUS **DELAYED** GRIEF

The concept of anticipatory grief, used in connection with delayed grief, refers to two different moments in this process. One takes place before the loss occurs, normally when a loved one is diagnosed with a disease that has no cure. At this point, the family begins to come to terms with the idea of what will take place, the acceptance of loss begins, the pain of imagining an impending death.

It also sets up a stage characterised by what it entails to witness the physical and emotional deterioration of a loved one, the attrition produced by long hours in hospital, as well as changes and readjustments in schedules, meals, and the organisation of life in general. This period requires each member of the family to adapt their routine to be able to take care of the relative who is ill, whether that may be at the hospital or at home. It also encourages closeness with the loved one, in order to spend as much time as possible with them. And at the same time hope is still maintained, in spite of the diagnosis.

Nowadays, most authors consider that anticipatory grief is a positive adaptive response in the face of death because it offers people the opportunity to begin to work on the profound changes that come with loss. It is more than apparent, that anything we may anticipate is less shocking in comparison to a sudden or unexpected death; however, it implies witnessing the patient undergo painful scenes, due to medical interventions or due to the suffering caused by their ailment.

Anticipation may help grievers prepare for what lies ahead. But, as with grief, not everyone is going to experience it in the same way, not even within the same family. The agony and the moment that death occurs will be especially critical and delicate for the family. The basic guidance that professionals present at the time of death should provide family members is mainly moral support and solutions for their specific problems.

When death finally takes place, it is common for an emotional explosion to occur within the family. During these moments, perhaps the only help that can be given is to offer a comforting presence: adopt a restrained attitude of listening and affection, respect the manifestations of mourning and offer ourselves to take care of daily tasks, no matter how simple these may be.

Anticipated grief and the period of hospitalisation itself can become more complex due to what we know as “family surrender.” This phenomenon consists of the inability on the part of the family to offer an adequate

response to the multiple demands and needs of the patient, as well as the situation in general.

How we can accompany the family

The care provided to family members who are close to losing their loved one will be aimed at relieving their fears and solving difficult situations that may arise:

- Offer clear, concise and realistic information to understand the disease's process, the symptom's meaning and the treatement goals.
- Have the availability, understanding and support of the medical caring team.
- Set aside time to stay with the patient.
- Intimacy for physical and emotional contact.
- Listen to the expression of their emotions: sadness, anger, grief and fear. The patient's family needs to be listened to and their feelings need to be understood and accepted.

On another hand, delayed grief is the reaction that appears long after the death of the loved one. It is an incongruous answer in time. Grief takes time to manifest itself because there has been a previous blockage of the process, either due to the impact caused by the loss or because the bereaved was unable to process it at the time. It is also known as a "frozen grief".

Delayed grief is sometimes solved spontaneously: the person becomes aware of the previous blockage and how they are taking charge of the new reality. Occasionally, someone else from their circle is the one who detects this blockage and refers the bereaved to therapy.

The difficulty that we encounter with delayed grief is that, due to the time that has gone by since the loss, professionals sometimes have difficulty

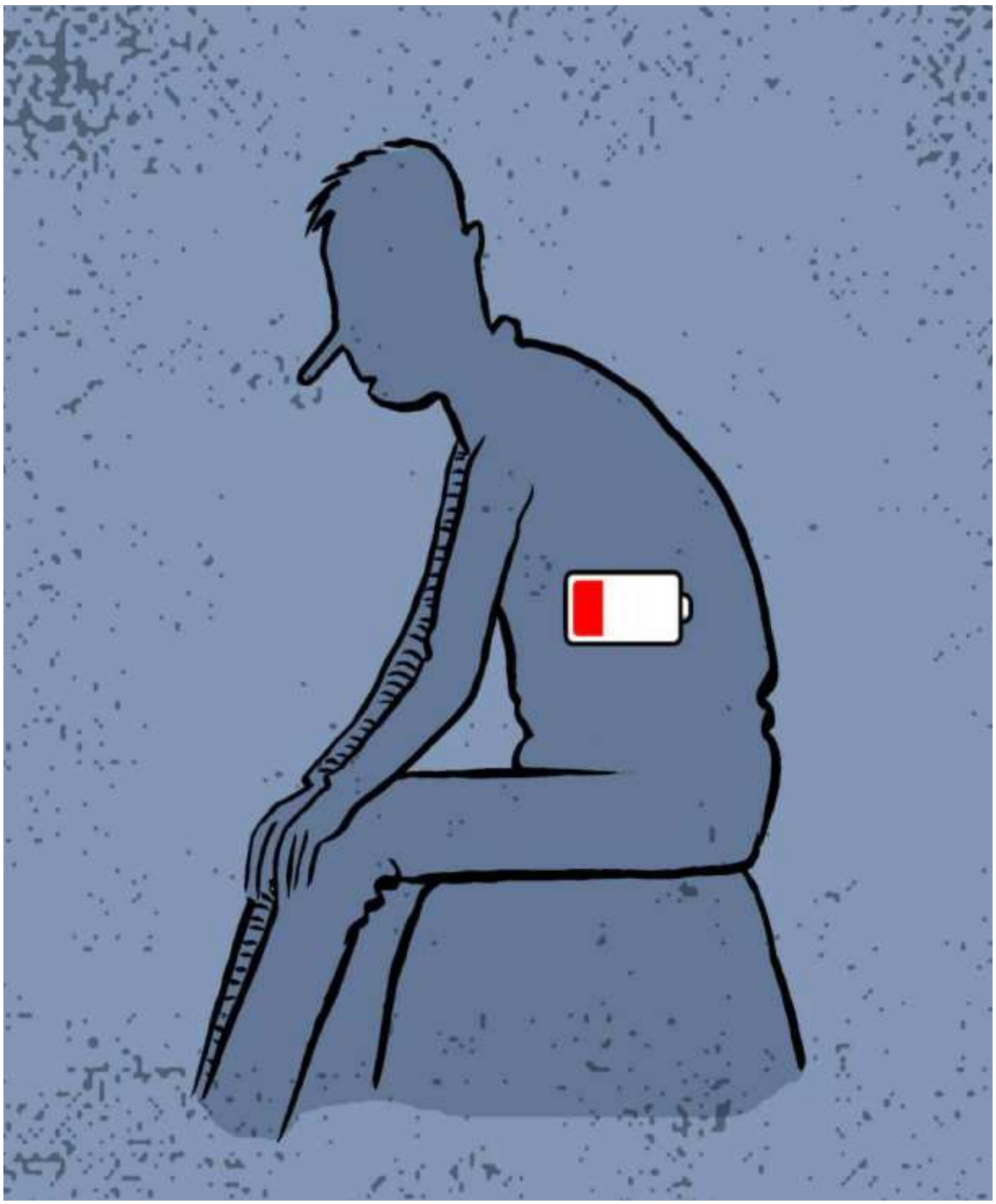
associating a patient's symptoms to grief and it is diagnosed as depression. Another difficulty stems from the fact that social support towards the bereaved disappears over time, thus when grief "defrosts" social support is no longer present.

REMEMBER:

- **Anticipated grief takes place before death.**
- **There continues to be hope.**
- **The griever can experience a lot of depletion arising by being aware of the deterioration and the changes that occur in the family in order to adapt to taking care of the patient.**
- **Delayed grief is the one that appears long after the death of the loved one has occurred.**
- **This grief may occur because the death of the loved one has been shocking, or because the bereaver was not prepared to process it at that time. It is important to detect it in order to work on it as grief and not as a depression.**

CHAPTER 8

GRIEF AND **PSYCHOSOMATICS**



Psychosomatics is the study of all the physical reactions reflected in the body that lack an organic explanation. We are talking about emotional reactions that cause changes at a physiological level: muscle pain, headaches, rise or fall in blood pressure... everything that leaves a sign on the body.

In this context, we may find symptoms that range from those that can be easily explained by the emotional reaction, up to other symptoms caused by an encapsulated emotion that -in appearance- do not have an obvious relationship with grief. This can make a person "wander" from doctor to doctor, after the death of the loved one, searching for a cause to their discomfort.

When I come across a case like this in therapy -a patient whose discomfort is not only psychological, but also physical- the first thing I do, is to send them to the doctor for a referral to the specialist if it is due to a pathology that has an organic origin. Grief is a process that involves a lot of stress for the patient and this stress can influence the body, making it weaker.

It is quite usual for health to be affected during grief. This can be due to several factors:

- **Neglecting body care during the illness**. This is common due to the amount of hours spent in hospital, eating out, reduced resting time, or the abandonment of treatments that were in progress, among other factors.

- **Mimicry with the patient.** It is possible that the bereaver comes to reproduce some of the symptoms experienced by the deceased person. If they died from stomach cancer, the bereaver may express digestive or intestinal discomfort; if they died from a heart attack, the bereaved may present symptoms related to an increase in blood pressure, etc.

- **Sustained stress over time.** It may also occur that the physical discomfort is connected to a deeper meaning on a psychological level, and these are the elements with which expert grief psychologists work. In these cases, we resort to the feeling and focalise all the attention there, amplifying it and allowing for it to express itself. There is no direct translation of that meaning, each person associates their emotions with different meanings and the psychologist only validates and releases them.

In a traumatic grief case, I treated a man whose brother had died after heart surgery. This patient had a very painful feeling in the diaphragm, which at first did not attract our attention. He worked this discomfort with a physiotherapist, but the sensation did not disappear. After a few sessions with EMDR, he was able to associate that feeling to a tube that had been placed inside his brother in order to drain an infection he had in his heart. Up until that moment, that image had remained cornered in his memory and connecting with it caused him a great deal of pain. He cried a lot throughout the entire session; but during the following one, this feeling had completely dissolved.

This is just one of the many cases I have seen in therapy throughout my career; perhaps the most obvious one. However, during the daily practice of grief psychotherapy, when working with the body of the bereaved, I encounter feelings that enclose meanings that are related to the process of loss.

These cases must be differentiated from others where the physical problem is only a distraction from the main process, ie. a way to defend oneself from the pain endured by grief.

A woman who had lost her husband endured ongoing headaches. These headaches prevented her from leading a normal life and even from being able to speak clearly during therapy. During more than five sessions we talked about her discomfort, about the intensity of the headaches, or the frequency and what she associated them with. They had no apparent relationship to the grieving process, yet it was the first thing to appear during the sessions. Each appointment began with a comment regarding how much her head had hurt that week. In the sixth session, I asked her to talk to me about her husband, placing her headache slightly aside for a while. She cried a lot and spoke in great detail about what his death had been like and how much she missed him. I did not ask her to not feel her headache, but to also bring back the memory of her husband whilst keeping that physical pain in mind. The process was slow, but we gradually stopped talking about her headaches and started speaking only about her husband, until the pain dissolved.

On another occasion, a young man whose mother had passed away in a rather traumatic way came to my office referred by his family doctor due to a digestive problem that lacked an organic basis. During the first sessions we talked about his medical issue and defined how it was affecting him. After the fourth session, I asked him to tell me about his mother.

Soon afterwards, from one session to the next, the digestive problem disappeared as if by magic. Throughout the following sessions, we were able to analyse details of his mother's death and, gradually, the grief also dissolved.

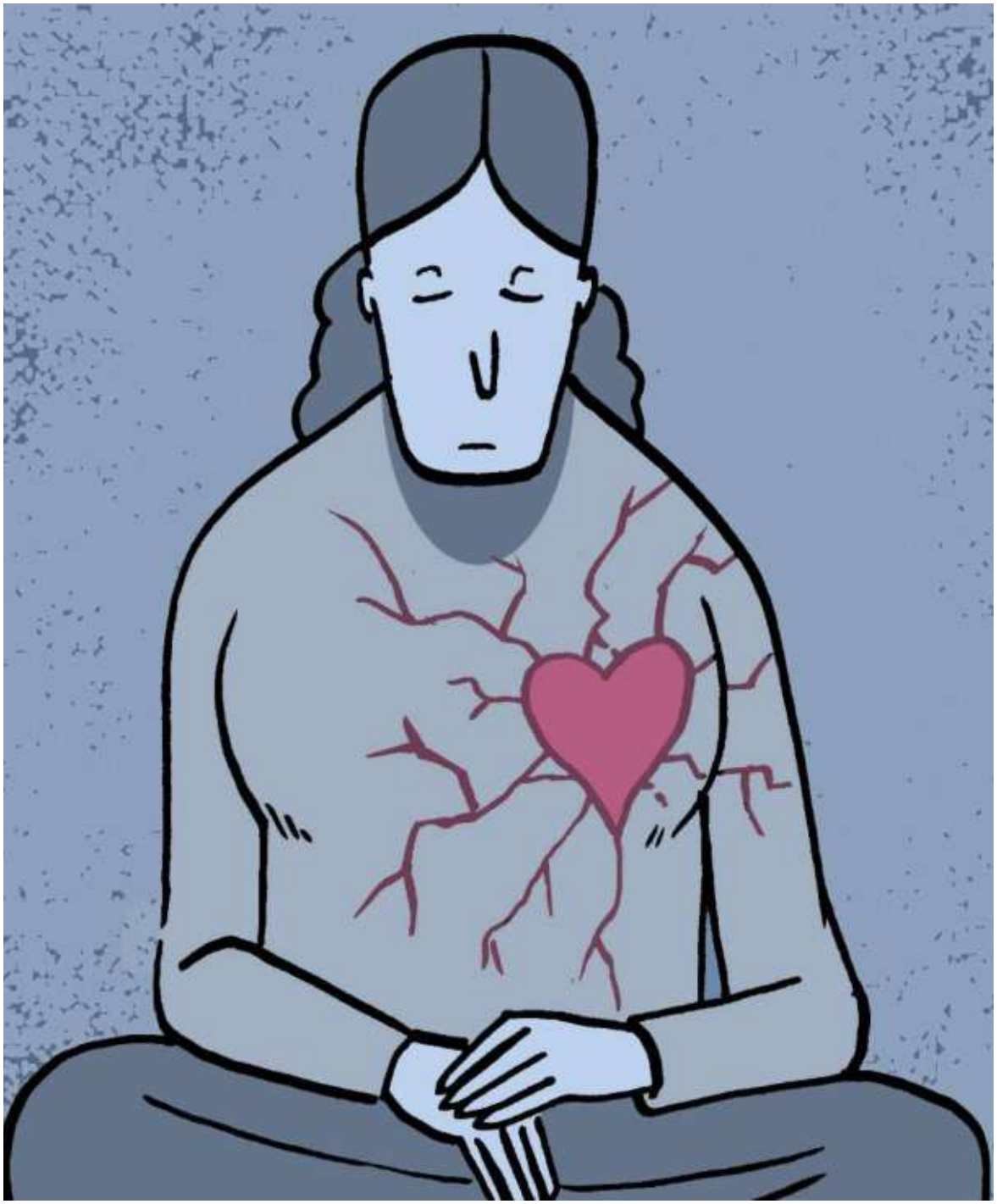
During the first sessions it is always important to leave room for the patients to freely express themselves. Only once the bond has been formed can we prompt interventions that can break that defence.

REMEMBER:

- **Grief may have a mirror effect on the body that needs to be taken care of.**
- **Organic origin disorders must be ruled out.**
- **It is important to reveal the meaning of the physical symptom.**
- **Sometimes it is necessary to distinguished between when the symptom is a defense and when it has a symbolic content that needs to be revealed.**

CHAPTER 9

GRIEF VERSUS **DEPRESSION**



In an attempt to put our clinical experience into words and deepen the study of grief, we have tried to define this process and describe the differences between normal and complicated grief.

Human beings usually establish categories: we classify and systematise reality. This implies setting the limits and boundaries between what is and what is not a concept. The need to label disorders comes from an attempt to generate a universal language among mental health professionals, one that allows us to communicate regardless of the different viewpoints and diverse ways of conceiving disease and psychological health.

This means speaking in a common language that allows us to understand a complex diagnosis in few words. However, labels can be limiting and, in fact, it is difficult to establish categorical differences between grief and other realities.

Traditionally, grief is distinguished from major depressive disorder, but a differentiation between normal grief and complicated grief is also established. Comparing grief and depression implies comparing two similar entities that, nevertheless, belong to different categories, as one of them -depression- is systematised, defined and included as a disorder in the DSM-5; while grief is defined as a disorder, but not recognised as such.

Grief is something that supervenes -it can happen or not- and it cannot be prevented; whereas depression can be prevented, and it has degrees and nuances. Both disorders can occur at the same time, but usually one of the two is in the foreground and the other, in the background.

Some articles argue that comorbidity between grief and depression is impossible. Moreover, they establish a distinction that, at first sight, seems straightforward. However, between grief and depression there are hefty differences that in our opinion prevent their comparison, as they belong to different categories. The first of these is that depression is a disorder and grief is not, as by definition it is the normal process that ensues after any loss. In any illness -for instance, the flu- an event could interfere: for example, an accident. In this case, we would not try to prioritise which of the two prevails, because they cannot be compared. Without a doubt, grief triggers an emotional, cognitive and behavioural process: as is the case with any other event, although perhaps the latter has fewer studies.

By establishing the impossibility of comorbidity between grief and depression, we are silencing grief, ignoring it, relegating and treating it

solely as depression. This is not surprising, as we live in a thanatophobic society that protects itself from pain and flees death until it has no other choice but to face it. This causes us to live with the idea that death only befalls other people, that we are invincible and can control each and every aspect of our life.

Eventually, when death finally creeps into our lives -whether by accident, foreseen or unforeseen- pain strikes the foundations of our structure and causes us to stagger. It is then that we begin to handle the belief that death is insurmountable, which thus prompts us to protect ourselves from pain by avoiding it, hiding it or making it invisible once again. Hence, it should not surprise us that it is also invisible at a clinical level.

On another hand, it seems somewhat simplistic to try to reduce these symptoms into a category as rigid as major depressive disorder. Depression usually requires medication, while grief, as a rule, does not. This distinction raises some questions:

- Can grief generate depression or be its direct cause?
- Can depression complicate the grieving process?

The grieving process triggers a series of reactions that can lead the person affected by this loss to isolate themselves, change their routines or lose the reinforcing stimuli they had access to before.

When a bereaved person falls into the darkness of their sadness, can they end up developing a depression? Has what was once a normal reaction turned into a depression? Is time what differentiates health from disease or what is normal from pathological? Are six months a normal period in the case of grief, but not so if the period is six months and a day? Our opinion based on experience leans more towards the criterion of the clinician than towards diagnostic descriptions, even at the cost of losing some scientific rigor, in the interest of greater efficacy and therapeutic success.

Grief involves an enormous revision of values and beliefs for the afflicted: it invites us to reflect and question opinions that were held to be certainties. This questioning often causes the bereaved to undergo a process of personal growth. As a result of this, working with grief at a therapeutic level can mobilise resources in the individual that help to unblock the entrenched processes. In this sense, human beings are like a forest: it does not matter

what you have influenced, as everything is restructured and organized around what has been modified.

There are many unanswered questions regarding grief. The attempt to answer those questions we posed at the beginning of this chapter has raised further questions. This suggests that there is still a lot of ground to explore regarding grief and that theory evolves slowly.

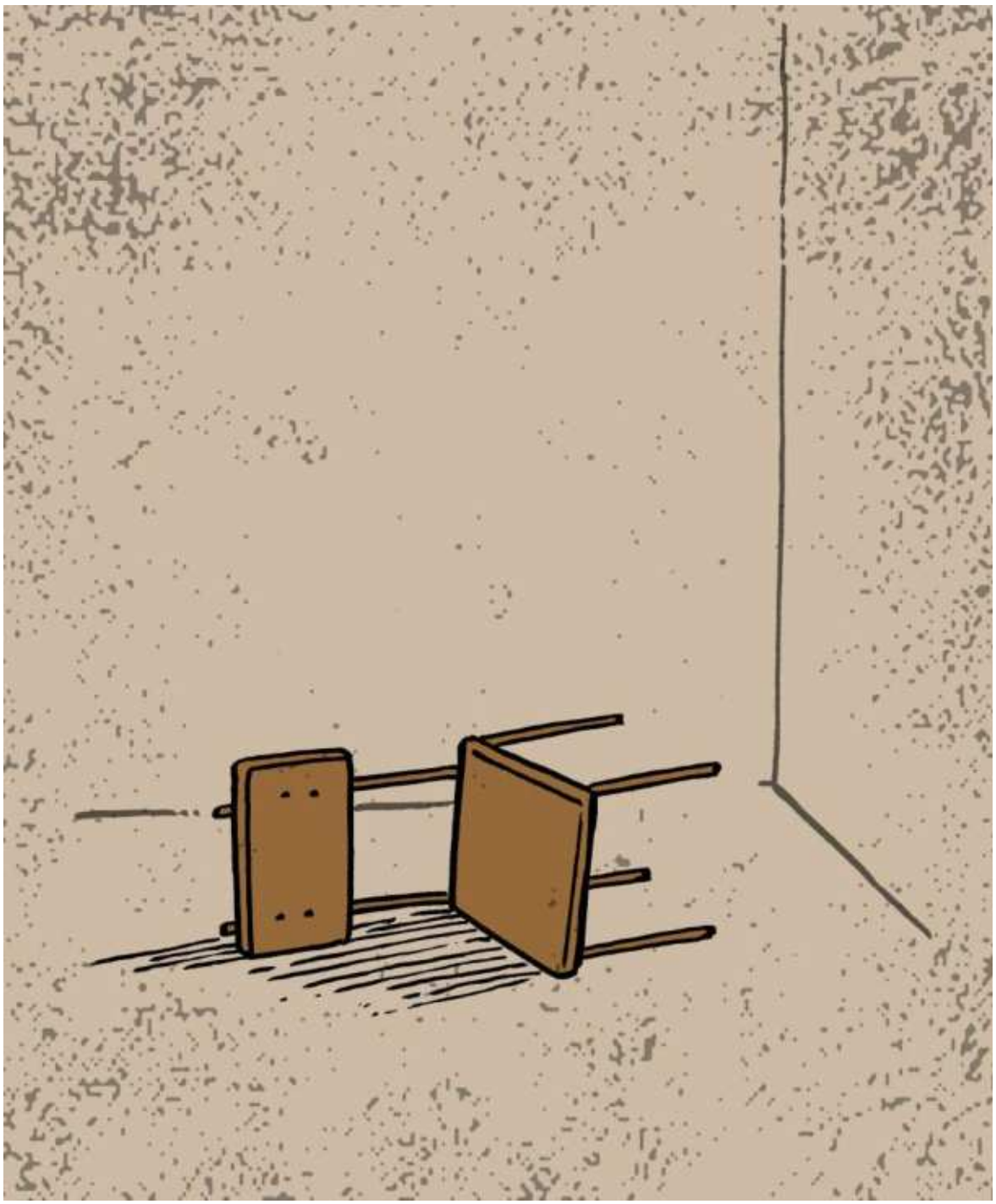
At the same time, we have found that the role of clinicians -who draw on theory and experience to answer the specific questions posed by our patients- follows one path, while the role of the grief researcher -who amasses concepts, builds hypotheses and consolidates theories that they place at the service of the clinician in a strategic alliance for both-, follows another route, which is set at a different pace.

REMEMBER:

- **Grief is not the same as depression, although it does share some symptoms.**
- **Grief does not imply a loss of self-esteem.**
- **In grief the world is what has turned into a dark place.**
- **Medication does not seem to improve the grieving process, however it does help in the case of depression.**
- **There is no consensus between researchers and clinicians and it is difficult to define the limits of both disorders.**

CHAPTER 10

GRIEF DUE TO A LOSS BY **SUICIDE**



Suicide is more than a taboo and can seem a source of shame or disgrace for the family and the social circle of the person who commits suicide. It is a death that is not mentioned, that does not show up in the statistics: it is the death produced by a deliberate decision to take one's own life.

This reality often leads the suicide of a loved one to remain hidden, making their loss even more painful, because it is a death that encloses a secret. Beyond cultural and social judgment, a death by suicide is a reality that causes a lot of suffering, that must be addressed.

Is death by suicide different from a natural or accidental death?

It may seem so, but in reality, death is the same for everyone: the cessation of vital functions required to make life possible. However, in this case, the fact that it is the person who inflicts death upon themselves, can lead to reflections and blockages by the family and social circle. The only thing that changes is the judgment that society carries out and, quite often, the family as well on an unconscious level. It is difficult to establish, in general, the nuances of this type of grief, thus I will limit myself to a few broad brushes that will allow us to comprehend the most common situations.

When dealing with suicide grief in therapy, it is necessary to bear in mind that it may require more time and it might come along with traumatic images.

The need for time is associated with the ability of each griever to discuss what has happened. If we try to intervene too soon or if we push the person to move forward, we may lead them to abandon therapy, as the bereaved will not feel that what they have experienced is understood or respected, or they are not prepared to tolerate that level of pain.

Occasionally, it seems as though talking about the details regarding the death constitutes disloyalty towards the deceased or the fear that psychologists will judge this behaviour may arise. Hence, when we approach the bereaved, we have to pay special attention in building trust, so that they see us as trustworthy people who will not judge the suicide. If more time is required, it will be added to the therapeutic process: time and patience.

I often find myself with grievers who are reluctant to talk during the first sessions about the suicide or about how the death occurred. They will only address it when they feel ready to do so. Frequently, remembering details of the death can raise traumatic images or bring up traumatic feelings. Trauma can stem from the circumstances in which the death occurred or the way in which the news of the suicide was transmitted: if the griever was witness to any shocking images involving deterioration, if they were the ones who found the deceased, etc.

One of the most frequent aspects in therapy is that people are constantly searching for a "reason", one that explains why their loved one committed suicide. This reason may remain hidden and each person must build their own justification. The search for an explanation goes hand in hand with the acceptance of a very shocking reality. The griever may experience feelings of guilt for not having been able to avert the suicide, which is just another way of denying death and exerting a false control over life.

Another "recurrent" detail is the pain caused by imagining how much the suicide victim had to be suffering in order to end up making that decision. In this context, it is common for the bereaved to experience guilt for not having have noticed it or for not having been able to alleviate that pain.

Common elements:

- Taboo.

- Pain.
- Feeling incomprehension.
- Wondering about the reasons that led to the suicide.

Usual elements:

- Impacts / traumatic elements.
- Physical alterations (correlative to trauma…).
- Feeling guilty.

Things that work:

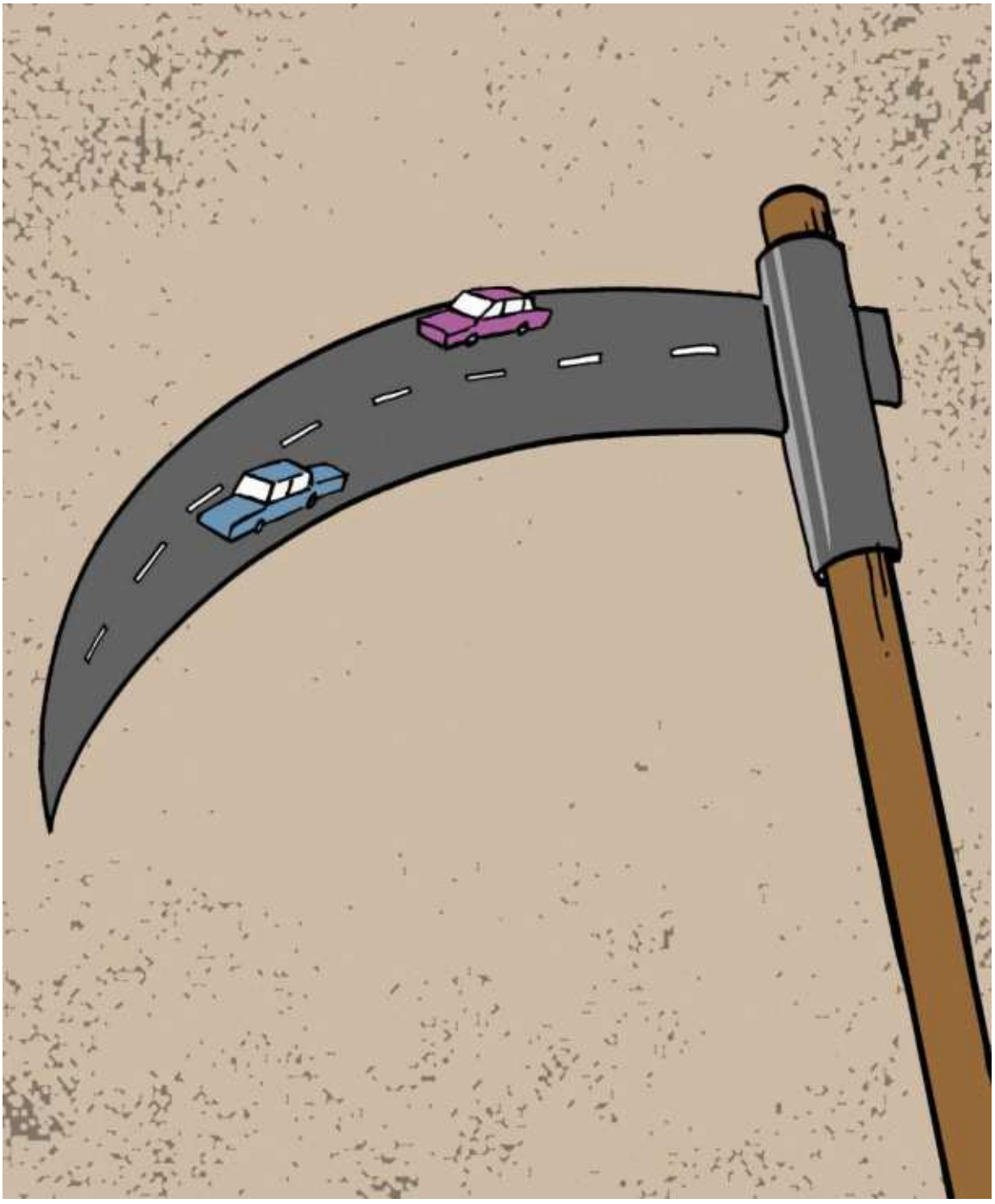
- Sensitivity.
- Patience.
- Normalising all reactions and placing them in context.
- Encouraging dialogue on all the issues and nuances without pressuring to do so.
- Staying calm when faced with "strange" reactions.
- Encouraging a medical review for the griever's physical symptoms, allowing the bereaved to have control over something small.
- Creating stories that help to explain what has happened.
- Generating hope.

REMEMBER:

- **Suicide often entails a taboo.**
- **It frequently includes traumatic elements that add more pain to the grieving process.**
- **It is essential to give the bereaved time and to be sensitive when addressing this subject in therapy.**
- **One must not be frightened by the patient's revelations.**
- **It is advisable to discuss the causes of the suicide.**

CHAPTER 11

GRIEF DUE TO A **TRAUMATIC DEATH**



Within the traumatic grief category, we include all those that are caused by the sudden and violent death of a loved one: traffic accidents, work accidents, homicides, attacks, etc. In most of these cases, grief is joined by post-traumatic stress disorder (PTSD), or at least by some of its symptoms.

This disorder is listed in the DSM-V as a separate chapter, within the second section involving disorders. However, beyond scientific reviews, it is important to understand the bases on which this grief is sustained.

Trauma is assembled around three axes:

1. **The traumatic event**, be it an accident, a homicide or an event that, although objectively it may seem harmless, is traumatic for the bereaver because they do not have sufficient resources to cope with it. In this sense, I have occasionally treated people with a grief that, in appearance, could have been healthy -loss of an elderly parent, after a long illness, which after all is a fact of life- and yet, they had developed a traumatic grief. The key to this is the way in which this event is experienced, which depends on the resources that the bereaver has available. Their subjective perception of the event is more important, and it always happens to be associated with horror, destruction or the feeling of devastation.

2. **Constant agitation or disturbance**, also known as activated arousal.

3. **The avoidance** of everything connected to the traumatic event and the related images regarding this situation that may have been stored.

The presence of some or all of the symptoms associated with post-traumatic stress will force clinics to spend some more time working on the remission of these types of signs. One technique that has proven to be effective in treating this disorder is the EMDR (*Eye Movement, Desensitisation and Reprocessing*).

This technique is a therapeutic tool that benefits the processing of the traumatic event -in this case, a traumatic death-, if applied by a trained psychologist. The technique consists in assisting the bilateral stimulation of the brain -based on dual attention-, which removes symptoms, or at least greatly decreases them.

Bilateral stimulation occurs through different strategies, either with eye movement, bilateral sounds or tapping. The latter is used to integrate the trauma with all the information that has been stored in the neural networks -the emotional and the rational-, in order to incorporate it into a more normalised life story, where all the information has been released.

EMDR allows the bereaved to work around their avoidance issues. In the end, it is about being able to "be present" regarding everything that has happened, because avoidance prevents processing. With EMDR, the tolerance threshold the patient has towards these images is amplified, making them realize they are able to withstand it.

According to several studies, sudden loss is more difficult to elaborate than other deaths in which the loss can be anticipated. This difficulty is due to the fact that the bereaved lack the opportunity to mentally or emotionally prepare themselves for the loss. Mental and emotional processes need a certain amount of time so that they can assimilate the impact. Frequently, a shock process is set off, in which the griever cannot believe what has occurred. This blockage, normal at the beginning, is linked with the assimilation process, where defence mechanisms are activated in order to protect us from the reality of death.

The defining characteristic of this type of grief is the feeling of unreality that the bereaver expresses regarding the death of the loved one. Therefore, primary support will focus on helping them work through the reality of the loss.

It is especially important to reminisce with the bereaved how they experienced the death itself: how they received the news, how they and their social circle reacted, how the farewell rituals were carried out, etc. The counsellor or therapist will deliberately use the words "dead" or "deceased" to help them work through the first task of grief. Under no circumstances should this task be forced, as any attempt to resolve the traumatic grief in a hasty manner can cause undesirable reactions in therapy. When the patient is ready, it is important to "listen" and, above all, to move forward gradually. Sensitivity is essential in trauma intervention.

Other frequent sensations regarding traumatic grief are feelings of guilt. It is common for the bereaver to fantasise about different endings, with different "What ifs" ("What if I had not left", "What if I had not left them the car keys", etc.). In this way, the bereaved keeps the deceased alive in their heads and, thus, block the first task of grieving.

Coming closer towards the reality of what happened and contextualising the moment that death occurred are useful resources in order to work on the acceptance of loss. Contextualising the moment of death consists not only in sticking to how it occurred, but also in what happened days before, how the bereaved was, how the deceased was, what was happening in their lives… Thus enabling the bereaved to accept that accidents do occur, that it was not up to them whether or not death took place, this is to say: managing to finally remove power from all those "What if...?"

The elaboration of this type of loss will depend on the acceptance by the bereaved that bad things occur, that things are not under our control and that accidents or tragedies almost always involve a multitude of factors. The final message that the expert must rescue for their patients is a message of hope: "You will overcome it, do not pressure yourself, give yourself time", "You're fine as you are, trust your resources, trust your own abilities, trust therapy". Without this message of hope, it will be hard to bear the pain brought about by loss. This type of grief may require a greater commitment from the therapist's part.

REMEMBER:

- **We must respect each patient's rhythm, because each person is unique and, if we analyse the specific context, most reactions are normal.**
- **It is not useful to pressure the patient to lessen the pain or for it to last less.**
- **Observe and validate the bereaved person's reactions.**
- **Display calm.**
- **Make it easier for the patient to trust you.**
- **Offer hope for the pain to be easier to bear.**
- **Turn to medication when the anxiety is very intense or to EMDR to handle the most stirring images.**
- **We must be aware that behind all of this, there lies a human being who is suffering a lot and who needs another human being to protect, validate and be committed to them and their process.**

CHAPTER 12

GRIEF DUE TO A **DISAPPEARANCE**

Grief over the disappearance of a loved one -whether or not it occurred under violent circumstances- is a process as painful as one that could result in death. However, grief has the additional pain of ambiguity, uncertainty and doubt.

If it is already difficult to accept a loved one's death when there is physical evidence of their demise, in cases involving a disappearance it is almost impossible to work on the first task of grieving: accepting the reality of the death. This is because there is no way to prove it. The law requires ten years to go by, in the course of which no clue or lead can be found, before officially declaring the death of a missing person. This affects those close to them on a legal, financial (inheritances, widow's or orphan's pensions, etc.) and emotional level.

We can all probably remember a case with great media coverage, in which the relatives of a missing person made a pilgrimage through the different television channels, anxiously looking for new clues that would allow them to feed their hope of finding their loved one alive. In addition, in all cases involving a disappearance, society is moved by citizen appeals, whether or not they have a social projection.

Occasionally, if the disappearance is of public domain the bereaver's suffering can increase, as the number of people who express their opinion about the case rises exponentially and, every time a programme talks about the subject, they "reexperience the disappearance" of their loved one. Lawsuits and trials related to the disappearance will feed the pain of the relatives. Still, public recognition of their situation helps to alleviate their pain and the fear that the missing person will be forgotten.

There are no statistics or specific studies that describe the specifications of this type of process. For those who experience this type of loss, the struggle to reconnect with their loved one is of utmost importance, so they focus all their energy on promoting the search for the missing person, paying private investigators, creating profiles on Facebook or attending television programmes. Their life is led by an eternal search, as it never ceases, because they associate the idea of abandoning with that of surrendering or with being a worse father / mother / son / friend, etc.

In therapy it is uncommon to find a case of grieving due to disappearance, since -as previously mentioned- these bereavers focus their energy on the search and not on the absence. But if we were faced with this type of

case, we would focus on the pain caused by the absence because this is real. In the case of a missing person, it is impossible to offer the grieving person data that confirms the reality of the death of their loved one (which hinders processing the first task), but it is possible to work on the grief caused by the absence of the loved one and the pain of unmet expectations. Work at an emotional level can also focus on the guilt and anguish caused by uncertainty - two emotions that are very difficult to alleviate - as well as the fear that the missing person's existence will be forgotten.

- **Uncertainty in grief**

During the first moments after the disappearance of a loved one, it is normal for the relative's attention to be focused on the police investigation and the help the media can offer by spreading the news in order to find clues regarding the whereabouts of the missing person.

It is difficult to imagine that a person immersed in the search of a loved one would want to receive support to resolve their grief. But if they did, it is easily imaginable that it would be a complicated case.

One of the characteristic features of this type of case is that the relatives of the missing person always hope to find them. However much time has elapsed, it is

always possible to imagine that their loved one is alive elsewhere because, as long as their body is not found, there is no evidence to sustain they have died.

What can be done and how can we help in a grief process due to a disappearance

When caring for people who are grieving due to a disappearance - or over a grieving in which the demise is not evident - we can work on the certainties:

- The pain caused by the absence, which is already a loss in itself, regardless of how the case ends.
- Fear and uncertainty regarding what they imagine could have happened.
- Fatigue derived from that permanent state of waiting, of awaiting for news.

How to handle emotions caused by grief disappearance

It is difficult to direct the attention of the bereaver towards the pain and the sensations that appear with time, because the urgency is centred around the search. Frequently, people affected by this type of loss act impulsively, searching tirelessly, engaging with the media, giving interviews... This can lead to great physical exhaustion and stress around the immune system.

Psychologists have an important role in managing these ambiguous grief situations. Among other things, by offering some guidelines to the bereaved, such as:

- Rest adequately for a minimum number of hours each day.
- Disconnect the phone occasionally to avoid constant alertness.
- Keeping a healthy diet.
- Dosify the information that the bereavers are receiving.
- Dosify media and news exposure.
- Seek supports that provide comfort, companionship, or whatever each person may need.
- Adjust to the needs of each person, without generalising or comparing. Faced with a case of this type, we can help the bereaver by:
- Accompanying the fear and pain caused by the absence, allowing and validating them.

- Allowing them to express their feelings and vent. Naming what scares us allows us to distance ourselves slightly.
- Allowing them to remain hopeful, respect each person's rhythm, do not force or pressure.

These guidelines can help a person who wants to support them during the first moments, always keeping in mind that each grief case is unique and that not all people react in the same way.

In this specific type of grief, two fundamental points can be addressed:

- Help people to live with the uncertainty and actual absence, so that their functioning, their social relationships, etc. are affected as little as possible (Barros-Duchene, 2010).
- Long-term maintenance of a high level of pain and anguish, which time does not diminish, can have repercussions causing both psychological (depression) and physical complications.

REMEMBER:

- **Those who experience this type of loss concentrate all their energy on promoting the search for the missing person.**
- **The fact that the disappearance is in the public domain can increase the suffering of the bereavers, as the mediatic exposure will feed the relatives' pain.**
- **Therapeutic work can focus on guilt and anguish caused by the uncertainty, as well as the fear that the missing person will be forgotten.**

CHAPTER 13

GESTATIONAL OR PERINATAL GRIEF

Fetal death, whether it is intra-uterus or it takes place during delivery, entails the loss of a baby that was expected. In this chapter, we also include deaths that occur from the conception of a child to their first year of life.

Different losses are also added to the loss of a baby: loss of the moment one becomes a father or mother; if it was the first child, the loss of the role of being a father or mother; loss of a family structure and prospectives; loss of innocence regarding pregnancy and childbirth; loss of the right to mention that child in certain places, as well as the loss of the physical contact and the possibility of creating memories with the child.

These examples showcase that grief due to perinatal death constitutes a complex experience. Consequently, offering the bereaved space and time so they can express their experience, how they are living it and what this means to them, is essential in aiding the evolution of this process.

Perinatal grief can have the following complications:

- According to studies, between 10% and 48% of those affected will suffer from depressive disorders.

- After a perinatal loss, anxiety disorders emerge when faced with the possibility of a new pregnancy.
- The influence of post-traumatic stress disorders in instrumental deliveries, or caesarean sections, rates between 2% and 5%. During the month after the loss, this reaches 25% and four months later, it is up to 7%.

These data justify the importance of assisting this type of grief and how professionals must remain vigilant to its evolution.

In perinatal grief there are two antagonistic vital moments: life and death. This fact definitely marks a process that has specific nuances. For the pregnant mother, experiencing the beginning and end of life is a brutal shock.

On another hand, in no other type of grief does the bereaver experience such a high hormonal component that is directly aimed at motherhood, at the development of a bond and the creation of life. The death of the baby - either in the womb, a few days after birth or during childbirth - entails an abrupt rupture of the future mother's expectations: her body sends contradictory messages, prolactin *versus* cortisol and acetylcholine, forming a difficult cocktail for her to manage.

Another component which is absolutely differentiating is the *shock* mothers experience due to the loss; it is really complex to assimilate because the body sends them contradictory messages.

There is a taboo around this experience and little is said about the death that occurs during pregnancy, or in the moments close to it. We are not socially or professionally prepared to tend a grief with these characteristics: midwives, nurses, doctors… they cannot find words, nor do they know what to do under these situations. Some resort to common sense and their own skills, but there is no specific, "humanised" protocol established to address this heartbreaking experience. In this respect, Spain has a long way to go.

In Anglo-Saxon countries, with far more experience in this field, they have protocols for these type of cases. These include rooms equipped for parents in order to say goodbye to their child or take photos of them, or specialised clinics for women who have had previous gestational losses. In the rest of the world, hardly any of these resources are available; nonetheless, we should aim to achieve this goal: the development of units designed to address these special situations.

A final aspect common to this type of loss is the delegitimisation of this experience by the social circle, which often tends to downplay the grief with phrases such as:

- *"You can still have more children".*
- *"You did not even have time to become fond of him/her".*
- *"It is for the best...".*

In our society, the pain of a woman who has lost a baby prematurely is diminished of its value or importance. And, when referencing the father, the importance given to them is usually non-existent. This fact causes couples who are going throught this experience to isolate themselves and share their pain only with people who have undergone the same situation as them.

Regardless of the nuances of this type of grief, the general formulas discussed in previous articles remain valid, respecting or adapting them to the needs of each particular case.

Aspects that assist this process

There are several factors that can help to overcome this type of grief:

- **Time will be an important ally:** Not the only one, but pain is mitigated over time. Grief requires time, like in any process.
- **The legitimation of pain:** We have talked about this on other occasions, we must allow and normalise pain, because everything that we resist persists and everything that we allow flows.
- **Ask for what we need.** Grief calls for parents who have lost a baby to focus on their own needs, becoming active agents and seeking out what they require by involving the community. We do not confront grief alone: we live in communities and this process is also lived and solved in community.
- **Take nothing for granted.** Sometimes words have different meanings for each person. It is essential to clarify the meaning of loss, what it implies for each individual to be feeling better or feeling worse, because it is within the meaning of loss where the key to each grief lies and it's what differentiates one grief from another. To let go of the pain, it is necessary to delve in the experience, communicate, open up to others and share.
- **Remain confident that it can be solved and overcome.** We can nurture it with our own messages or the words of others, with quotes such as *"This too shall pass"*, or *"Do not despair, because clean water falls from the blackest clouds"*, or *"There was no night, no matter how dark it was, that it did not dawn"*.

Perinatal grief is a deeply shocking type of grief that produces a great deal of pain and also has an impact on the social sphere. As this makes people want to try to help, but sometimes it hinders the process instead of assisting it.

Things that help us:

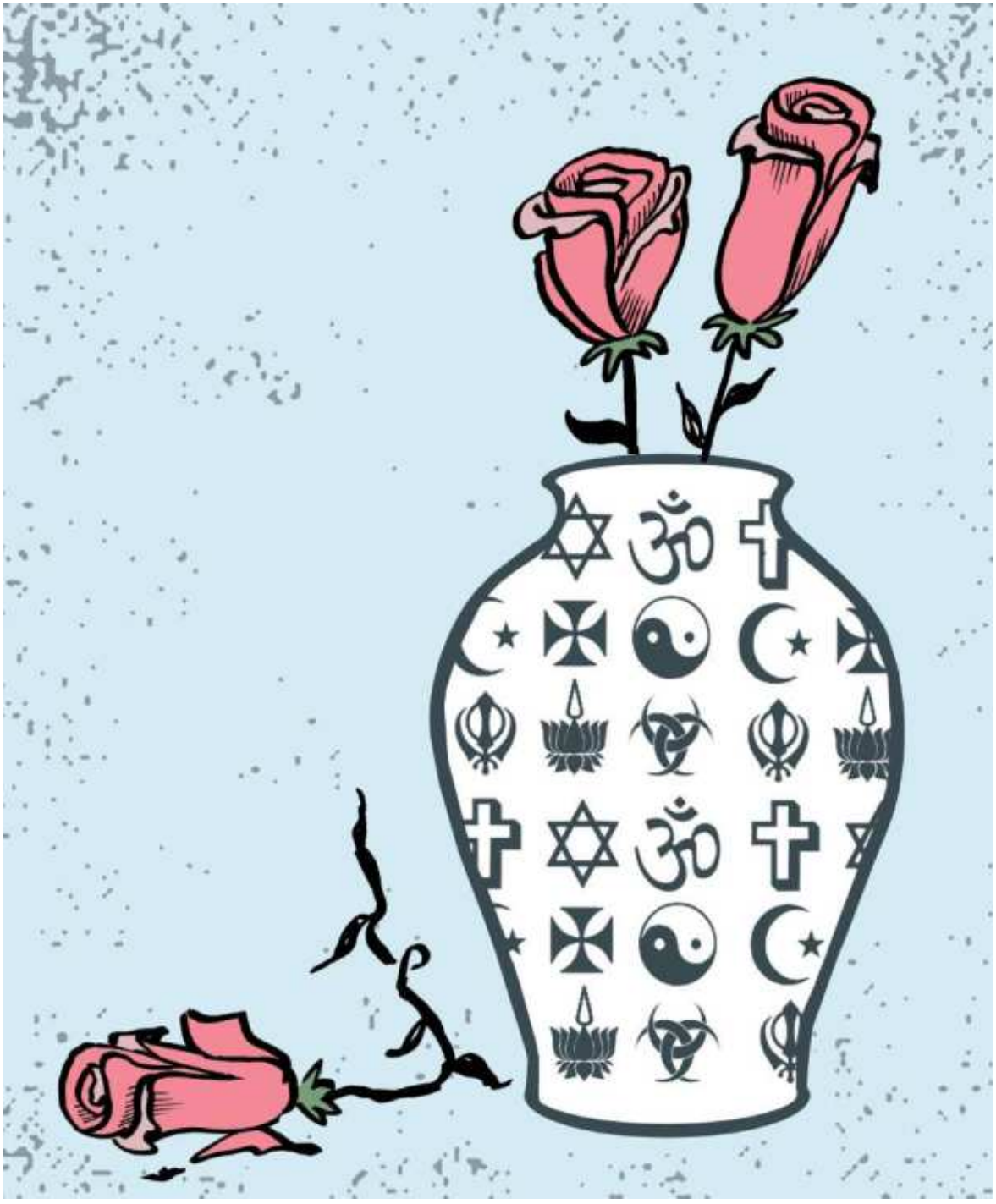
- Gentleness.
- Sensitivity.
- Being present.
- Respect: not telling the bereaved what they should do or feel.
- Humanity: technical knowledge falls short under this situation.

REMEMBER:

- **Different types of grief are also added to the loss of a baby, which makes it a complex type of grief.**
- **There is a taboo around this experience that constitutes a shock, especially for the mother, since her body sends contradictory indicators.**
- **A common aspect of this type of loss is the delegitimisation of the experience by the social sphere, which tends to downplay it.**
- **Offering time and space so that the bereaver can verbalise their experience, how they are going through it and what it means to them is essential.**

CHAPTER 14

GRIEF AND **FAITH**



Vilified by some and extolled by others, faith -as could not have been otherwise- emerges surrounded by a halo of mystery. Many people wonder about the role that religious beliefs play regarding grief resolution. Thus, throughout this chapter we will analyse some of the questions that faith poses.

First of all, faith confronts us with questions that we cannot answer; after all, faith itself is based on the principle of believing without evidence. Faith can be a refuge for those who have lost a loved one, bearing in mind that one of the promises that religion makes is that we will be reunited with our loved ones when we die and that the person we have lost, is now in a better place.

For a lot of people, faith is a very important support. In our experience as psychologists, we have found that faith is a bastion that allows believers to relieve pain. There are those who, in the face of loss, cling to faith like a lifeline, which provides them with peace and serenity. However, there are also those who do not believe and who do not find this factor essential in order to overcome grief.

If we interpret faith in a rigorous way, the acceptance of death can become complex, as some messages may seem to be contradictory, although in reality, they are not. In order to understand this statement, it needs to be analysed in detail. For example, when the Catholic Church says that people do not die, it is not denying the reality behind the physical evidence (that the body stops functioning), it is arguing that a human being is not merely a body, but rather that it is composed of body and soul. And, by asserting that a human being does not die, it refers to said spirit or soul.

Faith is not at odds with Science, but rather, our interpretations of faith are what sometimes dissent. When the Catholic Church says that the soul goes to Heaven -or to God's house- it does not refer to a physical heaven, nor to a house with bricks, but we need images that can represent what we consider as "eternal life" to be like; as by giving it content, it allows us to grasp it in some way.

When they tell us that we can talk to our loved ones after their death, they do not mean that we can send them messages, nor do they mean that they can hear, speak or see as we are used to doing, as physical functions cease to function and the dead do not see, nor hear, nor feel pain or joy. However, we can address them or pray to them as those who pray to God

and not that does not imply waiting for an answer. As you can see, we are discussing abstract, vague concepts that could be difficult to understand by a human being without the use of symbols or metaphors.

Faith allows us to give sense, meaning and order to the things that happen to us, this is why trying to pathologise or question those who practise it is not a good idea. It is also true that there are many people who go through grief without needing faith. Throughout our professional experience we have witnessed both cases.

In conclusion, having faith is a positive factor to help overcome grief, but it is not essential. A mature faith not only lightens the burden of loss, but it also offers hope and allows us to find meaning in death. Faith cannot be imposed on those who do not have it, nor can it be extracted from those who do.

Superstitions regarding grief

One of the oldest questions that human beings ask themselves is if there is life beyond what we know, if we can or cannot believe in an eternal life, if we will see our loved ones again. Different religions and this epigraph, in a much more condensed way, try to answer this and other questions.

Frequently, a lot of people ask us for advice regarding the doubts they have on subjects related to afterlife: what happens after death?, what power do the belongings of the deceased have?, whether or not they can be contacted... Some raise these questions openly, in a natural way, and others feel ashamed when thinking about it and ask about it, expecting rejection or judgment on our part.

On this subject, I do not uphold a categorical opinion, since it seems important to me to reflect on these questions that are presented so frequently. There are two positions before them and both seem legitimate to me: one option is to give a scientific answer - stick to the physical, what we know, what we have verified - and leave aside the most spiritual part, always being respectful of beliefs of each person and with the options they make in their attempt to overcome the pain.

Another option is to pay attention to these doubts, listening to them, legitimising the meaning that the spiritual has and what it means for each one of us. It is about being open to answers that imply the possibility that there is something beyond what is strictly objectifiable or measurable.

It is a position that neither affirms nor denies: it only contemplates the possibility that this is so. This position cannot be feigned, it is shared or not shared. It implies admitting that, in some way, there are people who have the sensitivity to perceive things that are not evident, that are intangible and go far beyond the purely testable.

Although the two options seem valid to me, this second position seems closer to what our patients need from us. Otherwise, if we give them an insufficient answer, we run the risk of leaving them at the mercy of unscrupulous people, those capable of trying to answer their concerns by guiding them down through dangerous paths for their mental health, or that may lead to fraud.

I understand that this conclusion may be controversial. Until relatively recently, I prided myself on being strictly scientific and professional, asking my patients to focus on what we could assert emphatically. Often this answer is enough for them, and they follow my advice, but for others it is not enough and that keeps them in a constant attitude of search that prevents them from overcoming their grief.

Prior to writing this epigraph, I have been very hesitant and have reviewed the possible risks associated with offering the possibility of believing in something else to these types of patients: that is, what could be wrong in offering answers that are not verifiable, but that allow us to understand aspects that are profound. My conclusion is that I do not find any danger in this, but I do find the possibility for the bereaver to find peace, to free themself from guilt, to find a different meaning to the loss.

In his book "*Many Lives, Many Teachers,*" American psychiatrist Brian Weiss also offers an approach that can revolutionise the way in which we understand life and death. He declares, after having practiced hypnosis to work on symptoms that did not remit with conventional therapy, that life has no end, that we rotate from life-to-life learning things that we need to learn, that after physical death we enter an intermediate state in the that we rest and our teachers can teach us things. That we are called to love, to help others, to teach. And that we take from each of the lives that we live lessons that are shaping our spiritual baggage.

Weiss also states that when people die - as we understand physical death - they see a light of irresistible, warm, attractive beauty, after which our loved ones appear and we enter a period of rest in which the mind or the soul can reflect or evaluate what it has learned in its life and what it needs

to learn, until it reaches the full wisdom that is love. As he tells it, death appears as something desirable and not as we have perceived it until now. Can you imagine the paradigm shift this would mean for anyone who has lost a loved one? As I understand it, it would allow us to reach the following conclusions:

- Death itself does not imply suffering.
- There is an afterlife full of peace, fulfilment and reunions.
- All of our experience is related to what we need to learn and that is what gives meaning to our existence and our death.
- We tend to love and knowledge, and that energy full of love and wisdom is what brings us closer to God.

I understand that there may be professionals who are scandalised by this content, but after having known it I feel responsible for making it public, since I understand that it cannot bring harm, but it can bring many benefits.

In any case, as professionals we do not have all the answers, nor do I think we will be having them in the shart term. With this, I am only try to make this content accessible so that it can be used at the service of patients who need it, not as an imposition but rather as another alternative.

Extremely personal reflections

As for our own personal opinions as psychologists, it is difficult to take a stance on a subject where so many factors are involved.

We consider that it is impossible to establish a categorisation in relation to mourning, since there is no mourning the same as another, rather the opposite: we defend that mourning is what adds to what a person already is. As there is no single person equal to another, neither can there be a duel equal to another.

Individual experiences shape, colour and modify the experience of grief for each one of us. For this same reason, the authors stand out from any attempt to consider grief as a separate entity. Grief can only be measured and evaluated in the light of the identity of the bereaved and their personal history, all in all taking into account their culture, ideology and values.

Individual experiences shape, colour and modify the experience of grief for each one of us. For this same reason, the authors stand out from any attempt to consider grief as a separate entity. Grief can only be measured and evaluated in the light of the identity of the bereaved and their personal history, all in all taking into account their culture, ideology and values. Then - and only then - can we determine whether a person is going through a complicated grief or not; or if you require therapy or not.

REMEMBER:

- **A too stern interpretation of faith can complicate the acceptance of the loss of the loved one, other than that, faith is not incompatible with Science.**
- **For those who have it, faith is an important support in helping them overcome grief, but it is not essential in order to elaborate this process.**

A.1 What always works during grief

In recent years, our entity has frequently received inquiries about grief via email, most of them from people who have recently lost a loved one. When I say "recently" I mean that, in general, when they contact us, only a couple of weeks or even less have gone by since their loved one passed away.

These people write to us in anguish, overwhelmed by the intensity of the emotions they are experiencing, feeling misunderstood. They request, in a few words, for a short guideline so that they can continue with their lives, reposition themselves in the first days or in the first weeks after the loss.

To all of them, to those who have seeked advice from us in the past and to those who continue to ask, this letter is addressed to a recent griever:

What to do at the beginning of the grief process

When grief hits us, we need to be told that everything will be fine, that the pain will pass, but we also need to be told how to do it.

Respecting the principle says that no single grief is the same as another, I dare to propose below a formula of five key ingredients that must be present in a healthy grieving process, regardless of whether each individual will need them to a different extent.

Grief's formula

This formula is an easy acronym to remember, taken from the Spanish "TERCA". Each letter stands for the initial of one of its main components. Undoubtedly, this is a debatable formula and one that can be improved, but it is a starting point from which to begin taking the first steps in those first instants after the loss.

- **T** (from the Spanish *Tiempo:* **Time**). Time is a fundamental element in any grieving process. It is not the only ingredient, nor is it the most important one, but it is an essential one: time has to go by in order for this process to end, and yet we know that time does not heal everything, but rather the key is what each individual does with their own time. This is to say that time will play in our favour or against us, in relation to what we do. If we search for and take the determined decision to get through it, we will most probably manage to do so, if however, we merely wait for time to go by, the most probable outcome is that grief will hinder intactly.

- **E** (from the Spanish *Esperanza*: **Hope**). It is a vital component in any psychological process, as well as in grief. It is extremely important to keep the hope that it can be overcome, that we are to begin with enduring a healthy and spontaneous process that will resolve itself without a medical or psychological

intervention. In so doing, it is vital to always trust one's own capabilities, both with the process itself, and if it is necessary, with therapy.

R (from the Spanish, *Red de apoyo:* **Support network***)*. Grief is a process that requires the presence of other people. We live in society, it is harder to overcome grief alone than with people who supoort and allow us to legitimise and normalise grief's pain. This is the way we keep pain away from us. Without this, it would remain inside of us.

C (from the Spanish *Compasión*: **Compassion**). Other people's compassion and our own is probably one of the most powerful ways with which to confront grief, to undertake the path without any demands, pressure, with respect... Trusting that each indivual's own pace is correct, this is because we cannot control our heart.

A (from the Spanish *Amor*: **Love**). Love is along with compassion, the most powerful and thereapeutical force in the universe. Other people's love, expressed through their presence, their frequent visits, their assistance on day-to-day tasks..., the love that arises from those professionals that get involved in the process, true love as referenced by Carl Rogers and of course, the love we offer ourselves, shown through selfcare.

It is signficiant that this letters form linked to rapid grief resolution, the Spanish TERCA; as a great deal of stuborness and firm resolution are required to overcome grief. As it normally is not resolved on the first try, but rather requires quite a few tries.

A.2. Examples of answers and key points regarding grief: A study of ten cases.

Through the presentation of these cases, we aim to offer guidelines into answering the concerns a grieving person may face. For a significant percentage of those who seek advice, these answers are sufficient. For the remaining cases, a more profound therapeutic intervention will be required.

1) Erika is a woman who made an enquiry regarding the pain felt by a very close friend after the death of a loved one. She states that she wants to help her friend and asks us for guidance.

Good morning, Erika:

When we lose a loved one, it is normal to feel pain. I know that it is impressive and sometimes even scary to see how sad the people we love or with whom we maintain friendship ties are. But pain cannot and, above all, should not be plugged. It is normal to feel pain, and guilt is one of the many forms this emotion can take. What you tell me falls under the category of "normal" in a grieve process.

The way in which you can assist them is by:

Stay close by them and offer your help.

Let them express their pain without questioning it and without feeling frightened by it.

Tell them that pain does not always feel that way, and that others have overcome it and that they will too.

Offer concrete help: to go shopping, accompanying them to deal with paperwork ...

Keep a hopeful message: it is a normal process, that follows the loss of a loved one and it occurs with a wide range of reactions, almost all of these reactions are normal.

If in six or seven months the pain remains exactly the same, you can visit a mental health professional, who will surely be able to help or accompany you throughout the process.

Wishing you both the best,

Yours sincerely.

2) Mayra is a woman who inquires how she can help a sister of hers who has lost a child. She wants to know if it is harmful for her sister to listen to an audio that she keeps.

Good morning, Mayra:

Thank you for contacting us for advice and for acknowledging our work. It is difficult to answer your question. There are no things that are good or bad in themselves, because there are no universals when it comes to reacting to grief, that decision only depends on what you want, what comes from your heart. From what you say, what you want is to bring her to the memory of his voice and that is nice, regardless of whether it may hurt her as a mother. The audio does not hurt her, what causes pain is that her son has died and, in any case, it is okay that it hurts, that is not going to destroy her.

Crying is the way to heal from a broken heart. The progress of grievng is not measured by whether the bereaved cry or not, it is normal that the loss of their child hurts. What matters is the intention behind your actions, not so much what she does with it. In any case, do not be afraid thinking that their grief will go backwards or forward, that is not something that depends on you. Human beings are very strong and we are prepared to overcome the losses that come our way. Trust her and her ability to excel.

It is not easy to lose someone and to get over it, but it can be done. Good luck.

Yours sincerely.

3) Agustina is a woman whose son has been dead for a week and is scared of her own reactions.

Good morning, Agustina:

I am very sorry for your loss. I understand that now, just a week later, you feel pain and you feel terrible. It's normal, don't panic. You are grieving, which is the normal process that follows the death of a loved one. Grief comes from "dolus", a word of Latin origin that means pain. It is normal to feel pain in the face of loss, the strange thing would be not to feel it. Surely everything you feel is normal, it is difficult to make an intervention at this time. What is recommended for these first days is to take care of food and rest, and, if you are very distressed or have difficulty sleeping, ask your doctor to prescribe something so that you can be more calm. Grief is a healthy process in principle and you have to go through it. Although it may seem difficult right now, the human being is prepared to respond to the loss, even that of a child.

I hope that my words serve as consolation and guide you in these first moments, but if not, do not hesitate to contact us again.

Yours sincerely.

4) Liz is a woman who is worried because her boyfriend has lost his mother and does not want to recibe any help. She contacts us seeking guidance.

Good morning, Liz:

The best way to help a person who has lost a loved one is to be present, care for their needs, and respect their time. There is no single way to accompany a bereaver because each grief is unique. You can ask him what he needs from you or how you can help him. This is how you let him to understand that you consider him capable of overcoming his loss and that you are going to support him in whatever he needs, without harassing him and respecting how he feels. In any case, keep in mind that change is a door that only opens from the inside. That is something that only he can do. On our website you can download the Adult Grief Guide, which can help you better understand what is happening.

All the best.

5) Manuel is a man who has lost a son and wants to know if it would be good to join a group of parents who, like him, have suffered the death of a child.

Good morning, Manuel:

In response to your question, the grieving process is not a linear process, so sometimes it may seem that you are backing down. Sometimes it can also occur that, as the death of the loved one begins to be assimilated, the pain increases and that is experienced as a setback when in reality it is an advance.

In regards to your query, there are no universal answers. Some parents want to know more about their children and others do not, so it is best to ask them if they are interested in contacting you or not. If you feel like so, it may be a relief to talk to someone who has dealt with your child lately.

Best wishes.

6) Daisy seeks advice from us because she feels guilty for not having cared "enough" for her mother during her illness. She tells us that her mother did not want to go to the doctor or be helped, but still she feels guilty.

Dear Daisy,

Sometimes the situations that we live are very difficult, as in your case. How difficult it is to judge yourself when all circumstances were against you, when your mother did not cooperate, when your work did not allow you to spend more time with her. How hard it is to live with that and how difficult to have a compassionate look at oneself and to be able to say: "I did what at that moment I thought was good and what the circumstances allowed me to do".

Without that "permission" it is difficult to look at yourself with love. I think you need a therapy in which an expert can accompany you through your pain and help you to put words to it, drain it and forgive yourself. I'm so sorry for your double loss. Hopefully in a short time you can write to tell me that things are going better.

Best wishes.

7) Patricia consults us because she feels guilty for her father's death, she feels that she could have prevented it.

Good morning, Patricia:

I am very sorry for your loss and the immense pain it has caused you. One of the things that causes the most pain is to think that the death of a loved one could have been prevented. That adds a lot of pain to what already exists from the loss. It seems that what hurts you the most is not having been able to prevent it. This feeling of guilt is at the service of the denial of death.

I imagine that you will have thoughts in which you ask yourself "What would have happened if ...": if the doctor had done an X-ray before, if he had started the treatment earlier and thus a long list of possibilities. That denial is blocking the grieving process and keeping you from getting through it. Maybe it would be good if you could start a therapy that helps you express your pain.

Best wishes.

8) Ana is an adult woman who is scared by the reactions she has after the recent death of her mother.

Good morning, Ana:

I am very sorry for your loss and the pain it has caused you. It has been a very short time since your mother passed away and it is normal to feel pain after the loss of a loved one. It is also normal that you deny the death of your mother for a time, it is a mechanism that people use to cushion the blow. Still, I think it is a good idea if you can talk to someone to help you through this process. Unfortunately we do not know any psychologist in _____, we only work in Madrid. If I find something in your area, I'll let you know.

In the meantime, best wishes and I send you a big hug.

9) Paula is an adult woman who is worried because a friend of hers has lost her mother, expresses the desire to die and does not want to talk to her about it.

Dear Paula,

I understand your worries. In order to help your friend, you can just stay close to her and offer your help from time to time, until she accepts it. You cannot force the grieving process, it must necessarily start with the person who has suffered the loss. The feeling of wanting to die is normal in people who have lost a loved one, the desire is not the same as the suicide plan and she says she has no plans. Be on the lookout for her a bit, but also give her a vote of confidence.

Best wishes.

10) Alejandra explains that, five years after the death of her father, she began to feel very sad and to have a lot of discomfort. She does not understand why it has happened now and not before. She seeks to make sense out of what is happening to her.

Good morning, Alejandra:

What seems to have happened to you is that you "postponed" your grief. Sometimes we need to cushion the blow or give ourselves time and we just tackle it or face it when we feel capable. It is probably now when you can handle it, but keep in mind that grief hurts, it is its most characteristic note. In 90% of cases, grief as a process is resolved almost spontaneously, without the need for any professional intervention.

If you notice that you are blocked, or that it hurts in a way that is too intense, do not hesitate to contact a professional who is an expert in grief and who can help you overcome that process in the best possible way. Grief can be overcome, you just need to place energy on the process and, sometimes, a little help.

Sending you strength. All the best.

A.3. Common elements to all replies

- A brief and explanatory guide to the grieving process.
- Explain that the most valuable thing about help in grief resides in the presence of another human being.
- Allow and validate pain.
- Respect the rhythm of each one.
- Transmit confidence in the process and in the ability to overcome each human being.
- Offer help if necessary.

Example of a reply that could be offered by any medical service when a patient has experienced the loss of a loved one:

Dear griever:

You should know that the Spanish word "duelo", is a term with Latin origins, whose root "dolus" means pain. For this very reason, it is normal to feel pain at the loss of a loved one. You should also know that each person feels pain in a different way and that there are no rules into how to experience that pain, neither in terms of its length, nor in terms of its intensity.

We are prepared to overcome the pain that loss produces, all we have to do is to not interrupt the pain, but let it go, relying on the people who help us to be better and who allow us to live the pain in our own way.

Grief is more intense in the intermediate phase and is less painful just after death and at the end of the process. While we are grieving we cannot have hope, it is incompatible with pain. There will be days when you feel worse: during those days let yourself be carried away by grief, cry, unburden yourself. There will be other days when you feel better, during those days take advantage and go out with friends, take a walk.

Do not set rules for yourself to overcome grief and do not allow anyone to do so either. Do not try to set a pace to the process, to neither make it longer nor shorter, it is what it is. Keep hope alive because, as I have already told you, the human being is prepared to overcome the pain of loss, in fact, 90% of people who experience the loss of a loved one live a healthy grief.

EPILOGUE

Letter to a recent Psychology graduate

We do not know each other, but I know that you have just finished your degree in Psychology or your master's degree, and that you are thinking of practicing your profession in a clinic. You think that it is simple and that you have in your power all the tools to help many people. And you do not lack skills, but it is necessary that prior to beginning, you become aware of some things that you have not been told during your formative stage.

This is the letter that I would have liked to have received when I started working in grief therapy. I would have liked someone to have spoken clearly to me about the reality of this type of therapy, about what is not said in the courses and the difficulties that I was going to encounter, but also about how beautiful it was going to be.

Suggestions for the practice of clinical psychology:

- Don't spend all of your energy at the beginning, this profession is more of a long-distance race than a marathon.
- Start by accepting cases bit-by-bit. Don't force yourself or pressure yourself - if you feel uncomfortable or tired doing therapy, your patients will notice.
- Surround yourself with a team that can support you and with whose members you can vent.
- Combine your work with continuous training. This will give you ease and help you incorporate new tools into your interventions. Professional trainings are a great place to connect with people in your industry and network.
- Supervise yourself, at least in the beginning. Being able to contrast with another professional the approach you are giving to a specific intervention can make you feel much more secure.
- Do not be afraid of not having all the answers to an intervention. Experienced professionals also have doubts, we work with the most probable hypothesis.

- Trust the human being's potential. Professionals are not essential, creating a bond constitutes half of the therapy or maybe even more.
- Fill your life with things that feed you and that can counteract the wear and tear that therapy often entails. We accompany people during a difficult moment of their lives and that has an impact on us.

The pros of practising grief therapy

Psychology needs people like you, with a lot of energy, ambition and desire to succeed, wanting to help many people. We share a beautiful profession, but one that wears down a lot if you don't know how to protect yourself and even if you do.

We are lucky to be able to accompany people who suffer, but who will trust your criteria. The privileges of practicing in a clinic and offering grief therapy are evident: personal satisfaction, feeling that you can help and are important to your patients, contemplating how people improve and how strong the human being is... We are part of a unique relationship: the one forged between therapist and patient.

The emotional cost for the grief expert

However, professionals who work in grief therapy also pay a toll that we must be aware of. We often suffer with our patients. This may not be very orthodox, but it is the reality. Witnessing their suffering makes us vulnerable, it affects us in some way, and I think this is inevitable.

Sometimes, the fact that our work is based on human relationships confronts us with complex relationships with complaints, anger or undesirable reactions. It is necessary to assume that this is the price we pay for dedicating ourselves to this beautiful profession. Hence, the importance of each professional taking care of themselves in the way that is most beneficial to them. And this self-care is ethically necessary, because a burned-out professional can end up being negligent.

BIBLIOGRAPHY

CHAPTERS 1 & 2

- Gala León FJ, Lupiani Jiménez M, Raja Hernández R, Guillén Gestoso C, González Infante JM, Villaverde Gutiérrez MC, Alba Sánchez I. (2002). *Actitudes psicológicas ante la muerte y el duelo. Una revisión conceptual*. Cuadernos de Medicina forense, (30), 39-50.

- Gil-Juliá B, Bellver A, Ballester R. (2008). *Duelo: evaluación, diagnóstico y tratamiento*. Revista Psicooncología, 5 (1), 103-106.

- Prigerson HG, Vanderwerker LC, Maciejewski PC. *Complicated grief as a mental disorder: inclusion in DSM*. Handbook of Bereament Research and practice: 21 century perspectives. Eds. Stroebe M, Hansson R, Shut H. & Stroebe W. American Psichological Associaton Press 2007, in press.

- Bayes, R. (2001). *Psicología del sufrimiento y de la muerte*. Martínez Roca. Barcelona.

- Lacasta MªA, de Luis V. (2002). *Evaluación de resultados a largo plazo de un programa de atención al duelo*. Rev Soc Esp Dolor, (9), 502-509.

- García JA, Landa V, Trigueros MC, Gaminde I. (2005). *Inventario de Texas revisado de duelo (ITRD): Adaptación al castellano, fiabilidad y validez*. Aten Primaria, 37 (7), 353-358.

- Prigeston HG, et al. (1997). *Traumatic grief as a risk factor for mental and physical morbidity*. Psychiatry, (154), 616-623.

- Martikainen P, Walkonen T. (1996). *Mortality after the death of spouse: Rates and causes of death in a large finish cohort*. American Journal of public Health. (86/8), 1087-93.

- Parkes CM. (1964). *Effects of bereavement on physical and mental health, a study of the medical records of widows*. British Medical Journal, (2), 274-279.

- Zissok S, Shuchter SR. (1991). *Depression through the first year after the death of a spouse*. American Journal of Psychiatry, (148), 1346-1352.

- Jacobs S, Hansen F, Kasl S, Ostfeld A, Berkman I, Kim K. (1990). *Anxiety disorders during acute bereavement: risk and risk factors*. J Clin Psychiatry, (51), 269-274.

- Madison D, Viola A. (1968) *The health of the widows in the year following bereavement*. J Psychosom Res, (12), 298-306.
- Jacobs S. (1999). *Traumatic grief: diagnosis, treatment and prevention*. Philadelphia: Taylor & Francis, 89-101.
- Kaprio J, Koskenvuo M, Rita H. (1987). *Mortality after bereavement: a prospective study of 95,647 widowed persons*. American Journal public Health, (77), 283-287.
- Portillo MJ, Martín MJ, Alberto M. (2002). *Adherencia al tratamiento del duelo patológico*. Cuadernos de medicina psicosomática y psiquiatría de enlace, (62/63), 13-18.
- García JA, Landa V, Trigueros MC, Calvo P, Gaminde I. (1996). *El duelo por la pérdida del cónyuge: un estudio mediante grupos de discusión en Atención Primaria*. Originales Atención Primaria, 18 (9), 475-479.
- Gómez R. (2000). *Las ansiedades del médico frente a la muerte*. Psiquiatría Publica; 12(3).
- Barreto P, Soler M Carmen. (2008). *Muerte y duelo. Guías de intervención*. Madrid: Síntesis.
- Tizón, J.L. (2004) *Pérdida, pena, duelo*. Paidós, Barcelona.
- Rothschild, B. (2009) *Ayuda para el profesional de la ayuda*, Desclée de Brouwer.
- Worden, W. (2013) *El tratamiento del duelo*, Paidós.
- Rando, T.A. (1993) Treatment of complicated mourning, Champaign, IL, Research Press.

CHAPTER 3

- Bucay J. (2006) *El camino de las lágrimas*. Ed. Debolsillo.
- García-García JA, Landa V; Trigueros MC, Calvo P, Gaminde I. *El duelo por la pérdida del cónyuge: un estudio mediante grupos de discusión en Atención Primaria*. 1996;18:475-83.

- García García JA, Landa Petralanda V, Trigueros Manzano MC, Gaminde Inda I. *Inventario de Texas Revisado de Duelo (ITRD): adaptación al castellano, fiabilidad y validez*. Aten Primaria. 2005; 35 (7): 353-8.
- Faschingbauer TR. *Texas Revised Inventory of Grief manual*. Houston: Honeycomb Publishing; 1981.
- Neimeyer R. *Aprender de la pérdida. Una guía para afrontar el duelo*. Barcelona: Paidós Ibérica.
- http://www.somosprimates.com/2011/02/el-duelo-de-los-animales/
- Worden W (1991). *El tratamiento del duelo. Asesoramiento psicológico y terapia*. Paidós.

1st TASK

- Worden W (1991). *El tratamiento del duelo. Asesoramiento psicológico y terapia*. Barcelona: Paidós.

2nd TASK

- Worden W (1991). *El tratamiento del duelo. Asesoramiento psicológico y terapia*. Barcelona: Paidós.
- Neimeyer R (2002). A*prender de la pérdida: una guía para afrontar el duelo*. Barcelona: Paidós Ibérica.

3rd TASK

- Worden W (1991). *El tratamiento del duelo. Asesoramiento psicológico y terapia*. Barcelona: Paidós.

4th TASK

- Aldrich CK. *Some dynamics of anticipatory grief. IN:* Anticipatory grief (editado por Schoenberg B, Carr AC, Peretz D y Kutscher AH). Columbia University Press, New York, 1974.
- Siegel K y Weinstein. *Anticipatory grief reconsidered*. J. Psychosocial Oncology. 1, 61, 1983.
- Rosales C y Olmeda MS (2001). *El duelo anticipatorio*. Interpsiquis. 2001; (2).

- Gómez Sancho M. *Cuidados paliativos e intervención psicosocial en enfermos terminales*. Las Palmas de Gran Canaria: Instituto Canario de Estudios y Promoción Social y sanitaria (ICEPSS); 1994.

TRAUMATIC DEATH

DSMIV-TR. American Psychiatric Association (APA). (2002). *Manual Diagnóstico y Estadístico de los Trastornos Mentales DSM-IV-TR*. Barcelona: Masson.

DSMV. (2013). *DSM-5 Development*. American Psychiatric Association (APA). From: http://www.dsm5.org.

GRIEF DUE TO DISAPPEARANCE

- Acinas P. (2012) Duelo en situaciones especiales. Revista digital de Medicina Psicosomática y Psicoterapia. Vol 2.
- Barros-Duchene L. *Missing loved ones: helping families cope with the uncertainty*. Personal interview, 15th February 2010. International Committee of the Red Cross (ICRC).

PERINATAL GRIEF

- López García de Medinaveitia, AP (2011). *Duelo perinatal: un secreto dentro de un misterio*. Revista de la Asociación Española de Neuropsiquiatría; 31 (109), 53-70.