Delayed Resolution of Grief: An Unexpected Effect of the Gulf War

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Psychiatrists and psychotherapists are well used to the unfinished business which can be undertaken when memories of an earlier loss are triggered by a recent reminder. Such reminders may be any event which brings the original trauma powerfully to mind or which causes the person to recall aspects of the traumatic event which had been repressed or forgotten.
Editor

One of the less predictable effects of the recent Gulf War has come to my attention in connection with a number of people, who have in common that they are women, in their early 70s, bereaved in the Second World War. RAF action during the Gulf War seemed to have activated unresolved grief which had been dormant for nearly half a century.

It began with a telephone call in the first week of the Gulf hostilities. A 72-year-old woman (whom I shall call Mrs A) rang me, in great distress, to tell me of a panic attack she had been suffering for several hours and could no longer cope with on her own. It had begun when, watching a television bulletin, she had heard an RAF pilot speaking frankly of his feelings when on a sortie: he had said that the public might think they were brave but they knew better—they were terrified at times, even if they didn't show it or let it affect their performance.

An old grief revived

As the young man spoke, Mrs A found herself racked with uncontrollable tears. She switched off the television and made herself a cup of tea, but her feelings became more and more painful and difficult. She realised this must be connected with the fact that she had lost a dearly-loved younger brother, shot down in 1944, but she could account neither for the increasing intensity of her feelings nor for their persistence. As the day progressed, she began to panic. That she didn't know why she was feeling panicky simply made the panic worse, until she began to fear she was going mad. Eventually, having contacted several close friends (whose sympathy and concern, while welcome, made little difference to her state), someone gave her my telephone number.

I asked her about her brother's death. She told me he had been a wireless operator in a Lancaster bomber, stationed somewhere in England, and had completed many missions over Germany without incident. Then, shortly after a happy leave spent with his family, they had received an official notice that he was missing. There was an agony of not knowing; a sense almost of relief when news of his death arrived; then there arrived a duplicated letter from the King about the brave fighting man who had laid down his life for his country. As Mrs A talked, she kept apologising, in one way or another, for her emotions.

In the midst of this woman's distress, it began to seem that there was a complicating factor. She felt that she was somehow letting the side down by being distressed at all. Strangely, this seemed to be the central problem, over and above the more obvious tragedy of the death of a 19-year-old brother.

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Of the many aspects of Mrs A's tale that aroused my sympathy was the fact that she had been unable to visit her brother's grave in Holland, having developed a travel phobia—not surprisingly, most strongly with regard to aeroplanes —shortly after the events of 1944. Various studies, summarised recently by Scowen[1], have shown that it is important for loved ones to see the corpse of a victim of unexpected, violent death.

An essential first step in mourning is the primary acceptance of the reality; yet Mrs A had not even seen the grave. Her brother's death was a matter of telegrams, letters in official English, posthumous medals; there had been no social ritual to mark his loss, whether friendly, familiar, religious or otherwise.

Even the message from the monarch (presumably sent with the best of intentions) had the unfortunate effect of denying the healing effects of grief, since it suggested to the recipients that their sadness was somehow unpatriotic. Mrs A was left bereft not only of her brother, but of the normal and natural sadness and grief which she needed in order to mourn her loss.

When she finished her account I began to share these thoughts with her, but had to pause as her crying redoubled. Soon it was clear: for over *46 years* she had been unable to mourn her loss properly, waiting for some sort of permission for her feelings to surface and be expressed, which my first hesitant words had provided. The emotional atmosphere that the RAF pilot in the desert had stirred up had touched on the violent grief which had been so long and so deeply hidden. This had led to such a conflict between the need to feel the grief consciously, and the guilt engendered by that wish, that she had broken down.

This moving incident was striking enough in itself, yet I soon discovered, when I mentioned it to colleagues, that it was far from unique. Within a few days I had heard of over a dozen parallel examples, so it seems likely that this is a common phenomenon. Regrettably, the victims have all felt isolated, frightened and guilty about their feelings. It would help all of them to know that similar pain is being experienced by others and, most importantly, that it is not something shameful.

Perhaps the most important lesson concerns how relatives of servicemen killed in war should

best be treated. The official emphasis on the deceased's brave sacrifice may provide some useful short-term consolation for the bereaved, but it appears that a more beneficial long-term approach should seek to facilitate mourning rather than divert or postpone it. If bodies cannot be brought home for funeral ceremonies at which families participate, then it would help if photographs of the corpse could be made available. As Cathcart has emphasised, it is better to see a loved one's wounds than to spend the rest of one's life with fantasies, which are likely to be worse than the reality.

There are encouraging signs from the news bulletins: stories of counselling for servicemen, the release of filmed interviews with airmen talking of their feelings, including the tears they shed. We may seem to lack progress on preventing war but perhaps, if the notion is not too paradoxical, we may be becoming a little more humane in how we look after the participants.

References

1. Scowen P. Viewing the body after death. *Bereavement Care* 1990; **9**: 3.
2. Cathcart F. Seeing the body after death. *British Medical Journal* 1988; **1**: 297.

CONFERENCE REPORT

Third International Conference on Grief and Bereavement in Contemporary Society

This was held at the University of Sydney, New South Wales, from 30 June to 4 July 1991, under the auspices of the Australian National Association for Loss and Grief (NALAG).

It was attended by over 500 delegates from many different countries and fully lived up to the expectations engendered by previous conferences.

In addition to keynote addresses by Professor Robert Pynoos, Dr William Worden, Professor Selby Jacobs, Mrs Pat Sutton and the Hon Justice M D Kirley, 116 papers and workshops were presented. The Shamai Davidson Lecture was given by Professor Beverley Raphael.

It is impossible to give a comprehensive report since no one delegate could attend all papers. Highlights for me include:

Efficacy of counselling

Probably the most important contribution to our knowledge was made by a team from the University of Utrecht, Netherlands (reported by HAW Schut) on the efficacy of short-term counselling for widows. One hundred and thirty-two widows and widowers were studied and half (66) were assigned to either client-centred counselling (33) or behaviour therapy (33) (which involved structured and focused attempts at 'tackling behaviour or cognition that complicated the grieving process'). The General Health Questionnaire (GHQ), which measures psychosocial adjustment, was administered before therapy, at the end of therapy, and at follow-up 25 months after bereavement. As expected, there was a decline in GHQ scores in all three groups. The two treated groups improved more than the control (untreated) group. Of the two methods of treatment, those assigned to behaviour therapy had declined slightly more than those who received client-centred counselling.

When the sexes were examined separately it transpired that client-centred therapy was more efficacious for men (widowers), whereas behaviour therapy was more successful for women (widows). Those who were most 'emotional', depressed or lacking in self-esteem were said to have benefited more from behaviour therapy; on the other hand, people who felt 'very wronged' were said to have benefited more from client-centred therapy.

The author concluded that men cope less well with emotional issues and 'are inclined to follow a problem-focused trail of solution-seeking and apparently not being able to cope with the problems that can best be changed by emotion-focused intervention. Women, who are more inclined to make use of emotion-focused strategies, may be best helped by interventions not primarily aimed at the emotional impact of the event'.

Effects of bereavement on health

The incidence of symptoms of post-traumatic stress disorder (PTSD) following bereavement has also been studied by the Utrecht team. In another important study, Schut looked for the three criteria for PTSD as defined in the influential Diagnostic Statistical Manual (DSM III-R). In a self-selected group of 105 widows and 23 widowers a questionnaire was used to assess the prevalence of 'intrusive thoughts', 'avoidance' and 'arousal' (reflected in anger, panic, difficulty in concentration and insomnia) at four, 11, 18 and 25 months after bereavement. Of the sample, 20-31% met all three of these criteria on at least one of these occasions, with nine per cent reporting them at all four.

Although PTSD symptoms occurred with equal frequency following both anticipated and unanticipated deaths, they were more likely to persist for 25 months if the death had not been anticipated and those people who reported having said 'goodbye' to the deceased before death were less likely to complain of 'intrusive thoughts' thereafter.

This study suggests that it is not the duration of terminal illness *per se* that predisposes to lasting PTSD after bereavement. Rather it is the lack of opportunities to anticipate the loss. and the opportunities which anticipation brings of allowing leave-taking and the restructuring of assumptions about the world.

Bartrop's Australian research group have demonstrated an increased risk of cardiovascular, respiratory, musculo-skeletal and psychiatric illness in bereaved people followed up after an 11-year period.

Byrne and Raphael have dispelled the myth that bereaved elderly people are unlikely to develop psychiatric illness. In their sample of 57 bereaved and 57 non-bereaved Australian men, the bereaved were more likely to reach 'psychiatric' levels of emotional disturbance six weeks after bereavement, with 19 per cent satisfying DSM III-R criteria for a current Axis I psychiatric disorder, two-thirds of these being a 'Major Depressive Disorder'.

Types of bereavement

A study by Professor E Keijser examined the circumstances attending the deaths of 1,635 patients in the University Hospitals of Louvain (Belgium). This showed that relatives were only present at the time of deaths in 35 per cent of cases when the death was expected, and this proportion fell to 16 per cent when the death was unexpected. Only five per cent of babies died in the presence of a relative, although physicians and nurses were present at 90 per cent of these deaths and most parents subsequently received counselling from a social worker. Following other types of unexpected death, social workers and clergy were less likely to be involved than they were after more expected deaths! Fifteen per cent of hospital patients were on their own at the moment of death, but this proportion rose to 31 per cent of the deaths of patients of 80+ years.

In a comparative study of 173 widows and 156 divorcees in Cleveland, Ohio, Kitson showed higher initial levels of both pining and anger among widows three months after bereavement than among divorcees three months after divorce, but little difference between the groups at 13 months.

The bereaved child

Professor Pynoos had made a clear analysis of ways in which disasters affect children:

- Life threat and/or injury leading to post-traumatic stress disorder
- Loss leading to grief
- Worry about significant others leading to separation anxiety
- Stressful previous life experiences leading to renewal or exacerbation of previous symptoms.

He reported high rates of suicidal thinking, dysphoric and depressive reactions in children exposed to sniper attack in a school. Studies of children whose parents had died by violence were said to have felt reassured by seeing the body after it had been made presentable.

Contrary to popular belief, children over the age of six were found to cope remarkably well with the death of a parent, particularly if that parent was of the same sex as they were. Worden and Silverman's controlled study found no significant differences between bereaved and non-bereaved children on measures of anxiety, withdrawal or dependency. Overall, bereaved children were rather more angry and had more somatic symptoms than non-bereaved, but non-bereaved showed more attention-seeking behaviour.

The bereaved parent

Vance reported a prospective study by a team from South Brisbane (Queensland), who compared the responses of parents to stillbirths, neonatal, other sudden infant deaths and normal births. All bereaved groups showed significantly more symptoms than controls throughout the two-year period of the study, although there was some improvement in the bereaved. Parents losing a child by sudden infant death had more symptoms than those who lost a child by other neonatal death or by stillbirth. As might be expected, mothers had more symptoms than fathers.