Grief and loss in conflict and disaster affected societies

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Introduction

Why do we grieve? Wouldn't life be much simpler if we did not experience all those painful emotions that occur when someone we love dies? Perhaps so: no weeping and wailing, no stoical silence, no anger and irritation, no smiling and carrying on as usual; no sudden flood of pain and memories to overwhelm and paralyse, or the rush of tears when you hear a familiar tune. That sounds much easier. The trouble is that grief is actually the price tag on another emotional experience without which human life would be quite unbearable. We grieve because we love. Love is the essential emotion that keeps us connected and attached to family and friends and allows us to survive as rather puny animals in a hostile world. If we did not love we could not suffer loss, but neither could we survive is selfish isolation.

This chapter provides a brief introduction to understanding grief and loss in families living in disaster and conflict affected societies and provide some guidance as to how to support them. It will address the following questions:

- What is the impact of loss on individuals and groups in conflict and disaster settings?
- What is grief and how is it related to attachment?
- Is grief an illness?
- How does it affect our health?
- When is grief abnormal?
- What is mourning and why does it matter?
- What happens when large numbers die at one time?
- How do we distinguish between the effects of traumatic events and the effects of loss?
- Cultural bereavement
- Grief in childhood
- What can we do to help grieving families and children?

Most children will be seen in the company of their surviving adult relatives whose own mental state will have a profound effect on the child. A child and family doctor must therefore be responsive to, and able to assess and support the whole family. For this reason this chapter looks at grief in both adults and children. It outlines a general approach to supporting families and children, but does not give detailed management advice on the wide variety of specific symptomatic problems that can occur in grief (for example bedwetting or sleep disturbance). This is because there are a number of excellent manuals available on this topic, listed in the further reading.[1]

What is the impact of loss on individuals and groups in conflict and disaster settings?

The central experience for almost all those living in conflict or disaster affected communities is loss. Even if no one in your family dies, something will be lost. You may be injured or lose your health. Your home or your school may be destroyed, the neighbourhood swept away. Your, friends, workmates may be killed or flee. If you flee yourself you will lose everything that made up your world and kept you rooted and connected. As well as the external losses just mentioned you may lose aspects that are internal to your sense of self: feelings of being safe and in control, your sense of identity as a mother, father, schoolchild, farmer or shopkeeper. Some possibilities are illustrated in Table 1. Their effect can be overwhelming. Understanding how people react to such losses, how to distinguish between normal and abnormal grief and how to assist in appropriate mourning will be one of the key tasks for health workers in these contexts. It is also essential to understanding other psychological reactions such as PTSD and setting them in context.

Table 1: Some of the losses experienced by those exposed to conflict, disaster or life as refugees. Can you think of others?

Internal	**External**
Control	Family members
Autonomy	Friends
Security	Home
Identity	Community/country
Self respect	Work/school
Belief in future	Money and other material possessions
Sense of belonging	Physical health
Trust	Religion
Past	Language
Meaning of life	Familiar Life

What is grief and how is it related to attachment?

The ability to form strong relationships with others is necessary for our survival as human beings. We call this ability **attachment.** The sense of loss we feel when a loved one is absent, results in us searching them out. Attachment is the glue that keeps families and groups connected and together. Human beings could not have survived in previous eras if they did not live in groups which would enable them to feed and shelter themselves. **Loss** is the sense of sadness, fear and insecurity we feel when a loved person is absent. It can also be felt for things and places.

In the 1950s WHO commissioned John Bowlby to observe what happened to small children when they were separated from their mothers. In Britain in those days, if a child went to Hospital for an operation, the parent was not allowed to remain with them. John Bowlby sat watching the infant to see how they reacted, how they adapted to the separation and how they behaved when the parent returned. He defined a cycle of behaviours which can be observed in any infant separated from its mother and then reunited with her.

There would first be a period of loud and angry **protest.** The child would hope that its cries would bring mother running back. When this did not happen a period of **despair and withdrawal** followed in which the child would cry, not wish to engage with others, not eat or play. Later the child might appear to 'adapt'. She would start eating again, play with other children, make friends with the nurses and appear **detached** and indifferent to her loss. Indeed if the parent reappeared in this stage, the first response might be to ignore them, and then if they did engage to be naughty and **angry**. Only after some time would the original relationship reform and **re- engagement** occur. Bowlby noted that this **attachment/separation behaviour** is most visible in children of 6 months to 3 years old. However, these behaviours can reappear in any of us throughout the life cycle when faced with separation from someone we love.

> Attachment behaviour is any form of behaviour that results in a person attaining or maintaining proximity to some clearly identified individual who is conceived as better able to cope with the world. It is most obvious whenever a person is frightened, fatigued or sick, and is assuaged by comforting and care-giving. At other times the behaviour is less in evidence. Nevertheless for a person to know that an attachment figure is available and responsive gives him a strong and pervasive feeling of security and so encourages him to value and continue the relationship. Whilst attachment behaviour is at its most obvious early in childhood, it can be observed throughout the lifecycle, especially in emergencies. Since it is seen in virtually all human beings (though in varying patterns), it is regarded as an integral part of human nature and one we share (to a varying extent) with members of other species. The biological function attributed to it is protection. To remain within easy access of a familiar individual known to be ready and willing to come to our aid in an emergency is clearly a good insurance policy - whatever our age.[2]

Many writers have noted the similarity between a child's behaviour after separation from a parent, and our reactions to the loss of a loved person who has died. Death reactivates attachment behaviour. Faced with the permanent loss that death represents we may find ourselves angrily protesting, searching and yearning, trying our best to maintain and hang onto the connection. Or we may experience periods of indifference and denial as away of avoiding the pain. Many people move between periods of acute grieving and yearning and periods of avoidance/detachment. In the past some have argued that these feelings occur in stages. Elizabeth Kubler Ross [3] constructed a model of bereavement in which the individual was said to progress through periods of :

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

It was suggested that people could become stuck at different stages and 'grief work' was necessary to progress through all the stages to recovery. There is now a growing understanding of the enormous variability in our responses to bereavement. How people grieve and how they cope will depend on individual factors such as their temperament and personality. What were their experiences as a child? Were they loved and securely attached to those who cared for them or abused or insecure? This will affect the way they form relationships with others people, and the way they experience loss. So will their age, sex and the experience of previous losses. It will also depend on the nature of the loss and how it occurred: was it sudden or expected? Violent, unjust, part of a massive loss or after prolonged illness? What did the loss mean to the person? Were they thrust into isolation and poverty, or possibly, liberated from an abusive relationship? In

all cases social factors such as cultural and religious beliefs and community and family dynamics will play a role in determining how grief is experienced and expressed. So will the current social situation: Is the family in danger or flight, what material resources are there? Do they face legal difficulties because of the loss? Is there social support or are they isolated? The case examples below and the vignettes in the appendix all illustrate these variations.

Table 2 illustrates the wide variety of emotional, cognitive, behavioural and physiological and changes that can occur in reaction to bereavement. An individual may have some, all or none of these. The reactions may occur in many patterns and combinations depending on the factors above. Some individuals experience few, others more. In some people reactions change over time or come in varying combinations.

Table 2 Reactions to Bereavement [4]

Affective	**Cognitive**	**Behavioural**	**Physiological-somatic**
Depression, despair, dejection, distress Anxiety, fears, dreads Guilt, self-blame, self-accusation Anger, hostility, irritability Anhedonia—loss of pleasure Loneliness Yearning, longing, pining Shock, numbness No reaction	Preoccupation with thoughts of deceased, intrusive ruminations Vivid memories Sense of presence of deceased Lowered self-esteem, self-reproach Helplessness, hopelessness, pessimism about future Suicidal ideation Sense of unreality Memory, concentration difficulties Suppression, avoidance, disbelief Fantasies	Agitation, tenseness, restlessness Fatigue, apathy Overactivity Searching Weeping, sobbing, crying Social withdrawal Normal behaviour and continuation of normal activities Agitation, tenseness, restlessness IN CHILDREN Acting out Regressive behaviour School difficulties Rapid maturing	Loss of appetite Sleep disturbances Energy loss, exhaustion Somatic complaints Physical complaints similar to deceased Loss of appetite Sleep disturbances **Endocrine and immunological changes:** Susceptibility to illness, disease, mortality

They may feel anger and sadness at the same time. An anniversary, or a particular place may trigger the memory, which reactivates the feelings of grief again, years after the event, perhaps interrupting a long period of acceptance. Some have described grief as a "relapsing illness". Stroebe and her colleagues have created a model to show how many people may fluctuate between a loss orientation of yearning and sadness and a restoration orientation more avoidant states of denial and getting on with things:

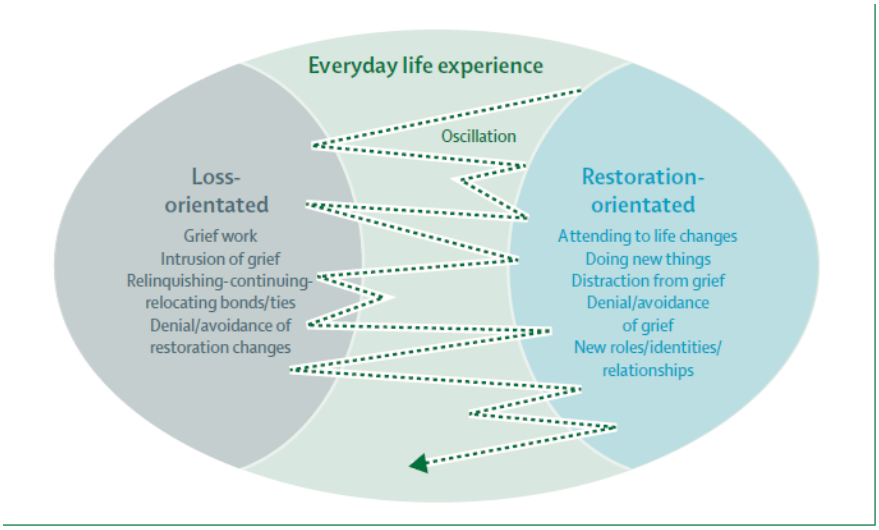


Figure 1:The dual process model of coping with bereavement[5]

Which feelings and behaviours occur, which state dominates and what is regarded as normal for both children and adults will depend very much on how grief is expressed in that culture, by that family and in that individual as well as the religious values, temperament and personality of the individual. For example in Bosnia, it is regarded as appropriate for Serbian women to attend the funeral and to display their emotions visibly, keening and weeping. Muslim culture values a more stoical approach and sees the vivid display of emotions as inappropriate. In some cultures, for example parts of South East Asia, vivid dreams may be regarded as appropriate messages from the dead, in Western culture dreams may be seen as an upsetting form of sleep disturbance. In Kosovar families with whom I have worked there was often one individual (usually an older adolescent girl), who might cry a great deal, hyperventilate and faint, while the rest of the family remain stoical. The fainting girl might cause concern but also seemed to play a role in vividly expressing grief for the rest of the family, whose concern for her also acted as a form of distraction from the loss. (See Appendix, Vignette 2.)

Is grief an illness?

Near the end of his life Sigmund Freud was consulted by a woman who had become depressed following the death of her husband. After listening to her, Freud quietly stated, "Madam you do not have a neurosis you have a misfortune." [6]

Acute grief may be painful and feel like an illness but it should be understood, in all its variety, as a normal reaction to loss. Some combinations of reactions do appear to mimic some acute mental illnesses. For example loss of appetite, combined with sleep disturbance, sadness, ruminations and various somatic complaints appears similar to clinical depression. But the diagnosis should not be made if someone has suffered an acute loss. Some individuals may adopt the behaviours of the deceased, dress in their clothes, act strangely or hear their voice, see them and talk to them. Again this should not be regarded as psychotic behaviour but as a possible manifestation of acute grief. Or there may be flashbacks, vivid intrusive thoughts and dreams of the deceased, and the individual may be anxious and aroused, similar to those with post traumatic stress disorder (PTSD). None of these reactions are necessarily pathological.

How does it affect our health?

That is not to say that bereavement does not have physical and mental health consequences.[7] Bereaved people experience more physical complaints, make more health consultations, use more medication and experience more hospitalizations. Paradoxically those grieving intensely actually make less health consultations than the normal population and high intensity grief is a predictor for more severe physical disorders a year later. Perhaps this is because early warning signs were missed. Regarding the impact of bereavement on mental health, the majority of people recover but there is a greater vulnerability to depression, anxiety and PTSD.

Bereavement is associated with increased mortality from many causes. People who have suffered a recent bereavement are more likely to die of alcohol related disorders, coronary artery disease, unnatural deaths and suicide. It is thought that the additional risk may be due to a variety of factors: Loneliness, changes in social circumstances, less material resources, lack of care. The risks are higher in the earliest months and greater in specific groups: mothers who have lost a child and widowers. So it is not nonsensical to say you can die of a 'broken heart'.

When is grief abnormal?

The decision as to what is abnormal and inappropriate grief will depend on an understanding of the individual, the family, the culture and the context from which they come. You cannot decide what is abnormal without this cultural and personal knowledge. The community and family may be able to tell when they feel the grief is too intense or too long or unusual in its manifestations. The new Diagnostic Formulations that psychiatrists use to categorise mental disorders DSMV and ICD 11 are moving towards a formulation for prolonged or complicated grief. For example the suggested definition for ICD 11 is as follows:[8]

Prolonged grief disorder is a disturbance in which, following the death of a person close to the bereaved, there is persistent and pervasive yearning or longing for the deceased, or a persistent preoccupation with the deceased that extends beyond 6 months of the loss and that is sufficiently severe to cause significant impairment in the person's functioning. The persistent grief response goes far beyond expected social or cultural norms, and depending on cultural and contextual factors, it may not be appropriate to make the diagnosis before 12 months after the loss.

What is mourning and why does it matter?

Mourning is the name for the culturally appropriate processes which help people to pass through grief. All societies and cultures mourn but in different ways. Mourning processes usually include acknowledgement and acceptance of the death, saying farewell, time periods for grieving, processes to continue attention towards the dead and to move beyond it and make new attachments. It might be helpful to take a moment and jot down on a piece of paper the ways that you mourn the dead in your own society. Try answering the following questions:

- How do other people know that someone has died or that you are bereaved?
- What happens at funeral?
  - What are the burial customs?
  - What happens to the body?
  - Who visits the bereaved?

- What are the different roles, if any, for men and women?
- What do small and older children do?
- Are there different ceremonies at different time periods after the death to mark different stages of mourning?
- What ways do you use to remember the dead?
- What is the role of dead person in continuing family life?

Different societies have different time periods set aside for mourning, and different ideas about what is appropriate behaviour for different family members. They may also have different views on the appropriate role of children in these rituals. Sometimes families may be in conflict over what it is appropriate to communicate to children and what is the appropriate way to mourn. This is particularly the case in societies in a state of upheaval. (See Appendix Vignette 1 below)

What happens in situations of massive loss?

Conflict, disaster and displacement disrupt the possibility of appropriate mourning. There may be uncertainty over missing relatives. The body may have been lost, abandoned, treated inappropriately, or buried in a mass grave. The normal mourning rituals are impossible to carry out during flight. Other processes also occur in large scale upheavals. For example in Aceh after the 2004 Tsunami people found themselves living in a landscape swept completely clean by the Wave, where every familiar marker had disappeared along with their communities, families and livelihoods. There were no bodies and no places to go to remember the dead. In Haiti after the Earthquake people camped out among crushed houses that entombed their families. Massive losses that affect whole communities may remove entire social networks of support. And even in functioning communities, they have the effect of depriving each individual of the normal support that they would have received if their loss had been singular occurrence. Because everyone is affected, few are in the position to play the role of visitor, and comforter. There is no one to come round, help the bereaved widow with the child care and household tasks, arrange the funeral and cook a meal, because everyone who survived is in the same situation. Everyone struggles alone. And the bereaved may become more reticent than usual about their own feelings, not wishing to burden similarly affected neighbours. At the same time the pain of the loss is amplified by the knowledge that the bereaved person's loss is one of many in a community. The outside world is focussed on the scale of the event: *300, 000 dead, half a million killed*. Lost within these figures, the individual bereavement becomes insignificant- just one of many thousands, adding to the pain of the survivor.

Case example: Giving significance to loss. In early 2005 I was working on the East Coast of Sri Lanka after the tsunami. On one occasion walking along a completely deserted, devastated street, a man came running up to me. I was holding my camera and assumed I might have offended him by taking pictures. *No no* he said *please take a picture of THIS HOUSE*. I looked at the gutted empty building and did as he requested, then turned back. He was near to tears. *My mother died here*. So we sat on the ground and he talked for sometime about his mother. I suddenly realised that for this man I was more than just a sympathetic ear, I was the outside world witnessing and memorialising his individual loss. Not just 10, 000 dead, but his mother. I was making her significant.

Traumatic experiences, grief and mourning

Traumatic experiences can interfere with mourning. Avoidance that may be protective in coping with the memories of a traumatic event may make it difficult for the bereaved to mourn their loss because the memories of the lost person are always accompanied by painful memories of the circumstances of the loss, so 'remembering' is too painful. In such circumstances, the traumatic symptoms may need treatment before the bereaved person is able to mourn. Table 3 illustrates the differences in emotional cognitive and behavioural reactions that may occur.

Table 3: Distinguishing the impact of traumatic events and loss[9]

REACTIONS TO LOSS	REACTIONS TO TRAUMATIC EVENT
Separation anxiety	Anxiety about threat re traumatic event
Sadness more than anxiety	Anxiety more than sadness
Yearning and preoccupation with loss	Fearful, anxious and preoccupied with traumatic event
Sense of security intact	Personal sense of safety challenged
Primary relationships disrupted	Primary relationships intact
Intrusive memories are images and thoughts of the deceased	Intrusive memories of traumatic event plus re-experiencing accompanying emotions
Memories sought after positive and comforting	Uncontrollable intrusions: negative and distressing
Dream of dead person is comforting	Nightmares of event are terrifying
Seek out reminders of loved ones	Hypervigilant, scanning environment for threat
Avoidance of reminders of absence of loved one (denial)	Avoidance of reminders of threat
Anger at loss	Irritable, diffuse unfocussed anger and rage
Guilt at not doing enough	Guilt at surviving
Mourning as a tribute to dead	
Sleep EEG normal	Increased REM sleep intensity
Coping involves reconstructing life without loved one	Coping involves reestablishing sense of safety
Recovery: Resolve attachment issues	**Recovery:** Habituate to fearful responses

Cultural bereavement

The Australian anthropologist and child psychiatrist Maurice Eisenbruch has pulled some of these experiences together in the term "cultural bereavement" to describe the massive losses experienced by refugees and all those displaced by war.

> Cultural bereavement is the experience of the uprooted per-son - or group - resulting from loss of social structures, cultural values and self identity: the person - or group - continues to live in the past, is visited by supernatural forces from the past while asleep or awake, suffers feelings of guilt over abandoning culture or homeland, feels pain if memories of the past begin to fade, but finds constant images of the past (including traumatic images) intruding into daily life, yearns to complete obligations to the dead and feels stricken by anxieties, morbid thoughts and anger that mar the ability to get on with daily life. It is not in itself a disease but an understandable response to catastrophic loss of social structure and culture.[10]

In his work with Cambodian adolescents he found that those refugee children who had been encouraged to assimilate rapidly into a new culture, suffered more cultural bereavement than those encouraged to participate in traditional ceremonies and cultural practices. He believes that the concept allows for a more integrated and culturally sensitive approach to the experience of loss, than attempting to classify any disabling symptoms only in terms of pathological categories according to Western diagnostic criteria such as PTSD or traumatic bereavement. Disabling symptoms may be best addressed by a combination of restoring appropriate cultural practices and, if necessary, symptomatic relief.

Grief in childhood

These are some frequently asked questions about children who have suffered a bereavement

- Do children grieve?
- Are they too young to understand?
- Should we protect them from unpleasantness and distress?
- Will loss in childhood cause later mental illness?

Children's understanding and reactions to death

Children's reactions to death are as variable as those of adults and any or all of the reactions listed in table 2 may occur. The most important point to note is that their understanding of death changes according to their development and life experiences**.** The following notes are based on Western experience and should be taken as a guide. Working with victims of conflict and disaster in many low resource settings has taught me that in many societies, particularly rural ones, children understand death at an earlier age. In other respects the categorisation below holds true.

Under five years

There is little understanding that death is final. For example a 4-year old child in England, having helped to formally bury his dead pet rabbit in the garden, then asked if he could now dig it up so that he could have the rabbit back. Magical thinking results in misconceptions about causes and effects. An egocentric view of the world can lead to feelings of responsibility. "Mummy won't come back because I was naughty." Reactions are similar to those following any separation: The longer the absence the greater the distress. It may be followed by detachment, so that the surviving family may think the child does not care. Regressive behaviour, soiling, wetting, clingy behaviour, sleeplessness and minor illnesses can all occur.

Over five years

Children begin to understand that death is irreversible, that certain physical changes occur, and that there is permanent separation. They may still not regard it as something that can affect them. They may continue to have some magical, concrete and egocentric thinking. At this age children more commonly use concepts of good and bad, they are curious about cause and effect, and able to articulate concern for others.

There is a desire to stay connected to the dead parent. Many children dream about and talk with the dead parent frequently; feel the dead parent is watching them and keep physical objects associated with them. One study found that 43% of children in a large community sample thought about the dead parent on a daily basis one year after death.[11] The reactions are variable. Boys are already learning to suppress feelings. 91% of the children in the same study cried on first day; 50% had transient emotional and behavioural problems. Concentration and school work are affected. Repetitive play is very common.

Ten to adolescence

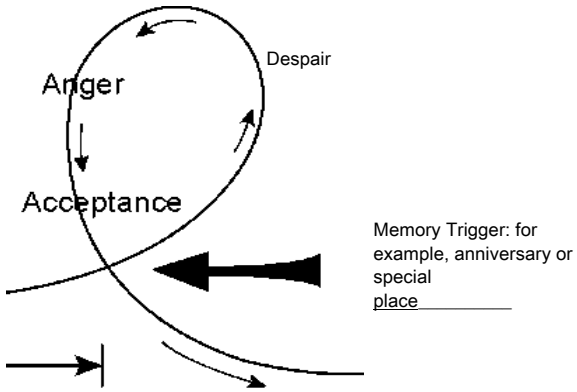
There is a growing understanding of abstract concepts: for example that death is universal and inevitable and can affect them personally. There is a growing concern with justice and injustice, and an awareness of inconsistencies. The conflict between the desire for autonomy and need for closeness can be resolved by "indifference and detachment", or by identification and nostalgia. In a group for adolescent refugee boys ethnically cleansed from Northern Bosnia (all had lost their homes, some had lost their family) all spoke passionately and with great longing about their home-towns, describing them as the "most beautiful place to live".[12] Revenge fantasies are not unusual. There are less somatic and behavioural problems, and a depressed mood is common. Poor concentration and lack of interest occur at school. The oldest child who has lost a same sex parent is at greatest risk.

Case example: The surviving brother: G is a 13-year-old boy. During a long and brutal war his elder brother was killed on the front line. G was always very close to his brother. Three years later he continued to think about him on a daily basis. He visited the grave frequently and watched the video of the funeral once a week. He did not like to sleep alone and felt sad much of the time, although he was doing well at school. He talked about his brother a great deal. He wanted to be as much like his brother as possible, whom he believed was one of the

As in adults, the reactions to bereavement are enormously variable: Age, personality, culture and family values, especially the way the parents or surviving caretakers react will all affect the expression of grief. Children within one

family exposed to the same losses may all handle grief in different ways. (See '**Case example Telling the story'** below.) And the experience of grief may wax and wane. When discussing grief feelings with children I sometimes use the image of a wave.[13] I ask them to imagine they are standing at the edge of the sea and a big wave comes along and knocks them over. They feel terrible but manage to struggle to their feet, then there is a period of calm water before the next wave. This time they are more prepared so that when the next wave comes it does not knock them over. What will happen over time is that, although the waves never go away completely, the periods of calm sea will grow longer, the waves get smaller and the child grow stronger (see Figure 2).

Figure 2: Waves of grief: the time intervals between waves get longer and the waves get smaller.



Long-term effects

Many worry that if children experience the loss of someone significant early in life it will have long term mental health effects. Research evidence suggests that children who suffer an early bereavement do have a higher incidence of psychiatric disorder in later childhood and that adults bereaved of a parent in childhood are more vulnerable to psychiatric disorder than the general population, particularly to depression and anxiety, precipitated by further losses.

Life events research shows that the following events are the most likely to be associated with later mental illness:

- Those that require people to undertake a major revision of assumptions about the world
- Those that are lasting in their implications
- Those that take place over a short period of time with-out preparation.

A traumatic death can have all these features.

However there are significant factors that can mediate the impact of a bereavement. The child's long term mental health also depends on:

- The response of the surviving parent or relatives
- The availability of other support
- Subsequent life circumstances
- The degree of continuity in the child's life
- How the loss is viewed by others
- What resources are available

This list provides an immediate guide as to what things need to be done to enhance a child's resilience and coping in the face of loss. The **Case example: Different girls** from Pakistan illustrates how important these aspects are and how much difference the behaviour of surviving relatives can make:

Case example: Different Girls After the Pakistan Earthquake in December 2005 I worked with children who had lost their parents. Contrast the experiences of two young teenage girls from the same rural, Islamic society, affected by the same terrible event, but living in some what different settings with quite different responses from those caring for them. Samira was 14 and living with her Aunt and Uncle and her six younger brothers and sisters in one tent in a displaced persons camp near the town of Balakot. Her village had been completely destroyed and her mother and father killed. Samira acted as mother to her sibs and helped her aunt care for her cousins. The aunt and uncle had told the children '*your mother is in the village and will come soon.*' Samira and her smaller sisters looked ill kempt and neglected. They cried constantly, which suggested the comforting lie was not working. They knew their house had been turned to rubble, so where was their mother now? When I asked Samira what she thought, she told me in a whisper that her mother was dead. The aunt and uncle gave me permission to explain to all the children what had actually happened. Their calm reaction suggested I was confirming something they already knew. Samira also told me she would like to get out of the tent. As Samira was the eldest girl she carried the burden of household tasks and childcare and her aunt was very reluctant to let her go the camp school or any other of the activities arranged for children. However she let the younger ones go and their improved mood was obvious. Samira continued to weep and grieve. Finally when the Aunt herself was engaged in a livelihood programme with other camp women she gave Samira permission to go to school. This had the immediate effect of alleviating some of Samira's sadness. In contrast 12 year old Aisha still lived in her village higher up in the mountains above the town. She too lost her mother when the house was destroyed. She moved in with her grandmother but stayed in her village. I met her laughing and playing with other village children. She had just had her hands hennaed in beautiful flower patters. She had been told her mother was dead and said she still felt very sad. But she liked living with her grandmother and she did not cry all the time. When playing with other village children she was able to be happy and she had many relatives and friends that cared about her.

Figure 2: Key actions to support grieving families:

- Attend to basic needs
- Access resources
- Assist mourning in culturally appropriate manner
- Answer questions provide information
- Accompanying
- Available
- Attention to individual loss: give significance
- Altruism-opportunities
- Avoidance as required
- Advice as needed

How do we assist grieving families?

Not all grieving families require a health worker's intervention. But in situations of conflict, disaster and displacement the natural sources of social

support are absent for the reasons listed above. In this case the health worker is the supportive community. Some key activities are listed in the Figure 2. Your role may be to accompany and support the bereaved as any neighbour might do in normal times. Obviously if a family lacks basic resources or is not safe, helping to address these basic needs is a priority. Help may be needed to tracing missing bodies or identify them. Outsiders may have a significant role to play simply by encouraging and partaking in the normal processes of mourning. This may be assisting an individual organise a funeral or it may be helping a community. Vignette 3 provides an illustration of how one NGO assisted mourning in a disaster affected community. If any individual has symptoms of distress that are so great they cannot function or carry out tasks necessary, providing symptomatic relief will help.

Regarding discussion of the loss, you should follow the lead of the bereaved. This usually means: being able and available to listen without forcing talking. There is no evidence that 'grief work', that is the experiencing, confronting and working through of negative emotions, is helpful. There is some evidence that it may have long term negative consequences. Contrary to some popular Western stereotypes, positive emotions in the early period after loss are indicative of good outcomes, not pathology. Individuals who choose the more avoidant orientation (see figure 1) are not in harmful denial and this does not have to be challenged.[14]

On the other hand it is not necessary to 'break down' continuing attachment to the deceased. Good memories assist mourning and give pleasure and comfort. This connection may be maintained throughout a bereaved person's life without pathological effect. Depending on the culture it may involve regular visits to the grave, talking actively or praying to the dead, frequent dreams or visions. Indeed ritualized celebrations of connection with the dead in some societies actually strengthen living family bonds as they bring families together.[15] A continuing connection should only cause concern if continuing yearning, searching and longing causes misery and dysfunction, dominates life in the long term and prevents the bereaved from forming any new attachments.

If the loss has occurred as a result of some form of political injustice or abuse, unresolved issues of reparations and justice may prolong grief and make mourning difficult. Helping victims access justice maybe another part of your role. See **Case example: When to tell the story** below.

How do we help grieving children?

Many families present to health workers because they have concerns about the long-term impact of events on the child, and want advice on how to talk about such abnormal events with their children. The health worker's role should be to facilitate the process of normal grieving, help to sustain and support the protective aspects mentioned in this chapter. While treating pathology where it is evident, you should take care to avoid pathologising where it is not. A particularly important role may be facilitating clear communication between family members. As some of the case studies and vignettes illustrate, many families are concerned that telling the child what happened will cause unnecessary distress and that as the child is "too young to understand", it is better to lie or avoid the subject when it comes up. Children are very protective of surviving parents and quick to sense when a question causes distress. They may avoid asking for information because the questions make the parent cry. False information leads to confusion and a lack of trust. The following case: **Case example: Telling the truth** illustrates this.

Case example: Telling the truth The father was a member of a "Liberation Army" and killed in the fighting. His 32-year-old wife had two surviving children of eight and nine and continued to live with her husband's relatives. She told the children their father was working in another country. The children would frequently ask her why he did not phone and if he would bring them presents. They were confused because other children in the village told them their father was dead. When they questioned their mother she would start to cry, so they became nervous of asking her. Mother and brother-in-law asked for advice as to what to do and accepted my suggestion of sitting with the children and explaining in simple terms what had happened, answering all the children's questions as they came up, and sharing the experience of grief. Mother told me that the relief of not having to lie to the children had slightly eased her own distress and made it easier to respond to them. Moreover rather than being bewildered by their father's silent absence the children now talked about him in the village with pride.

The following is a list of pointers specifically for supporting grieving children:

1. Provide consistent, enduring appropriate care

- Reunite children with their families or extended families as soon as possible
- In the absence of family create enduring family type networks with a low ratio of caretaker to children.
- Consistent care-giving by one or two caretakers, not multiple different volunteers (however well intentioned) is essential to prevent attachment problems particularly in younger children

2. The more continuity with the child's previous life the better. Children may wish to avoid traumatic reminders, especially at the outset, but complete removal from a familiar environment will cause more pain and problems in the long run.

3. Support the carers by attending to basic needs and their own mental states. Help them to access the appropriate agencies to solve the practical problems they will encounter. Attending to basic needs is essential. Engaging in the process of rebuilding their lives helps families to come to terms with their losses (see Appendix, Vignette 1).

4. Facilitate normal grieving and mourning- with memorials for absent bodies, and appropriate religious ceremonies

5. Don't hide the truth

a. Children need clear, honest, consistent explanations appropriate to their level of development.

b. They need to accept the reality of the loss, not be protected from it.

c. Magical thinking should be explored and corrected. What is imagined may be worse than reality and children may be blaming themselves for events beyond their control.

6. Grief work and debriefing may not be therapeutic or appropriate: the insistence on getting a child to "debrief" or tell

the story of their loss may not be therapeutic or appropriate. Not all cultures put a high value on the ventilation of individual feelings, as Western culture does. The therapist's goal should be to encourage a supportive atmosphere for the children, where open communication is possible, difficult questions answered, and distressing feelings tolerated. This means that the child will be free to express their grief in the manner they find appropriate to the person they most trust, and at a time of their own choosing.

7. Provide symptomatic relief: Help the family to cope with traumatic symptoms such as bedwetting, nightmares, regressive behaviour, if they exist. Give the parents information as to what to expect and straightforward management advice.

8. Restart normal educational and play activities as soon as possible

9. Help the child maintain connection with the lost parent. Encourage the parents to allow the child to choose a memento to keep, access to photographs, or let the child draw a picture, make objects, create a memory box. Answer the child's questions about the dead relative.

10. The question of justice will be important for families in situations of political violence. Many will state that they cannot come to terms with their losses while the fate of loved ones is unknown, bodies unidentified, or perpetrators at large. These issues will affect the children, and older children may bring them up spontaneously and wish to discuss them. Health workers may be asked their own views. Stating a willingness to learn and understand, along with an awareness of one's own biases and subjectivity is the most helpful position. Political and cultural literacy are essential. The family should be put in touch with the appropriate human rights or justice agencies if they wish to give formal evidence, so that the therapeutic and confidential nature of your own work remains clear and the family are not confused as to the purpose of the interview. Giving testimony to such agencies should always be at their own request. In this case it may prove therapeutic (see **Case example: Telling the story**).

Case example: When to tell the story

The family consisted of three surviving children (two girls and a boy) who had witnessed the death of their mother and aunt and fifteen other members of their extended family. They

Appendix

The following three examples are drawn from field work in various conflict and disaster situations. They show the variability of responses and give example of practical ways to support grieving families and communities:

Vignette 1 - Complex needs and conflict in a grieving family

A is a high school student of 18, living in a rural area in the heart of a conflict region, the second eldest of seven children (four girls and three boys). She wanted to study medicine. Her life and health were normal, until the shelling began and her family fled to the forest, where they spent three months. The local police of a different ethnic origin found them and separated men from women and elderly men and sent the latter home. They got home to find their village full of army and police and themselves under siege at their home, where they were harassed and sometimes beaten. Meanwhile their invalid, pensioner father was shot in a massacre of 10 men from the village. He was buried while they were under siege. A was referred to me one month after this by a local doctor concerned at her mental state. When I first saw her she was extremely sad and frightened. She was crying all the time, ruminating about her father being captured. She found everywhere frightening, and was too frightened to go to sleep, but when she did fall asleep, woke early. She had no appetite, and a diurnal mood swing.

I first assessed her at the doctor's home where we had a long talk at her instigation, about all that had happened to her. I felt the severity of her depressive symptoms might necessitate using an
antidepressant, but delayed making a decision until I was able to assess her at home with her family. I visited them a week later and found all seven of them living in one restored room of their fire damaged home. To my surprise, A was a great deal better, her sleep and appetite having returned to normal over the week. She informed me that she felt this was because of feeling she had someone to talk to, and who "wanted to come and visit". However all the female members of the family were preoccupied with father's death, tearful in discussion of it, and in conflict over how to manage the grief. The mother and one sister no longer wanted to wear the symbolic mourning clothes and to move on. The other three sisters were wearing black mourning bands in their hair and wanted to do so for the appropriate period of a year. One of these sisters complained she was having some panic attacks. They also all felt angry and concerned about their material circumstances. They had no access to father's pension as this would have meant going to a police station run by the ethnic group in power to get new identity papers (all burnt) and identifying themselves as from a conflict area and as members of a family that had suffered a massacre victim. Anxiety made sleep difficult.

Interestingly the boys in the family (14, 8, 7) appeared cheerful, busy and well, insisting they were symptom free, although they missed their father. All the boys attended school regularly. The girls did not go, as there was no money for books. They therefore sat around at home with little to do.

We agreed to have family meetings to help them resolve their conflict about how to grieve; and relaxation therapy to provide some symptomatic relief. We did this as a group and they practised themselves on a daily basis, mother running the group. Over the weeks there was a marked improvement in the whole family. The three girls continued to wear their mourning bands and the mother was more tolerant of this. A began to press me to help her get an ID card so that she could go to a nearby town, get a job and earn some money. However the security situation deteriorated too much for this to be possible. My last visit before evacuation was distressing, as there was fighting on the nearest main road and the sound of shelling of nearby villages. We all knew that they might have to flee again in the near future.

I returned to the family three months later. They had spent these months internally displaced pushed from one village to another, with very little to eat. During this time the 14-year-old son, who had separated himself from the

family believing he endangered them, had been killed along with another male relative. The family had returned to their home to find it completely burnt to the ground except for an outhouse. They had nothing left and were using an ammunition box as a table, and sleeping under a small piece of plastic in the garden, because the outhouse attracted snakes. As previously, the healthiest members of the family appeared to be the smallest boys, who denied any symptoms except some tearfulness now and then. They appeared active and cheerful except when witnessing their mother's distress. The mother was devastated, and could not stop crying. She could not sleep or eat or function and expressed suicidal ideas. A had moved to an aunt in a nearby town and had a number of somatic symptoms. We provided clothes, basic material equipment for the house. Her mother was started on antidepressant therapy.

The family then lost contact with our service for six months. They had been provided with materials to build a warm room but the aid agency had failed to realise that with no adult males left there was no one to build it. The family therefore moved into a grim damp refugee flat in town. The mother had found the antidepressants helpful but had run out of medication. Two daughters had escaped the situation by marriage. The boys were well and attending school. The other daughters remain trapped within the prison of their mother's unremitting grief. They spent all day in the flat with their mother talking and crying. She did not wish to be left alone. They wanted to show her how much they cared for her and insisted on doing every household task, which added to her feeling of being a useless burden. We began "family work" again: encouraging the girls to join the free local youth club and to allow the mother to re-establish her maternal role in the family, supporting her by restarting the antidepressant medication at her request, and getting in touch with the aid agency about their house.

Some reflections on this case. For most families of this particular ethnic group, the immediate and respectful burial of the dead is crucial. This is followed by seven days of visiting by friends and family, who sit all day with the bereaved and discuss the dead. These normal mourning processes had not been possible either for the father or son. It seems likely that the surprisingly sudden symptomatic relief A gained from my initial intervention, was through my contributing to some of this normal mourning by being an outsider who visited and listened. A family approach meant that differences could be brought out in the open in a respectful way. The family also formed a natural group that could encourage and support each other in doing relaxation work. Attending to human rights concerns such as identity papers and security was also important. However all this was undone by the second round of conflict and loss. There is something particularly devastating about loss coming again immediately after having begun to work one's way to recovery. Being made homeless and not being given support to rebuild their house has contributed to their sense of bereavement and powerlessness, and prolonged the period of grief. The mother told me repeatedly that if she could start rebuilding her house she would feel better.

Some families are strongly patriarchal. There are different coping strategies available to boys and girls. All the women in this family came across as strong and capable, but all felt that the loss, first of an invalid father, and then of the eldest boy, had destroyed the family's capacity to function at all. Much of the work with grieving female survivors has to address their insecurity and lack of confidence in their own self worth. This family required a complex approach: participation in normal mourning; attention to basic needs; help with family communication; symptomatic relief; help in re-establishing normal family roles and adapting to new ones in the absence of male support.

Vignette 2: Supporting the whole family

Family B had lost more than 20 members - mostly female and children - in a massacre. I was asked to visit because of concerns for the mental health of the surviving children who had witnessed the attack and were all under six. At the first session most of the remaining extended family, including the children, had gathered to meet me in the only intact room

in the house. I already knew the outline of what had happened and used this first meeting to draw a genogram. I have found that in situations of mass violence, in a culture where the extended family is of central importance, this simple technique has a number of useful functions.

- It is a collective act, everyone joins in, introducing themselves and explaining their connection to others.
- It is interesting for the children, who join in the actual drawing on a large piece of paper in the centre of the room.
- By asking them to include those who have died, it allows for a collective naming of the dead. In this family my symbolically putting a black simple line through these names took on a ritual significance and the children were quick to point out when I missed someone out.
- The naming allows the person to be identified, but how much is said about that person or what happened, is up to the family, thus it opens the possibility for story telling without forcing the issue.
- What is said about the dead is said in front of the whole family so that there is collective narrative from which the children are not excluded.

Once the genogram was done the family told me their concerns about the children and their own fears about letting the children talk as it seemed to upset them. At this meeting I gave the simple advice about communication outlined above and arranged to meet the family regularly and to have play therapy with the children. At the next meeting, the family informed me they were concerned about the eldest teenage girl who fainted regularly at the same time every afternoon, and was the most nervous and sensitive member of the family. Her sister was one of the dead and her mother was particularly concerned about her health, but never cried herself. They wanted reassurance that the girl was not seriously ill. Having provided this I wondered aloud if the teenage daughter was in some way grieving for the whole family and that this exhausting work might be causing her to faint. It also meant that mother did not have time to think about her own sadness. The daughter said she wished her mother would cry a little and not worry about her so much in which case she could look after her.

By the next meeting the daughter was no longer fainting and mother was now actively grieving. I continued with family meetings and play therapy over the next six months. During this time the oldest child (5 years) of the section of the family in which the mother had died began to tell his father fragments of what he had seen and to ask questions about his mother. The father had taken out photographs of her to show to all the children. At no point did the children tell the story to me, nor did I insist upon it, seeing my role as facilitating and supporting communication within the family. Over the following year the children changed from tearful and withdrawn, to outgoing, cheerful, communicative and energetic. They all attended the formal reburial of their family. Their father remarried and their new step-mother was well accepted. He began on the process of rebuilding his house. They remained well at our last contact and the eldest child had begun school without problems.

Vignette 3: Assisting communal mourning: The South East Asian Tsunami that occurred on Decemeber 26 in 2004 destroyed an area along the coast of Northern Sumatra 300 miles long and six miles wide. At least 130,000 were killed in that country alone and 400,000 left homeless. In some villages more than 70% of the community were killed. One issue was the problem created by large mass graves. For example outside the provincial capital Banda Aceh approximately 20,000 people were buried in a small piece of land next to the main road, without identification and no acknowledgement of their lives. Nothing grew there. Driving from the airport, one might witness a lone figure standing or sitting on the ground in quiet meditation or prayer. Our NGO psychosocial team talked with local community leaders

to understand how to assist the Acehnese people in their mourning at this site and took up their suggestion to collaborate in building a Quiet house. The house was built by local people in less than 10 days with NGO supervision. It overlooked the gravesite and provided shelter, privacy and beauty for the relatives of the dead, without the traffic of the main road intruding. The house was designed to emphasise traditional culture and landscaped with flowers and trees. To give comfort the Imam wrote a well-known Muslim Prayer "From him (Allah) we come and to him (Allah) we return."

One of the local workers became tearful explaining. "I think my family are buried here but I don't know. This is why I don't come here …but now I can come and talk to them. It is very important for the people of Aceh to have a place where they can come and feel a sense of loss and family again." The project led to requests for further quiet houses at other sites.[16]

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