Ambiguous Loss and Grief in Psychotherapy

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Learning Objectives:

• Understand the different types of ambiguous loss and ID the growing number of public and private examples
• Understand how grief is defined
• Understand how these problems overlap with psychological disorders
• Explore treatment available including six therapeutic goals for treating ambiguous loss
History of Ambiguous Loss

• Term coined by Pauline Boss, PhD while in grad school in the 70’s
• Initially came out of her exploration of boundary ambiguity in work with families of US soldiers who were missing in action after the Vietnam War
• Led her to research many other situations where a family member was “not present but present” (i.e. families with missing children, adolescents leaving home, and missing from disasters) and “present but not present” (i.e. alzheimers)

Ambiguous Loss (AL) Defined

An AL is a loss:

• that is not simply death or physical absence
• which remains unclear or uncertain in some way
• that is difficult to find closure for since there is usually no official recognition of the loss
• that can be physical or psychological as long as there is some incongruence between absence / presence

Two Kinds of Ambiguous Loss

Physical Absence with Psychological Presence:
• Here, a family member is physically missing or not present but is kept psychologically present because there has not been a death or there is no proof of death
• The person / relationship is gone but not for certain

Physical Presence with Psychological Absence:
• Here, the family member is physically present but the mind or memory is severely changed or gone
• The person is here in body but so far away

Boss, P. (2006), Loss, Trauma and Resilience, NY, Norton
Examples of Physical Absence with Psychological Presence:

- missing soldiers
- missing airplanes
- tsunamis, earthquakes, severe storms
- missing from twin towers attacks
- airplane explosions
- kidnapped / missing children
- family member living somewhere else (divorce, college, institution, military setting, jail, foster home)
Examples of Psychological Absence with Physical Presence:

- alzheimers or dementia
- stroke or traumatic brain injury
- chronic mental illness (depression...)
- addictions / obsessions
- autism
- homesickness
What to treat?

- Ambiguous loss is inherently a “complicated loss.”
- With ambiguous loss lingering grief is considered a normal reaction to an abnormal type of loss
- Boss considers the source of the pathology to be the ambiguity, not a deficiency in the individual or family
- Grieving in these situations is complicated, as are the goals of the griever
What about grief?

Definitions of Grief:
• normal and expected emotional response to a loss
• personal reactions to a loss independent of the expected cultural standards
• process in which the bereaved remembers the loved one who has died and works to adjust to his or her life without them
• an emotional state of intense sadness in reaction to loss
Normal Grief Reactions:

- **Physical** (headaches, change in appetite, dizziness, insomnia, chest pain, muscle weakness..)
- **Emotional** (sadness, fear, anger, anxiety, guilt, relief, loneliness..)
- **Cognitive** (difficulty concentrating, problems w/ decision making & memory, disbelief..)
- **Behavioral** (crying, wearing clothing of deceased, distancing from people..)

- Does not lead to any changes in self esteem

Models of Grief/Grieving:

- **The Process of Mourning** (Bowlby – 1961)
- **Stages of Grief** (Kubler-Ross – 1969)
- **The Four Tasks of Mourning** (Worden – 1991)
- **Six “R” Processes of Mourning** (Rando – 1993)

-all end / finish with some kind of closure around the loss (acceptance, moving on, normal functioning/behavior is restored)
More “Pathological” Grief Terms:

- blocked grief, unresolved grief, conflicted grief, chronic grief, disenfranchised grief, pathological grief, distorted grief, prolonged grief, traumatic grief, complicated grief
- here presenting grief reaction is considered “abnormal” and there is a related difficulty in achieving healthy closure / healing
The DSM and Grief

• DSM IV basically stated that symptoms that looked like depression that began within two months of a loved ones death should not receive a diagnosis of Major Depressive Disorder

• Earlier versions stated a full year should pass before giving such a diagnosis

• DSM V removed the “bereavement exclusion” and leaves it up to the clinician to differentiate between a Depressive Episode following bereavement and typical grief following bereavement.

• DSM V change acknowledges one can be grieving AND be depressed
DSM V

• Change suggests that a Major Depressive Episode after losing a loved one is no different than a Major Depressive Episode following any other kind of loss or significant life event

• As long as patients present with at least 5 of the 9 required symptoms for at least two weeks the diagnosis of MDD can, and should, be made
Still many differences between “typical grief” and Major Depression:

<table>
<thead>
<tr>
<th>Clinical Indications of typical grief:</th>
<th>Clinical Indications of Major Depression:</th>
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<tr>
<td>May have tendency to isolate, but generally maintains emotional connection with others</td>
<td>Extremely “self-focused” and feels like an outcast or alienated from friends and loved ones</td>
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<td>Hope and belief that the grief will improve, or end, someday</td>
<td>Sense of hopelessness, believes that the depression will never end</td>
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<td>Maintains overall feelings of self worth</td>
<td>Experiences low self-esteem and self-loathing</td>
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<td>Experiences positive feeling and memories along with painful ones</td>
<td>Experiences few if any positive feelings or memories</td>
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<td>Guilt, if present, is focused on “letting down” the deceased in some way</td>
<td>Guilt surrounds feelings of being worthless or useless to others (unrelated to the loss)</td>
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<td>Loss of pleasure related to longing for the deceased</td>
<td>Pervasive anhedonia</td>
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<td>Suicidal feelings are more related to longing for reunion with the deceased</td>
<td>Chronic thoughts of not deserving, or not wanting, to live</td>
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<td>May be capable of being consoled by friends, family, music, literature, etc.</td>
<td>Often inconsolable</td>
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What about “Complicated Grief?”

Persistent Complex Bereavement Disorder

• Not included in final version of DSM V
• Got placed in “conditions that may be a focus of clinical attention”
• Characterized by symptoms lasting at least 12 months (6 months in kids) after the loss of a loved one
Persistent Complex Bereavement Disorder

- involves persistent longing for the deceased
- longing may be associated with intense sorrow and frequent crying or preoccupation with the deceased
- may also be preoccupied with how the person died.

Any 6 of the following symptoms also required:

1. Marked difficulty accepting the death
2. Disbelief the individual is dead
3. Distressing memories of the deceased
4. Anger over the loss
5. Maladaptive appraisals about oneself in relation to the death/deceased
6. Excessive avoidance of reminders of the loss
7. Desire to die to be with the deceased
8. Being distrustful of others
9. Feeling alone/detached from others
10. Belief life has no meaning or purpose without the deceased
11. Experience a diminished sense of identity
12. Difficulty engaging in activities

Other Common Diagnoses that Can Accompany Grief:

- Posttraumatic Stress Disorder
- Anxiety Disorders (Panic Disorder, Generalized Anxiety Disorder)
More about Ambiguous Loss:

• Boss considers it a relational disorder
• Needs to be treated with “relational interventions”
• Need to take into account the effects and changes in the family and the extended family
• **Goal** = ability to live with the ambiguity because there is no closure available with this particular kind of loss
• **Goal** = to begin coping and living with lack of a solution
Assess Systemic Effects on the Family from the Ambiguous Loss

- Are roles changed / confused?
- Is there family conflict or alienation?
- Have family rituals / celebrations been changed or cancelled?
- Are family boundaries unclear?
- Is the family decision making process frozen?
- Is safety or financial security an issue?
Factors Predictive of Resilience in Face of Ambiguous Loss:

• Belief in God
• When their community has similar beliefs
• Certain personality traits
• Notwithstanding the above three, the most important predictor for resilience in situations of AL is the person's ability to learn how to hold two opposing ideas in their mind at the same time

Key Intervention With AL: Both-And Thinking

- My loved one is both gone – and still here
- I think he is dead – and maybe not
- I both wish it was over and wish that my loved one keeps living
- I am both sad about my lost hopes and dreams and I am searching for new hopes and dreams
Boss’s 6 Guidelines for Living with AL:

1. Finding Meaning
2. Adjusting Mastery
3. Reconstructing Identity
4. Normalizing Ambivalence
5. Revising Attachment
6. Discovering New Hope

1. Finding Meaning: Making Sense of the Loss

- **What helps?** Naming the problem, talking with peers, using both-and thinking, forgiveness, small good works, continuing but changing family rituals and celebrations, religion/spirituality, hope

- **What hinders?** Hate and seeking revenge, seeking retribution, family secrets, isolation, seeking closure

- **Therapy Methods/Guidelines:** Narratives, Dialectical, Systemic (Family and Community), the Therapeutic Relationship
2. Adjusting Mastery: Modifying the Desire for Control and Certainty

• **What helps?** recognizing the world is not always fair, decreasing self blame, externalizing blame, managing and making decisions, increasing success experiences, accepting (sometimes) what will not change, identifying past competencies, mastering one’s internal self (meditation, prayer, mindfulness, yoga, exercise, music, etc.)

• **What Hinders?** Believing that you have failed if you are not “over it”

• **Therapy Methods / Guidelines:** Narratives, increase human connections, the therapeutic relationship
3. Reconstructing Identity: Knowing Who You Are Now

• **What helps?** Finding supporting family or “family” members, redefining family/marital boundaries, being flexible about gender and generational roles, who’s in/out, who are you now?

• **What hinders?** Resisting change, forced uprooting, isolating or disconnecting

• **Therapy Methods/Guidelines:** Narrative Use, The Therapeutic Relationship,
4. Normalizing Ambivalence: Managing the Anxiety from Mixed Emotions

- **What helps?** Normalizing anger and guilt, but not harmful actions; seeing conflicted feelings as normal, talking about them with a professional, using the arts to understand ambivalence, managing ambivalence once aware of it, developing tolerance for tension

- **What hinders?** Denying or keeping secret that you sometimes “wish it were over,” expecting typical coping and adaption

- **Therapy Methods / Guidelines:** Voluntary use of narrative methods with trusted others, Being Fully Present, The Therapeutic Relationship
5. Revising Attachment: Letting Go Without Certainty of Loss

• **What helps?** Recognizing that your loved one is both here and gone (grieving what you have lost, acknowledging/celebrating what you still have), developing memorial ceremonies and goodbye rituals, finding new human connections

• **What hinders?** Holding on without also developing new attachments

• **Therapy Methods / Guidelines:** Therapeutic Relationship and Couple, Family and/or Group work all useful for creating reconnections

• What helps? Becoming more comfortable with ambiguity, spirituality, laughing at absurdity, redefining justice, finding something to control or master to balance the ambiguity

• What hinders? Isolation, insisting on always having the answer, seeking closer instead of meaning

• Therapy Methods / Guidelines: Psychodynamic, cognitive and psychoeducational approaches
7th Guideline

- In her Book, *Loving Someone Who Has Dementia: How to Find Hope While Coping with Stress and Grief* (2011), Dr. Boss discusses the 6 guidelines we just reviewed for living with AL.
- She also adds one more for the caregivers of those with Dementia:

7. Take The Time to Mind Yourself
Self exploration

• “While accepting the unknowability, therapists and professionals need some hope that what we do is for the most part helping those who are traumatized by ambiguity. To do this, we focus optimistically on the capacity of human beings to change and remain resilient despite ambiguous loss. This includes us.”

Core Questions for Clinicians:

• Who is in your psychological family?
• What ambiguous loss have you experienced?
• What type? Physical? Psychological? Both?
• What did it mean to you then? What does it mean now?
Thank You For Your Time

Have a great day, unanswered questions and all!!
References:


References (cont.)


