

Recovery From Unnatural Death

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This is written for someone who has experienced the death of a friend or family member by an unnatural dying—accident, suicide, or homicide. Helpful information is included in a condensed and organized way so you can find what you need quickly. Another reason for brevity is our determination to present accurate information. This is not the place for complex theory or explicit instructions that tell you what you should or should not do. In our view, it would be misleading to promise short-term answers to something so overwhelming. Instead we emphasize that one should not be burdened by the expectation that they will quickly recover. Recovery suggests regaining who you were before the death. You will provably be changed by this event and will spend the rest of your life accommodating to what has happened; unnatural dying of a friend or family member is the sort of life change that will change you.

The Uniqueness of Unnatural Dying

When someone close dies, it is natural to mourn their loss—to think of them with sorrow and miss their presence in your life. If they died from a natural death (from disease or old age), then the dying would be understandable. One could understand what was going wrong in their body and why they couldn't be saved—and if the natural dying went on for weeks, months, or years, you would have time to adjust to what was happening and could begin to say goodbye.

This is not the case with unnatural dying; when someone close dies an unnatural death, you not only mourn their loss but are forced to adjust to the unnatural way that they died. It is a double blow: not only have they died, but the way they died is senseless. Unnatural dying is abrupt, and traumatic. There is no time for goodbye.

Unnatural dying contains unique dimensions that make it different than natural dying:

Violence—The dying is injurious and often mutilating.

Violation—The dying is transgressive. Except for suicide, unnatural dying is forced upon the deceased who has no choice in avoiding or preventing it.

Volition—The dying is a human act of intention (with homicide or suicide) or some degree of negligence or fault with accident.

These three V's of unnatural dying (violence, violation and volition) give a different meaning to death. Family members may not quietly and peacefully accept what has happened. Even if they wanted solitude and tranquility, their surrounding community would not allow it. There will be an immediate response for the media and police

whenever an unnatural death occurs. This demands a thorough investigation to document how this happened, who was responsible, and punishment that promises redemption. Unfortunately, this social response promises more than it delivers. Family members have no choice—they must cooperate with the media, the police and sometimes the courts.

Obviously this is not fair. It is already “too much” to accept such a dreaded dying. It is hard enough to remain resilient and stable without the media and police questioning—questions that often suggest that the victim was somehow at fault for what happened. Besides, these are questions you would be bound to seek answers for yourself—this is a part of the never-ending search for meaning to the dying.

Early Response To An Unnatural Death

There seems to be at least two distinct reactions to unnatural dying: the first and most primary is *traumatic distress* to the unnatural dying and a second, underlying response is *separation distress* to the loss of the relationship. To illustrate the descriptive differences, the distress patterns are listed below.

	Traumatic Distress	Separation Distress
<i>Thought</i>	Reenactment of dying	Reunion with the deceased
<i>Feelings</i>	Terror	Pining and Sorrow
<i>Behavior</i>	Avoidance of reminders of the dying Protection of self and others	Searching

Trauma distress is the stronger and more immediate response. In the initial days or weeks after an unnatural death, it is common to avoid the reality of the dying—to be enveloped in a numbness that cannot admit to what has happened. This protective numbness is challenged by a reconstruction of the way that the person died. Often, our minds construct events in the form of a story with a beginning, middle, and an end. The story of an unnatural dying, even though it was not witnessed, may become an intense and terrifying reenactment. This reenactment story of the dying often includes the last thoughts, feelings and behaviors of the person who died. Even though you weren’t there, your imagination of what your loved one experienced may become a dreaded replay or reenactment. During the initial weeks of adjustment, these reenactment fantasies may occur on a daily basis, and also recur as nightmares at night. These reenactments make it difficult to concentrate because of the accompanying terror that you and other family members are now at risk for an unnatural dying as well. It is the persistence of this traumatic story of the unnatural dying for many months that may distort your view of the world as no longer safe, trustworthy, or caring.

Intertwined with this initial response of trauma distress are waves of separation distress. In most instances, the permanent loss and separation from the relationship is a major disruption. A close friend or family member is an important part of your own identity and in losing them; you lose a part of yourself. It is difficult to begin accepting the finality of this loss until your mind is less preoccupied with the terrible fantasies of the dying. Acceptance of the loss will be delayed until your mind is able to calm and divert

itself. Separation distress follows the realization that your friend or family member will never return as a tangible, physical presence. If you have an established religious or spiritual belief system, the permanency of this loss will be softened by the promise of continual spiritual existence and reunion at the time of your own spiritual release with death. But that belief system will only serve to soften the despair, and place it a more hopeful context. It will not allow the total denial of your loved one's "here and now" absence. Just as the mind composes stories of the trauma of the dying, so it creates stories about separation. With separation distress, the theme of the story is different from traumatic reenactment: most commonly, the theme involves an intense *fantasized reunion* with the lost person. The image of the deceased becomes a persistent figure in one's mind and there is a strong yearning for their return and a reconstructive fantasy of rescue and repair. The yearning often involves an active "searching"—to places (including the grave site) associated with the deceased and an involuntary visual scanning for their face in a crowd, or an anticipation of hearing their voice when you return home. Your mind is acutely alert for any sign of their presence and the fantasy that once found, you will comfort them and protest that they no longer put you through something so traumatic again!

Exceptions

A minority of individuals will experience little, if any, trauma or separation distress. They respond with a stoicism and grudging acceptance of this tragedy. While stoicism may be followed by a delayed response of grief months or years later, this a rare occurrence. Long-term study of stoic responders suggests that stoicism is a favorable sign and should not be challenged. Adjusting to an unnatural death does not always mean the acknowledgement and expression of traumatic or separation distress. Not everyone cries or struggles with fantasies. It is best to respect the uniqueness of any response and not expect that others experience what you are experiencing—especially other members of your family.

An even rarer explanation of muted or absence of distress is when the deceased was burdensome, hated, or feared. Under these circumstances, their death may be followed by a sense of relief more than distress. This relief is difficult to share with others and may cause some secondary guilt or shame because, "I am feeling relieved that this person can't make me suffer any more." Under these circumstances, relief is a natural feeling.

Complications

There are several factors that are associated with very intense and prolonged responses of trauma and separation distress—distress that will last for many months and will handicap functioning at work or at home:

- **Death of a child**—Perhaps the strong separation and trauma distress after the unnatural death of a child is associated with the strong care taking and nurturing assumptions that form a basis of such a relationship. The child had a vulnerable dependency upon all members of the family when they were tiny; most particularly, the parents or sometimes parent "substitutes" such as grandparents, older siblings, or aunts or uncles. Because of the underlying attachment, a strong sense of responsibility for the child, their unnatural death *at any age* may cause

not only intense trauma and separation distress, but a sense of somehow failing the obligation of protecting the child from harm. The persistent belief that “I somehow could have prevented this from happening” is especially intense after the death of a child.

- **Age and Gender**—Young women (less than age 40), who lose a spouse or child, are at much greater risk for complications than young men. Undoubtedly there are sex-linked differences between men and women, reinforced in our society and culture, that allow women to be more open and responsive about their distress. It is also obvious that the loss of a young woman’s spouse has immediate implications for her economic security—so she may not be only distressed but poorer as well.
- **Intense Reenactment Imagery**—There are several studies that suggest that persistence of intense traumatic distress (daily occurrence of reenactment imagery or thoughts) beyond two or three months from the time of the death is associated with dysfunction and the need for treatment. The daily repetition of the reenactment story and the accompanying feelings of terror and anger will make it increasingly hard to concentrate at work or to communicate meaningfully with friends and family members.
- **Previous History of Emotional Problems**—Many studies have demonstrated that a past history of psychiatric disorder (particularly, depressive and anxiety disorders) makes an individual more vulnerable to developing unrecovered grief.

When Does Distress Become a Disorder?

The difference between distress and disorder has major implications for management. Distress refers to a nonspecific pattern of subjective signs and symptoms of discomfort that last for a short time, have a minor affect on one’s functioning, and spontaneously disappear without treatment. The majority of individuals who are coping with an unnatural death match this definition.

A significant minority of individuals who have experienced an unnatural death of a friend or family member will develop a psychiatric disorder within the first year after the death (estimates range from 25% for depression to 40% for anxiety disorders). Unlike distress, a disorder presents with a predictable syndrome of specific and objective signs and symptoms that last for a much longer period of time (months or years), have a major impact on function for which specific treatment has been developed.

The two psychiatric disorders that are commonly associated with complicated or unrecovered grief are major depressive disorders and anxiety disorders. These disorders are defined by the process of self-report interviews and psychiatric examination. There is no objective laboratory or pathologic test that will define a psychiatric disorder. Other sorts of tests define *diseases* (like diabetes or cancer) where there are measurable, physical changes. Instead, psychiatric disorder is defined by the presence of sufficient signs and symptoms to meet rigorous criteria for the diagnosis. Listed below are the

criteria for major depressive disorder and the type of anxiety disorder (posttraumatic stress disorder) most commonly associated with trauma.

Major Depressive Disorder

Five (or more) of the following symptoms have been present during the same two week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). NOTE: In children and adolescents, can be irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
3. Significant weight loss when not dieting or weight gain (e.g., a change or more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. NOTE: In children, consider failure to make expected weight gains.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly everyday.
7. Feelings of wordlessness or excessive or inappropriate guilt nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation with out a specific plan, or a suicide attempt or a specific plan for committing suicide.

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Posttraumatic Stress Disorder

The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
2. The person's response involved intense fear, helplessness, or horror. NOTE: In children, this may be expressed instead by disorganized or agitated behavior.

The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. NOTE: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. NOTE: In children, there may be frightening dreams without recognizable content.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusion, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). NOTE: In young children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Psychological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall important aspects of the trauma.
4. Markedly diminished interest or participation in significant activities.
5. Feelings of detachment or estrangement from others.
6. Restricted range of affect (e.g., unable to have loving feelings).
7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilance.
5. Exaggerated startle response.

Duration of the disturbance is more than one month.

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

If you meet criteria for one or both of these disorders, consultation with a mental health professional is strongly advised. Prospective studies of family members during the first year of bereavement show that 25% of subjects will meet criteria for major depressive

disorder and 40% will meet criteria for anxiety disorder (and many family members have both major depressive and anxiety disorders at the same time).

Management

There is no definitive treatment for bereavement after an unnatural death. Beware of anyone who claims certainty about what should or should not be done. Respect the uniqueness of your own response and search out the sort of support that meets your own needs. With the sensitive encouragement of family, friends, work associates, and spiritual support, most individuals will spontaneously improve. Their distress will linger for many years (particularly at commemorative times—birthdays, anniversaries, or the specific time of the year when the person died) but these responses of distress will no longer be so intense nor so preoccupying and the memory of the deceased will be more tranquil and positive.

Psychological Support

This form of assistance has the clearly defined, short-term goals of restoring one's sense of self-esteem, safety, and confidence of recovery in the future. The essential components for support are a trusting relationship, clear and concise information about the crisis, a nonjudgmental acceptance of responses, and a realistic and reassuring preparation for the future.

Support is inherent in most families, friendships, and social and religious groups who offer support during the early phase of bereavement. For most, a month or two of this intense concern and attention is sufficient, but for those who need longer term support, it is surprising to realize how impatient and intolerant the surrounding support figures can become.

Support Groups

Support groups offer free care. Most major metropolitan areas contain groups of family members and friends who meet to support one another after an unnatural death. These groups offer a particularly relevant resource in that all members have experienced the same form of traumatic loss. Members are able to empathize readily with one another. Leaders and member of the group are especially well informed regarding:

1. How to deal with the media
2. How to communicate with the police and the Medical Examiner's Office
3. How to understand the criminal judicial process
4. How to apply for Crime Victims Compensation if you are eligible.

Accurate information of this sort varies from one jurisdiction to the next, so local support groups can provide updated information that would take you countless hours to gather on your own.

Individual Psychotherapy

Some individuals remain distressed for several months after the death and are more comfortable in individual counseling. Finding an appropriate individual therapist may be challenging. A minority of therapists have been trained in the management of complicated, unnatural death recovery. A knowledgeable therapist will recognize that trauma distress leads to more dysfunction than separation distress. The presence of recurrent reenactment imagery and feelings of intense fear are strongly associated with the need for treatment. Once treatment begins, it is this trauma distress that takes priority in management. If the individual therapist is unaware of this need, therapy may reach a sudden impasse of heightened frustration, resistance, and termination.

Family Therapy

The unnatural death of a family member may have significant impact on the relationships between family members. Since the family system is a primary source of support during recovery, it may be helpful to have one or several family sessions. The objective of these sessions will be supportive—to allow family members to clarify how they are dealing with this tragedy and reinforce the acceptance and respect for individual differences. The entire family will be traumatized by the death. This is not the time to deal with long-standing issues of conflict. An inexperienced family therapist may create the same scenario of heightened frustration, resistance, and termination if they fail to deal directly with the shared traumatic distress.

Medications

The use of medications during bereavement challenges some commonly held beliefs:

1. Medicines will cover up the natural responses of bereavement.
2. Healing demands that any bereavement response (including a diagnosed disorder of depression or anxiety) must be expressed and transformed into mourning.
3. Interrupting this natural “healing” with medications will create an imperfect scar (a distorted grief reaction).

Recent studies citing the use of medications during the first year or two of bereavement disprove these absolute assumptions. The reader will recall our promise that we would not become imperative in our recommendations: we are **not** recommending that medications should always be considered with bereavement after an unnatural death. Their use is indicated for a distinct minority (those with diagnosed disorders of depression and anxiety) and are an addition to on-going psychotherapy. Studies have shown that medications will not supersede or replace therapy because they are selective in only relieving depression and anxiety—they have no direct effect on the distress of separation or trauma. This would suggest that the management of complicated grief reactions that did not include supportive therapy or individual therapy would be negligent and incomplete.

Basics About Medications

This is not the place to present detailed information about medicines for sleeping, anxiety, or depression. Those details should await your decision to try medications. The

consulting physician can present information about the specific medication at the time it is prescribed. However, there are some basis underlying principles that will reassure you of their use:

1. You cannot use any of these medicines if you are dependent on alcohol. The excessive use of alcohol is not uncommon with acute bereavement. Alcoholism requires acknowledgement, intervention, and abstinence before beginning medications. It is widely recognized that alcoholism may mask underlying disorders of depression and anxiety but treatment can only follow abstinence.
2. Newer medications for anxiety, depression and insomnia have few side effects and are potentially addictive or harmful to your body.
3. Medications are usually taken for a shortly period of time; anti-anxiety and sleeping medications for 6-8 weeks, and anti-depressant medications for 6-9 months. Thus, you would not be committing yourself to an indefinite and costly form of treatment.
4. Medications are selective in relieving the signs and symptoms of disorders of depression and anxiety. Chance of improvement are 70%--twice the rate of improvement with placebo or no treatment. Medicines will not numb you. You will still respond to feeling of sadness or happiness.

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