

# Avoiding the Tendency to Medicalize the Grieving Process: Reconciliation Rather Than Resolution

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Grief counseling is a common task for professionals working with older adults in long-term care. This can be a very stressful situation, not only for older adults facing death and family members feeling the effects of such losses, but also for staff members who tackle these issues. Furthermore, professionals and laypersons alike often speak about the time it takes to “resolve” the issue of grief. Yet, this may be incorrect language to use, because grief work may be best viewed as a process of reconciliation rather than resolution.

The loss of something or someone that has been held dear often cannot be brought to resolution, but this does not mean that psychological scars are permanent and cannot be reconciled. Human beings are resilient, yet loss and death does have a developmental impact on us. Today, bereavement has become medicalized, with the intent of using psychopharmacology to assist in bringing a resolution to grief. Yet, loss naturally brings bereavement, sadness, depression, and anxiety. Is medication necessary to dampen the effects of loss and bring resolution, even if resolution is illusory? The medicalization of bereavement and grief will be examined, with the intention of demonstrating the need to let grief run its course and to aim counseling interventions toward reconciliation, not resolution.

With loss and death come bereavement, grief, and mourning. Bereavement refers to the process of adjusting to the death of a loved one. The bereavement process has two components—the components of grief and mourning. Grief refers to the complex emotional responses that one has during the bereavement process, such as experiencing sorrow, hurt, anger, guilt, confusion, and other feelings that arise after suffering a loss (Hooyman & Kiyak, 2002; Santrock, 2006). Mourning refers to the culturally structured patterns and expectations of how individuals express their grief (Hooyman & Kiyak, 2002). The cultural environment plays an important role in determining how individuals will react or mourn the loss of an individual.

It is important to understand that grieving is a natural process that is experienced, which can be very important toward coping constructively with loss and death (Attig, 1996). The key here is that it is a process, a process that has to be worked through developmentally (Atchley & Barusch, 2004). Because individuals experience high levels of emotion during early stages of the loss, it may become very difficult for them to realize the process involved. However, they must be comforted on experiencing loss, and we can help them view it as a process that, if successfully worked through, will hopefully bring about reconciliation (Wolfert, 1992). The importance of reconciliation is paramount in this process. Resolution entails the end of something. However, when someone experiences the loss of a person who is very dear to them (or even other profound losses, such as the loss of independence or a limb, as is found among many nursing home residents or among amputees), the memories they have and the emotions attached to past life experiences are impossible to extricate. Attempting to use the strategy of placing loved ones or objects that have been lost and emotions associated with them out of one’s mind does not lead to successful bereavement. Nor is repressing the memories of persons or past experiences healthy. Reconciliation is again something that keeps our memories strong, yet developmentally allows us to reconcile ourselves with loss.

## To Medicalize or Not to Medicalize

It should be asked: can the process of bereavement be lessened and pain reduced by medicalizing bereavement and grief, in which common features such as sadness, crying, feeling empty, and having a profound sense of loss are endeavored to be resolved through pharmacological intervention, frequently through the use of anxiolytic or antidepressant medications? Should features of grief be treated as a disease or disorder that needs physical or biochemical intervention? Too often this is the result. Too often what is viewed as prudent intervention is intervention using artificial remedies directed toward short-term “magic bullet” approaches that attempt in misguided fashion to bring about a resolution to grief when nonmedical reconciliation should be the approach. Health care professionals in long-term or subacute settings have to be aware of the importance of psychosocial intervention in working with the bereaved, rather than quick medical and pharmacological fixes.

It must also be remembered that grieving does not have to begin at the time of death or at the time of loss, but it can start before the actual loss or death of the person, a type of anticipatory grieving. Fulton (1970) differentiated grief into two different levels: high-grief death and low-grief death. In the high-grief death, the death of a person is unexpected, while in the low-grief death, the death of the person is expected. According to Fulton (1970), the difference is not whether people grieve with greater intensity in one situation versus the other, but that when death is expected as in the low-grief death situation, the close relatives of the dying individual have already started to grieve before the actual death occurs. When this happens, they may be more prepared for the loss when it actually does happen.

With a hypothetical older adult scenario that is often witnessed in long-term care and subacute settings, the type of grief addressed by Fulton can have important implications for our approach toward helping a person cope with the death of a loved one. Often the high-grief death is quite difficult, because of the unexpected nature of the death. The low-grief death is also difficult, but the anticipatory grieving has started and working through the grieving process has also begun. This in turn can lead to quite a bit of grief work completed by the time of the actual death. When this happens and when grief work is quite satisfactory, a person's death comes as part of the normal, developmental transition found in the life cycle. Regardless of age, when the death of an older person is expected with anticipatory grieving, there is greater developmental continuity that may be found in the grief work experience than there would be in the case of an unexpected death. Something to be noted here is that without medicalizing the grieving process in the so-called low-grief deaths that are accompanied by a considerable level of anticipatory grieving, individuals do work through the process, reconciling the death of the loved one. Yet, there is often a compulsion to address the symptoms of grief medically, implicitly thinking that this will reduce grieving and even resolve the issue with a greater level of satisfaction.

### Social Death

Another important issue related to medicalizing bereavement and grief is dying with dignity. Since death in modern societies has been medicalized, a social death often precedes a physical death. Social death happens when the dying individual is isolated from his or her family and other loved ones, and people avoid the issue of speaking about the process of death with the dying person (Kastenbaum, 1977; Pattison, 1977; Hess & Markson, 1980). Often, dying people want family and friends to be with them and to speak with them in the final moments of life.

It is a common practice to alienate family and friends from the dying individual, and even to institutionalize death in hospitals or in sterile institutionalized conditions. Many individuals die with few, if any, individuals around them in the final hours, and this can be a very painful and empty process for the dying individual. The unnatural environment of medical settings has led many to seek hospice care as a solution to these problems, providing greater dignity and comfort.

Those working in long-term or subacute care have to be mindful of their counseling roles. The person may be under the care of hospice, yet still within an institutionalized environment, which continues to foster isolation and disengagement. It is critical to try not to disengage the bereaved and the dying from social and human contact. Addressing end-of-life issues within institutional care with workers who are aware of these developmental end-of-life transition issues is very important.

Developmentally, reconciling grief through advocacy of an engaged bereavement is often healthier than being disengaged and failing to completely reconcile grief, which can leave many questions unanswered and many emotions unchallenged. Many people still feel that isolating and disengaging the dying person, as well as disengaging those who are grieving, from the larger social environment will promote a better death or dying experience. This only promotes social and psychic death, in which the person fails to evaluate his or her own feelings regarding this important developmental transition (Pattison, 1977). In actuality, this is often a defense against apprehensions with the dying process, in which people distance themselves from the emotions involved in the experience (Cicirelli, 2002). Furthermore, many feel guilt after the death of the loved one, since they did not spend time with the dying individual and bring about adequate reconciliation. Again, these apprehensions are often fostered by professionals who work in these environments and should understand the developmental sequence that follows, instead of attempting to medicalize the dying process rather than addressing it humanly.

### Summary

Grief is a process that happens over time. Some individuals will adjust more successfully than others. However, for all individuals, the loss of a person with whom they have had close emotional ties is a dramatic consequence in their lives, whether the death was expected or not. The intense emotions that grief brings usually take one to two years to reconcile (Cavanaugh & Blanchard-Fields, 2006). There are occasions when individuals are unable to successfully deal with their grief, and this is when one has to consider obtaining outside help on a clinical level. Clinical and other types of medical intervention may be necessary at this time. However, many will never need this type of intervention and are able to reconcile this very difficult, yet inevitable, developmental task.

As is evident, death is part of life. However, the process of working through death and the grief that is associated with it is extremely important. Bereavement is a process, not just short stop and go points. Furthermore, although it is not something that is looked forward to, it is an important developmental task that needs to be addressed and not medicalized. Just as death is inevitable, dealing with the consequences of death is also a part of life, an important developmental task that has to be addressed, either successfully or unsuccessfully. Finally, those professionals working in long-term and subacute care need to realize that addressing this developmental task constructively with a proper perspective on bereavement is critical as one faces loss and death. Helping to foster reconciliation rather than resolution should be the goal. References

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