XI. Traumatic Grief: Symptomatology and Treatment in the Iraq War Veteran

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Symptoms of Grief are Distinct from PTSD and Depression

Although research into the prevalence and intensity of grief symptoms in war veterans is limited, clinicians recognize the importance for veterans of grieving the loss of comrades. Grief symptoms can include sadness, longing, missing the deceased, non-acceptance of the death, feeling the death was unfair, anger, feeling stunned, dazed, or shocked, emptiness, preoccupation with thoughts and images of the deceased, loss of enjoyment, difficulties in trusting others, social impairments, and guilt concerning the circumstances of the death. Recent research results, although limited to one sample of Vietnam combat veterans in a residential rehabilitation unit for PTSD, have supported findings in the general bereavement literature that unresolved grief can be detected as a distress syndrome distinct from depression and anxiety. In this sample of combat veterans, grief symptoms were detected at very high levels of intensity, thirty years post-loss. The intensity of symptoms experienced after thirty years was similar to that reported in community samples of grieving spouses and parents at six months post-loss. This supports clinical observations that unresolved grief, if left untreated, can continue unabated and increases the distress load of veterans. The existence of a distinct and intense set of grief symptoms indicates the need for clinical attention to grief in the treatment plan.

Attachment and Bonding of Soldiers are Essential to Unit Cohesiveness

Bonds with unit members are described by many veterans as some of the closest relationships they have formed in their lives. During Vietnam, soldiers were rotated in and out of units on individual schedules. Nevertheless, the percentage of returning veterans with PTSD who also report bereavement-related distress is high. In the Iraq conflict, young soldiers and reservists have remained with their units throughout training and deployment. Levels of mutual trust and respect, unit cohesiveness, and affective bonding will have been further strengthened by the experiences of deployment. While bonding and attachment to the unit may result in some protection against subsequent development of PTSD, unresolved bereavement may be expected to be associated with increased distress over the life span unless these losses are acknowledged and grief symptoms treated on a timely basis.

Traumatic Grief

Traumatic grief refers to the experience of the *sudden loss* of a significant and close attachment. Having a close buddy, identification with soldiers in the unit, and experiencing multiple losses were the strongest predictors of grief symptoms in the above sample of Vietnam veterans**.** Other factors that may influence the development of prolonged grief syndrome include: survivor guilt; feelings of powerlessness in not being able to prevent the death; anger at others who are thought to have caused the death; anger at oneself for committing a self-perceived error resulting in the death; tasks of survival in combat taking precedence over grieving; not being able to show emotional vulnerability; numbing and defending against overwhelming emotions; not having an opportunity in the field to acknowledge the death; and increased sense of vulnerability by seeing

someone close killed. Factors important in the Iraq War may include exposure to significant numbers of civilian casualties, exposure to death from friendly fire or accidents resulting from massive and rapid troop movements, and concern about culpability for having caused death or harm to civilians in cities. These factors may contribute to experiences of shock, disbelief, and self-blame that increase risk of traumatic and complicated grief reactions.

Experiences That Can Influence the Development of Intense Grief: What We Learned from Vietnam

The sudden loss of attachments takes many forms in the war zone. Soldiers may experience overwhelming self-blame for events that are not under their control, including deaths during the chaos of firefights, accidents and failures of equipment, medical triage, and casualties from friendly fire. The everyday infantryman from Vietnam lived his mistakes over and over again, perhaps in order to find some way of relieving pain and guilt from the death of friends. Many medics during Vietnam suffered tremendously when they were not able to save members of their unit, especially when they identified strongly with the men under their care. Pilots called in to fire close to troops were overcome with guilt when their ordinance hit American soldiers even while saving a majority of men. Officers felt unique responsibility for the subordinates under their care and suffered undue guilt and grief when results of combat were damaging. Soldiers who worked closely with civilians were often shocked when they witnessed deaths of people with whom they had come to develop mutual trust. Deaths of civilian women and children were difficult to bear. Many of these same experiences can be expected to affect combat troops in Iraq.

Normal vs. Pathological Grief

Bereavement is a universal experience. Intense emotions, including sadness, longing, anger, and guilt, are reactions to the loss of a close person. Common in the first days and weeks of grieving are intense emotions, usually experienced as coming in waves lasting 20 minutes to an hour, with accompanying somatic sensations in the stomach, tightness in the throat, shortness of breath, intense fatigue, feeling faint, agitation, and helplessness. Lack of motivation, loss of interest in outside activities, and social withdrawal are also fairly common. A person experiencing normal grief will have a gradual decline in symptoms and distress. When grief symptoms remain at severely discomforting levels, even after two months, a referral to a clinician can be considered. If intense symptoms persist after six months, a diagnosis of complicated grief can be made and there is a definite indication for clinical intervention. Complicated grief prolonged over time has been shown to have negative effects on health, social functioning, and mental health.

Acute Traumatic Grief

Survivors of traumatic events can experience acute symptoms of distress including intense agitation, self-accusations, high-risk behaviors, suicidal ideation, and intense outbursts of anger, superimposed on the symptoms of normal bereavement. Soldiers who lose their comrades in battle have been known to make heroic efforts to save them or recover their bodies. Some soldiers have reacted with rage at the enemy, risking their lives with little thought (“gone berserk” or “kill crazy”). Some soldiers withdraw and become loners, seldom or never again making friends; some express extreme anger at the events and personnel that brought them to the conflict. Some soldiers are inclined to mask their emotions. Any sign of vulnerability or “losing” it can indicate that they

are not tough enough to handle combat. Delaying grief may well postpone problems that can become chronic symptoms weeks, months and years later. The returning veteran who has developed PTSD and/or depression may well be masking his or her grief symptoms.

Assessment and Treatment of Acute Grief in Returning Veterans

Clinical judgment is necessary in deciding when and how to treat acute grief reactions, especially when they are accompanied by a diagnosis of acute stress disorder. While a cognitive-behavioral treatment package that includes exposure therapy has been shown to prevent the development of PTSD some persons with acute stress disorder, exposure therapy during the initial stages of grief may often be contraindicated, because it may place great emotional strain on someone only just bereaved. Bereavement researchers also are hesitant to treat grief in the first few months of a normal loss, wishing not to interfere with a natural healing process. In the early stages of grief, symptoms may be experienced as intense, but this is normal for the first days, weeks, and months. Soldiers surviving a traumatic loss in the war zone will be more likely to mask intense feelings of sadness, pain, vulnerability, anxiety, anger, and guilt. Balancing other traumatic experiences with the intensity of grief may feel overwhelming. Therefore it is important to assess and respect the individual soldier's ability to cope and manage these feelings at any time. A soldier may be relieved to know that someone understands how he or she feels after losing a buddy, or experiencing other losses including civilians or multiple deaths in the field, and communication with a clinician may be a first step in coming to terms with loss. However, that soldier may not be ready to probe more deeply into feelings and circumstances. Care and patience in the assessment process, as well as in beginning treatment, is essential.

Treatment during the acute stages of grief would best include acknowledgement of the loss, communication of understanding of the depth of feelings, encouragement to recover positive memories of the deceased, recognition of the good intentions of the survivor to come to the aid of the deceased, education about what to expect during the course of acute grief, and encouragement of distraction and relaxation techniques as a temporary palliative. Efforts to reduce symptoms of PTSD and depression as co-morbid disorders would take precedence over grief symptoms in the initial phases of treatment, unless the loss itself is the main cause of distress.

Assessment of Complicated Grief in Returning Veterans

Grief symptoms including sadness, distress, guilt, anger, intrusive thoughts, and preoccupation with the death should be declining after about six months during a normal grieving process. If symptoms remain very high after six months, clinical intervention is warranted. There are several instruments that may be helpful in assessing a complicated grief. The Inventory of Complicated Grief-Revised is perhaps most widely used and reflects current bereavement research. Another instrument is the Texas Revised Inventory of Grief, which has been used in a variety of populations and has been well validated. Both allow comparisons with normative populations.

Treatment of Complicated Grief in Returning Veterans

There have been no outcome studies of treatments of veterans for prolonged and complicated grief symptoms at this time. Clinical experience supports the importance of education about normal and complicated grief processes, education about the cognitive processes of guilt, restructuring of

cognitive distortions of events that might lead to excessive guilt, looking at the function of anger in bereavement, restoring positive memories of the deceased, restoration and acknowledgment of caring feelings towards the deceased, affirming resilience and positive coping, retelling the story of the death, and learning to tolerate painful feelings as part of the grieving process. These activities can be provided in individual treatment or in closed groups.

Regardless of the techniques that are used, what is central to treating veterans for prolonged and complicated grief is recognition of the significance of their losses, provision of an opportunity to talk about the deceased, restructuring of distorted thoughts of guilt, and validation of the pain and intensity of their feelings. What is most essential is that bereavement and loss be treated in addition to PTSD and depression for a more complete recovery.

Medications Helpful in Treating Grief Symptoms in Non-Veteran Populations

One research study has shown that paroxetine as well as nortriptyline may be helpful in treating complicated grief after six months. Bupropion has been successful in treating symptoms at six to eight weeks. Again, research has been limited and has not included war zone veterans.

Additional Resources

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