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ACUTE GRIEF : THE FIRST YEAR OF BEREAVEMENT[1]

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Bereavement is a universal human experience and mourning or grief is the typical response to bereavement. Infact, most cultures have well established mourning rites and patterns of behaviour expected of the survivor who has suffered the bereavement as well as for the community, so as to promote the resolution and recovery from this grief. However, precisely because it is considered a normal and socially accepted pattern of behaviour, it has not been the subject of scientific study except when the grief reaction had become excessive or under unusual circumstances.

Freud (1937) identified the characteristics of mourning as painful dejection, loss of interest in the outside world, loss of capacity to adopt any new object of love and inhibition of activity. The first report describing the symptomatology of acute grief is that of Lindemann (1944). He described the characteristic symptoms of normal grief as observed in the 13 relatives of the coconut grove fire victims as (i) somatic distress, (ii) preoccupation with the image of the deceased, (iii) guilt feelings (iv) hostile reaction, and (v) loss of previous patterns of conduct.

In the first of the 3 retrospective studies, Marris (1958) interviewed 73 widows in East London whose homes had been traced through the death registeration of their husband. He recorded five reactions that occurred following bereavement i.e. (a) lasting deterioration in health (b) difficulty in sleeping (c) loss of contact with reality (d) withdrawal and (e) hostility. Parkes (1965) carried out a study of recently bereaved adult psychiatric patients seen in OPD or admitted to hospital and information about their mental state was obtained from their hospital case records. On the basis of this, he attempted to identify the various components of the grief reaction following a major bereavement. More recently, Singh and Raphael (1981) in their studies of bereaved relatives from the Granville train disaster noted that bereaved parents seemed to suffer the highest morbidity as compared to widows or other relatives. Clayton (1974) has also referred to the observation that the bereavement of parents on the loss of their children overshadows the bereavement of the widowed.

The only prospective study of normal bereavement is one by Clayton et al. (1968) who studied the relatives of thirty of a total of fifty patients who died in hospital. The relation of the subject to the deceased was a spouse in 19 cases, parent in 9, grand parents in 2 and child in 10. They found that in normal bereavement in their subjects only 3 symptoms—depressed mood, sleep disturbance and crying, occurred in more than one-half of the subjects starting either during the terminal illness or after death.

Natterson and Knudson (1960) in studying mothers of fatally ill children, found that when a child died within four months after a fatal prognosis had been given, a large

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number of mothers showed a disturbed or intermediate reaction, whereas most mothers whose children lived longer than 4 months showed a calm acceptance of death when it came. Apparently a long illness prepares the relatives for the impending death whereas a sudden death is more likely to provoke an acute grief reaction.

It is now well recognized that the severity and duration of grief reactions following the loss of a loved person will depend upon a number of factors including (a) the nature of the relationship and degree of attachment (b) the age of lost person (c) the presence of social support systems (d) a sudden, accidental loss of a loved person, particularly of children is most traumatic manner for the bereaved person and hence would be expected to produce a full fledged picture of acute grief.

AIM AND OBJECTS OF THE PRESENT STUDY

Hence, when the Nangal boat accident occurred resulting in the death of 22 children, it was decided to undertake a detailed prospective study with the following aims:

(I) To document the clinical manifestations of acute grief.

(II) To study the normal process of recovery from acute grief.

The Boat Accident

The boat accident took place on 29th Sept., 1982 at Nangal in Punjab State, India at 4.30 P.M. when a privately run overloaded ferry, taking the children across the Nangal river, suddenly capsized in mid stream. There were 73 children at the time of the accident, in two boats, when one of the boats started sinking, the children panicked and screamed for help and in the process overturned the boat which capsized. 2 rescue boats were sent to save the children out of which one rescue boat also capsized and there was further delay. 51 of the 73 children in the two boats survived drowning. Out of the 22 children who were drowned, 13 were boys and 9 girls in the age group of 10-13 years.

MATERIAL AND METHOD

The sample consists of all parents of the 22 children drowned in the Nangal boat tragedy. Since they were all local residents they could be contacted and interviewed at their homes within 2-4 days of the accident.

The team of investigators were from among the staff members of the Department of Psychiatry, Rajendra Hospital, Patiala which included two psychiatrists, a clinical psychologist and a social worker. A list of symptoms of Acute Grief was prepared based on the observations of Lindemann (1944) and the Texas Grief Inventory which was used as a base line to record our subject's symptoms. Additional symptoms complained by the subjects or observed by the investigators were recorded independently by the four team members and if a symptom was recorded as present by at least 2 members of the team it was taken as present. All parents were systematically interviewed at their residences and each interview lasted between 40-60 minutes. The findings by individual team members were compared and tabulated later after discussion between all team members and the Professor of Psychiatry. After the initial visit subsequent visits were made at weekly intervals for 4 weeks, then at 3 months, 6 months and 1 year.

OBSERVATIONS AND RESULTS

Characteristics of the Sample: Age range of the 44 subjects was 30-50 years with 35 persons between 30-40 years and 9 persons in the 41-50 years range; 28 belonged to the hindu religion and 16 parents were sikhs. They were all literate and belonged to middle income group.

Initial Reaction : On hearing the news of the boat accident, shock, numbness and dis-

belief were some of the symptoms reported by a large number of parents. This either lasted for a few minutes to a day, or longer in a fews cases. "'No' it cannot be 'or' I can't believe it" were some of the expressions parents are reported to have said on learning about the death of their child. But on seeing the dead body most broke down and cried. However in two cases, gross denial of death was seen, e.g. one parent wrapped the dead child's body in a blanket to keep it warm and did this for nearly 24 hours before accepting the fact that the child was dead and the others called in doctors and insisted on giving oxygen inhalation to the dead child.

Symptoms of Acute Grief : Table 1 shows the bereavement symptoms elicited during the initial interview and are listed for males and females separately. They have been listed in order of frequency i.e. the most common symptoms are listed in the beginning and the least common at the end of the list. The first eight symptoms were reported as present in over 90% of all subjects and can be considered as almost universal manifestations of acute grief. These include : (1) sadness of mood, (2) sleep disturbance, (3) loss of appetite, (4) feeling of exhaustion and tiredness, (5) sighing, (6) overt weeping, (7) dullness and psychomotor slowing, and (8) loss of interest in work and social activities.

TABLE 1. *Showing grief symptoms in percentage of males and females during first week.*

Sr. No.	Symptoms	Males (N=22) %	Females (N=22) %	Total (N=44) %
1.	Sadness of mood	96	100	98
2.	Sleep disturbance	100	100	100
3.	Loss of appetite	96	100	98
4.	Feeling of exhaustion	96	100	98
5.	Sighing	91	100	96
6.	Overt weeping	91	96	93
7.	Psychomotor slowing	96	84	90
8.	Loss of interest in work & social activites	86	94	90
9.	Preoccupation with deceased	90	82	86
10.	Idealization of deceased	68	82	75
11.	Blaming and hostility	82	64	73
12.	Loss of purpose of life	64	68	66
13.	Generalized aches and pains	21	43	32
14.	Palpitations and restlessness	28	36	32
15.	Tightness and choking	18	32	25
16.	Sinking in abdomen	5	36	21
17.	Guilt	23	13	18
18.	Increased religiousity	36	32	34
19.	Belief in fate	22	28	25
20.	Retention of articles	14	20	17
21.	Sense of dead being present	13	9	11

98% subjects reported sadness of mood. Sadness of mood was present in 96% of the males and in 100% of females. However, one male subject did not report any sadness and on close observation also showed no evidence of depressed mood in him. On the other hand, he appeared over confident and cheerful, while talking to us and gave unnecessary details of tragedy site, the mode of drowning of boat and reaction of children and was clinically in a hypomanic state. It was found that all the 44 parents had sleep disturbance during the initial contact. Loss of appetite was present in 98% of subjects. This was followed by complaints of feeling exhaustion and tiredness again by 98% of the subjects.

Sighing was another common symptom found in 96% of the subjects with 91% in males and 100% in females. In most of the patients sighing was observed to be almost continuous throughout the period of observation at 1-2 minute intervals. Overt weeping was present in 93% of the total subjects.

An overall slowing down in both mental and physical activities i.e. psychomotor slowing was seen in 90% of the subjects and was observed to be more in males (96%) than in females (84%). It should be mentioned here that there were 61% cases in the mild psychomotor retardation group and 25% in the moderate group. 5% of the cases (a male and a female) showed severe reduction in psychomotor activity and were practically in a daze or semistuporose condition. 86%

subjects, were observed to be showing dullness in their behaviour and were noticed to be speaking in low, or subdued volume and tone with almost the same number in both sexes (82% males and 90% females).

This was followed by a general loss of interest in work and social activities and withdrawal from the environment in 90% of the total sample, being almost the same in males (88%) and females (92%).

Interestingly, apart from the symptom of sadness of mood and withdrawal from the environment and painful reality, these are all somatic symptoms which together express the underlying mental distress, the intense anxiety and depression of the bereaved person and are in line with the early observations made by Lindemann when he described mourning characterised as painful dejection, loss of interest in world, inhibition of activities and somatic distress. The above universal symptoms of grief are followed by the following four symptoms including: (9) preoccupation with the image of the deceased, (10) idealization of the deceased, (11) blaming others and expressed hostility and (12) loss of interest in life. These symptoms were noticed to be present in over half the subjects and their percentage ranged between 50% to 90%. This was associated with a marked withdrawal from all social activities and an active avoidance of social contacts in little less than half the subjects (43%). 66% subjects expressed a futility or hopelessness and helplessness, and a loss of purpose in life. It was found to be nearly the same in both males and females.

Coping mechanisms started almost immediately after the last rites had been completed. Preoccupation with the image of the dead child was the main coping mechanism used and was noted in 86% of all subjects. Idealization was seen in 75% of the subjects. Here the mothers (82%) idealized their child more than the fathers (68%). Blaming others and expressed hostility was another important coping mechanism utilised. 73% males and 64% females blamed school authorities for neglect, and government officials for inadequate life saving facilities, such as rescue boats etc. at the site.

The remaining symptoms elicited also deserve mention in order to understand the bereavement process. Although not universal, they do occur in between 20% to 50% of all subjects. These include: (13) generalised aches and pain in the body including headache, (14) palpitations and restlessness, (15) tightness and lump in throat, (16) sinking and emptiness in abdomen and (17) feelings of guilt. Complaints of headache, restlessness, and palpitations were found in 32% of the subjects. The complaint of palpitation was found to differ significantly, this being more common in females than males. Many subjects reported a feeling of choking or tightness in throat. These symptoms were found in 25% of the sample. Sinking and emptiness in abdomen was found in an additional 21% subjects.

In our sample, in contrast to the tendency to blame others and overt expression of hostility expressed by 73% males and 64% females, the guilt feeling was expressed by only 18% of the subjects. These parents held themselves responsible and guilty about sending the child for the picnic. In the majority of cases, this feeling of guilt or self blame was absent and was replaced by blaming of others for negligence in causing the accident and for failure to provide early help. A few cases openly expressed hostility towards the persons held responsible for the tragedy. Apparently, the bereaved individual gradually comes out of his initial stage of apathy, and psychomotor slowing, and this is replaced by excessive psychomotor expressivity and anxiety symptoms.

Increased religious activity and belief in fate are common socially and apparently approved patterns of behaviour in our culture an effective coping mechanism as it was emplo-

yed by over a third of all subjects (40% in males and 32% in females) to a marked degree.

Course and outcome during first year

Throughout the study no direct therapeutic intervention was done except responding to any specific request made by them. Table 2 gives the symptoms of grief found in the subjects at initial contact, 1st month, 2nd month, 3rd month, 6th month and at 1 year. Sadness of mood, which was present in almost all the subjects at the initial contact tends to persist in a majority of the subjects 75% at end of six months and 73% at end of 1 year. By the end of one year sadness of mood persisted in about three fourths of the subjects (that is in 73%) with a marginally higher frequency in females as compared to males (73% Vs. 68%).

Loss of interest in life and expression of death wish: initially almost two-third of the subjects had so much sadness that they expressed the death wish but after six months, only 27% subjects expressed this wish. This symptom was also equally prevalent in both sexes and it declined rapidly and was practically absent by end of 6 months being reported by only 6% of all subjects.

The symptom of sleep disturbance also shows a similar pattern, though less pronounced. Both the males and females reach a low level of 27% at end of six months--males showing an earlier and rapid reduction in scores during first 3 months. By the end of 1 year the overall percentage is still 25% although it is much less in males as compared to female 18% and 36%.

Overt weeping which was present in over 90% of subjects during first week, rapidly

TABLE 2. *Showing grief symptoms in percentage of parents during one year*

Sr. No.	Symptoms	1st W	1st M	2nd M	3rd M	6th M	1 Y
1.	Sadness of mood	98	93	89	86	75	73
2.	Sleep disturbance	100	91	82	61	27	25
3.	Loss of appetite	98	86	77	43	9	9
4.	Exhaustion & tiredness	98	89	84	68	14	16
5.	Sighing	96	82	66	41	9	2
6.	Overt weeping	93	80	64	39	25	39
7.	Psychomotor slowing	90	66	32	21	23	14
8.	Loss of interest in work and social activities	90	70	55	16	13	13
9.	Preoccupation deceased	86	89	82	77	57	59
10.	Idealization of deceased	75	86	84	75	64	59
11.	Blaming others & hostility	73	80	82	68	50	38
12.	Loss of purpose of life	66	48	36	14	6	0
13.	Generalized aches and pains	32	34	39	21	18	11
14.	Palpitations & restlessness	32	27	16	7	7	5
15.	Tightness & choking	25	18	7	5	0	0
16.	Sinking in abdomen	21	16	14	9	2	2
17.	Guilt	18	14	14	11	18	15
18.	Increased religiousity	34	40	57	52	54	43
19.	Belief in fate	25	23	48	52	66	75
20.	Retention of articles	17	21	24	32	34	34
21.	Sense of being present	11	21	16	9	4	4
22.	Premature ageing	—	—	9	23	34	34
23.	Weight loss	—	—	1	9	18	21

Abbreviation used: W=Weeks, M=Months, Y=Years.

declines and only 14% of the females and 9% in males showed this at 6 months, but by end of 1 year this number had increased to 39% of the total sample with 50% in females and 27% in males. This increase in percentage was probably the result of the 'Anniversary Grief' symptom, since the team attended the anniversary function and prayers organized by the parents.

The symptom of exhaustion and tiredness, loss of appetite, sighing and psychomotor slowing, almost recovered at end of six months. Exhaustion is reported by only 14%, loss of appetite by 9%, sighing 9% and psychomotor slowing 16% only. These symptoms also follow the pattern of the earlier symptoms when we compare the two sexes i.e. males showing somewhat earlier recovery in comparison to females.

Loss of interest in work and social activities which was reported by 90% of subjects at initial contact, recovers rapidly, only 13% of the subjects report this symptom at six months and 1 year after the tragedy.

The next two symptoms i.e. preoccupation with the image of the deceased and idealization of the lost person show a slightly different pattern. Preoccupation with lost person's memories is present in 81% and idealization in 74% of all the subjects at initial contact. These tend to increase slightly over first 2 months and then decrease slowly e.g. preoccupation with image of decreased shows an initial increase from 81% to 89%, and then deceased to 57% at 6 months and thereafter remains about the same being present in 59% at end of 1 year. Similarly, the symptom of idealization was present in 75% at initial contact, increases slightly to 87% in 2nd month and then decreases slowly to 64% at 6th month and 59% at 1 year. Thus, these two symptoms tend to reduce in the interval between third and sixth months and continue to be present in about two-third of the subjects at end of six months and at 1 year. There is no significant difference between two sexes.

Symptoms of blaming others and expressed hostility, was present in 73%, of all the subjects initially. Here again, we find a slight increase in first two months from 73% to 82% at end of third month and then comes down to 50% at six months, and 38% at end of 1 year. There is no significant sex difference although males more openly expressed hostility towards people held responsible for the tragedy and sometimes even threatened to take action against them as compared to women.

The next group of symptoms includes items such as aches and pains in the body, palpitation, restlessness, lump in the throat, sinking and emptiness in the stomach, these are all clinical manifestation of anxiety. They are present between 20% to 30% of all subjects initially, but they show a rapid resolution during first three months and are practically absent at six months except for complaints of aches and pains, which are reported by 36%, of the women and none of the men. Feeling of guilt is reported by 18% of all the subjects initially, this remains unchanged during the first 6 months and then drops only 3 percentage points to 15% at the end of 1 year. Thus this symptom though present in only 1 out of 5 bereaved subjects, in those whom it occurs, it tends to persist and is not affected by the passage of time.

The remaining symptoms seem to represent the coping mechanisms employed by the bereaved to handle the stressful situation. The most commonly used mechanism is withdrawal from social activities and avoidance of places and persons which evoke memories of the dead person. Initially it is indistinguishable from the social withdrawal and dullness related with the subjective depressive state but later this avoidance behaviour is seen to persist even after recovery from the depression. On the other hand, the other symptoms i.e. increased religiosity and belief in power of fate, are seen in 34% and

25% subjects in the first weeks and gradually increase over time. Increased religiosity is reported by 54% at 6 months and 41% at 1 year. The fall in increased religious activities after the 6 months is entirely due to reduction among the men from 59% to 36%. In women the figure remains constant at 50%.

Finally, the symptoms of weight loss, and premature ageing, manifesting as 'early greying of hair and wrinkling of face', which were not present at the time of initial contact, but were noticed first during the 2nd or 3rd months after the bereavement. Premature ageing was recorded in one-third of all subjects (34%) and loss of weight in 18% at 6 months and increased slightly to 34% and 21% by end of 1 year. For both these symptoms there was a marked sex difference–the symptom were significantly more in females as compared to males, weight loss was seen in 32% females as compared to 4% of males at end of six months and 32% and 9% at the end of 1 year. For premature, ageing figures were 64% and 4% at end of six months and same at 1 year, in females and males respectively.

DISCUSSION

Symptomatology of Acute Grief: The finding of the present study suggests that the process of grief and mourning is not a simple adjustment reaction with anxiety and depressive symptoms but is a major stressful event which sets in motion various adaptive processes at the biological, psychological and social spheres. All our subjects experienced marked distress with the first eight symptoms being experienced by over 90% of the subjects and the first 12 symptoms by over 50% of all subjects. This is in contrast to the finding of Clayton et al. (1968). However the very low incidence and variety of symptoms recorded in their study are possibly related to the following factors (a) 20 out of 50 patients' relatives were not available for study. It is quite possible that they were suffering from a more severe grief reaction and therefore avoided the interview, (b) The use of the depressive inventory for the recording of symptoms of grief precluded the recording of other symptoms of psychological distress, (c) It is well recognized that in adults the reaction to bereavement varies with the closeness of the relationship with the deceased, (d) All the deceased persons were admitted in hospital for serious ailments which had existed for between 3 months to 10 years prior to their death.

Outcome of Acute Grief: Although the prominent symptoms of grief all seem to subside by 6 months, which appears to be a biological end point for the grief reaction certain symptoms like an inner sadness or despair alongwith an idealized image of the lost person and the tendency to retain articles which remind one of the lost person tends to persist for a much longer time alongwith the development of psychosomatic symptoms that did not exist before and are probably long term consequences of having undergone a severe traumatic event–the bereavement and its consequent mourning process.

A long term follow-up is necessary to clarify the significance of this association as well as the role of other intervening variables such as the role of various coping mechanisms, used by the individual and the extent and nature of social support systems available to him during this period. Recovery from bereavement thus does not mean that the person returns to being the same person as he was before, nor do they forget the past and start a new life. Rather it implies: (a) intellectual and (b) emotional acceptance of the loss, (c) to modify his/her concept of self and relation with significant others and (d) an altered perception and relationship to the outside world.

The course of normal grief:

The course of normal grief can be visualized as occurring in the following four phases

during the first year. The time periods are average figures and there is considerable overlaps in individual cases (I) Phase of shock : 0-2 to 3 days; (II) Phase of stunned sadness, and hopelessness: 2-3 days to 2-3 months; (III) Phase of resolution: 2-3 months to 6 months; (IV) Chronic residual phase : 6 months onwards.

(I) *Phase of Shock* : This phase reveals that soon after having the news of the death there is an immediate reaction of (i) shock, (ii) feeling of numbness, and (iii) disbelief, (iv) denial of the death that has occurred. This phase may last from a few minutes or hours to a few days. The person may refuse to accept the fact that his loved one has actually died.

(II) *Phase of Stunned, Sadness and Hopelessness* : The second phase in the normal grief pattern consists of symptoms such as (a) stunned behaviour, (b) sadness and (c) hopelessness. This phase lasts from a few days to approximately 6-8 weeks. The individual is seen to be in a stunned state after certain amount of acceptance of the death of the deceased has taken place. Sadness of mood alongwith excessive weeping commences as the hard reality dawns on the bereaved. The bereaved individual looks despirited and feelings of hopelessness and helplessness are present. Psychomotor slowing is present. Periodic or continuous sighing is observed, the latter being more frequent in the first few weeks. Expression of guilt also starts from this phase in as small number of cases who hold themself responsible for the tragedy. For example statements such as, 'I wish I had not forced the child to get up and go when he did not wish to', 'I had enough indications, and still I sent him' are common. In the majority however, blaming of other individuals commences and is a prominent symptom in three-fourth of all subjects.

(III) *Phase of Resolution* : The next phase is the phase of resolution in which an individual after finally acccpting the finality of death tries to resolve or overcome the grief. This phase is seen to last from 6-8 weeks to 6 months. During this phase there is recovery from the apathy and dullness of the bereaved individual, seen earlier, and this is replaced by restless overactivity. In addition they show prominent somatic complaints, as having generalized aches and pains in the body etc. Idealization of the lost person still persists. Further, the tendency to blame others increases and there is an open expression of hostility. In our study, the parents had sued the school for negligence, some took active participation in taking out processions against the school authorities etc. However, the belief in fate also becomes more often expressed and becomes more prominent till the end of the first 6 months. The parent eventually starts believing that 'this was in my fate 'and' that this had to happen' etc. They are seen to become more religious and take active participation in holding of certain religious ceremonies than before.

Interestingly, we found that the above symptoms tend to decrease towards the end of this phase and there is a compensatory, replacing of the deceased or substituting starts almost towards the end of this phase. Parents start thinking of having another child in the belief that 'the same child will come back to us'. This search for the lost one persists and we found that almost 50% of the parents had decided to have another baby.

There seems to be a definite end-point in the sense that majority of symptom of acute grief (except sadness, and preoccupation with the image of deceased and idealization of the deceased) tend to subside by the sixth month.

(IV) *Chronic Residual Phase* : The last phase which lasts from 6 months to 1 year or more is the Chronic Residual Phase which shows the persistence of the symptom of sadness of mood. Only when alone or talking about the child they would occasionally weep

and recall the good qualities of the deceased, idealize him and remembered vividly certain events which increased their memories about the child, but at other times they function normally and do not show any evidence of a depressive reaction. They describe this state as one of 'despair'. This is associated with a second attitude of detachment not only from the loved person but from worldly pleasures and life itself. Persistence of belief in fate increased this detachment and acceptance that all was due to 'God's will' helped in the recovery of the bereaveds grief. Premature ageing and weight loss also takes place during this phase and there is considerably more ageing and weight loss seen in females when compared to males. We believe that ageing and weight loss may persist and several other psychosomatic disorders become manifest over the next several years. Further longitudinal follow-up of the subjects is being carried out to find out long term consequences of bereavement.

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