

Grief and Loss

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I opened this protocol by drawing attention to the cross-cultural issues in bereavement care because CARPA is used in regions of northern and Central Australia which have diverse populations, including many different Aboriginal language groups. In many cases service providers are of a different cultural background to clients.¹ Dealing appropriately with bereavement, grief and loss requires some understanding of cultural differences.^{2,3,4} Because of the variety of cultural responses it is inappropriate to be too prescriptive, and the best advice is generally to refer to local knowledge.^{1,5,6,7} The particular cultural issues that arise in many Aboriginal communities and were mentioned in the protocol (e.g. not mentioning the name of the dead, vacating the place where a person has died) are broadly relevant across Aboriginal Australia.^{6,8,9,10,11} This information may be particularly useful for non-Aboriginal workers new to Aboriginal community work.

A significant loss of a child or partner will cause detrimental effects physically, mentally or both in about a third of those most directly affected.¹² Such losses in the short term increase the risk of death from heart disease¹³ and suicide.¹² About 25% of widows and widowers experience major depression and anxiety disorders during the first year after the loss.¹²

The best way to help non-specialist care workers is to emphasise the range of normal grief responses, and advise how to support those who are experiencing normal grief. This helps the grieving person do the work of grief and reduces the harm of an inappropriate intervention. Normal grief responses can include presentations with physical health problems, inability to fulfil normal life functions, and what even appears to be suicidal ideation ('I wish I was dead').¹⁴ Visual and auditory hallucinations about the deceased, the so-called 'hallucinations of widowhood' are reported in about half of recently bereaved widows.¹⁵ These hallucinations can be distinguished from the hallucinations of psychosis by the circumstances in which they arise (appear at times of sleepiness or relaxation, i.e. hypnagogic hallucinations) and their transience – they disappear as soon as the person awakes.¹² Bereavement studies in Western societies have described a series of stages of normal grief reaction, including the anticipatory grief that may occur prior to an expected death.^{16,17} They have also described the responses of shock (including disbelief, denial, anger), acute mourning (searching and yearning, disorganisation, despair) and healing (acceptance, resolving the loss, reorganisation of life) that occur after a loss.^{17,18} Mourning practices are culturally specific.⁴ Examples include the wailing characteristic of Aboriginal mourners and the practice of making 'sorry cuts'. Aboriginal people tend to be more open in their mourning compared with many European Australians.¹⁵

Bereavement experts trained in a Western modality recommend the benefits of therapeutic listening, which includes history telling, and asking specific questions about the deceased, their death, and the relationship between them and the person grieving.^{14,17} They generally recommend mentioning the dead person's name and making frequent eye contact with the bereaved. **This type of bereavement counselling may be intrusive in some cultural circumstances, including in many**

Aboriginal communities.²³ Western models of grief therapy should be adapted to meet Aboriginal cultural needs as well as being responsive to individual experiences of loss.¹⁹ Health workers from outside the cultural group of the bereaved need to vary their responses in a culturally specific manner²⁰ and to seek local guidance about culturally appropriate behaviours.²¹

It was necessary to discuss the many sorts of losses that can result in and aggravate the grief response.¹⁵ This makes it easier to understand how a given death or loss affects an individual, enables identification of an abnormal grief response, and facilitates early specialist referral or intervention.¹⁴ There is some evidence that Aboriginal Australians suffer a high burden of accumulated losses (including those of culture, power, land, and hope), which may compound the grief response.^{19,22,15} Aboriginal families also suffer more premature illness and mortality compared with non-Aboriginal families.¹⁹ Some factors that increase the difficulty of a given bereavement relate to the life experience and personality of the person who is grieving, others to the person who has died, and the manner of their death.

The issue of blame may arise after a death, and 'payback' (revenge) may follow the death of an Aboriginal person, particularly when the death was sudden, unexpected or violent.¹⁵ Many concerns about the death and the care a person received during their last illness arise from poor mutual understanding. Aboriginal informants have emphasised the importance of 'hearing the right story'⁶, therefore there is value in giving information and in frank and open discussion of any concerns. Weeramantiri has recommended a 'post death conference' some weeks after a death to reassure the family that everything possible was done for their relative and to build trust.²³ Non-Aboriginal staff need to be aware of differences in causal attribution between Western medical and traditional Aboriginal belief systems⁷, and recognise the need for the bereaved to establish a 'social' as well as a medical cause of death.⁹

How is the practitioner going to deal with this? On request, find out information and arrange a meeting with family to discuss any issues, but please note you may not have all the answers.

In general, grief associated with the death of an Aboriginal person is handled through the family network, but it is important to recognise when outside help is needed.²³ An Aboriginal health worker (AHW) is more likely to know when there is a problem requiring referral.¹⁵ There is little evidence that pharmacological management is helpful, but specialist support is available from a wide range of psychological and spiritual counsellors.¹⁴ Because of the cultural differences a counsellor from the grieving person's own language and cultural background may be most appropriate. In most cases sleep patterns will return to normal. Occasionally medication can be useful. If asked it is reasonable to offer a brief course (maximum three or four nights) of sleeping tablets to help the person if they are not getting enough rest. Antidepressant medications are not indicated for acute grief.

I concluded the protocol by talking about the feelings of the health care worker because they are rarely acknowledged, yet are very important to both the worker and the patients they try to help.¹ AHWs are particularly vulnerable to stress following a death because they may have been related to the deceased, or cared for them, and may be the subject of blame.²³ A worker's ability to deal with others' grief and loss depends on how well they have been able to resolve their own. Additionally, stress and burnout amongst health care workers could be reduced if their own human experiences and feelings were acknowledged.

People react very differently to losses, depending upon their cultural background, personality, how they tend to handle stresses, previous experiences of a death or loss, and personal and social support.

- A range of emotion is common; ask if there is anything you can do.

Some deaths are harder to cope with, particularly if it was sudden or unexpected, the person had a difficult illness before they died, the family are worried about the care they got before they died, or the person who died was a child or young person.

- People grieving after such a death are more likely to have problems
- Be patient, and listen well to their concerns
- Offer to get any information the family wants about the person's illness and care, then share it with them
- Be open to helping the family seek explanations for the death including finding the autopsy and coronial results.

Do's and don'ts of getting involved in sorry business

Do: explain the conflicts, i.e. provide care, help as asked unless dangerous.

Don't interfere in the sorry process, especially payback and the violent sorry grief.

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