

MOOD DISORDERS

➔ Depression

➔ Survivors Guilt

➔ Loss & Grief

➔ Generalized Anxiety

This pamphlet furnishes general information on Psychological Mood Disorders to assist in understanding the nature of this type of injury or conditions. It will not make you a medical health care or mental health care expert but is just to offer you background information on Psychological Mood Disorders. It is not designed for mental/health care professionals conducting medical or mental health treatment and is not a medical treatment or mental health care reference document. It is also not a Department of Defense official document medical or otherwise. Any difference between the information in this document and any health care professional or mental health care professional should be resolved in favor of the medical, mental and health care professionals. Any references to medical information are not necessarily DoD's health care policies. Should you have a question on medical or mental health care treatment, ask a member of your medical care team or Nurse Case Manager.

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BUT FIRST: MOOD DISORDERS IN GENERAL:

GENERAL INTRODUCTION: **Mood Disorders** include disorders that have a disturbance in mood as the predominant feature. It should be noted that “mood disorders” are a natural consequence of most traumatic brain injuries (TBI).

This West Point ***Wounded Warrior MENTOR Program*** reference handbook is designed for the Mentors, Caregivers, and Survivors.

The subsets of **Mood Disorders** are: Depression & Survivors Guilt .

The major subset of Mood Disorders is **DEPRESSIVE DISORDERS** from which the others generally emanate from—or, in medical terms, are comorbid effects.

DEPRESSIVE DISORDERS

CLASSIFICATIONS OF DEPRESSION

Depressive Disorders (DEPRESSION) are either “Major Depressive Disorder,” “Dysthymic Depressive Disorder” or “Depressive Disorder Not Otherwise Specified.”

- ➔ **Major Depressive Disorder** Characterized by depression symptoms nearly every day, all day—called Major Depressive Episodes--for at least two (2) weeks of depressed mood—feeling sad, blue, down--OR loss of interest in things one used to enjoy accompanied by at least four additional symptoms of depression.
- ➔ **Dysthymic Depressive Disorder** This is characterized by at least two (2) years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet the criteria for a Major Depressive Episode.
- ➔ **Depressive Disorder Not Otherwise Specified** This is included for designating disorders with depressive features that do not meet criteria for Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder with Depressed Mood, or Adjustment Disorder with Mixed Anxiety and Depressed Mood or depressive symptoms about which there is inadequate or contradictory information.

Most of our Wounded Warriors will have “Major Depressive Disorder” --DEPRESSION

DEPRESSION

Major Depressive Episode



The essential feature of a Major Depressive Episode is a period of at least two (2) weeks during which there is either depressed mood or loss of interest or pleasure in nearly all activities. The individual is sad, hopeless, discouraged, or “down in the dumps,” has decreased energy, feelings of worthlessness, feelings of guilt, difficulty thinking, concentrating, making decisions, or, in the worst cases, recurrent thoughts of suicide to include plans and/or attempts. The person is in distress, socially impaired, has occupational challenges, or is personally challenged to do well in areas of normal human functioning—they have to exert increased effort to succeed/act normally in everyday human interactions. Increased irritability is often manifested.¹

¹ Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition, Text Revision. (DSM-IV TR). © 2000 American Psychiatric Association

SYMPTOMS & WARNING SIGNS OF DEPRESSION

Not all people with depression will show all symptoms or have them to the same degree. If a person has four or more symptoms, for more than two weeks, consult a doctor or mental health professional right away. While the symptoms specified for all groups below generally characterize major depression, there are other disorders with similar characteristics including: bipolar illness, anxiety disorder, or attention deficit disorder with or without hyperactivity.

SYMPTOMS OF DEPRESSION

- Feelings of Sadness or Irritability
- Loss of Interest or Pleasures in Activities
- Changes in Weight or Appetite
- Changes in Sleeping Patterns
- Feeling Guilty or Worthless
- Can't Concentrate, Remember Things or Make Decisions
- Fatigue or Loss of Energy
- Restless or Sluggish
- Thoughts of Death or Suicide

Depression is treatable

Nearly 90 percent of people with clinical depression can be treated successfully with medications and psychotherapy done together. Some depressions among the elderly may respond better to electroconvulsive therapy (ECT). ECT is an effective treatment that is used in extremely severe cases of major depression when very rapid improvement is necessary, or when medications cannot be used or have not worked. Improved procedures make this treatment much safer than in previous years.

FOLLOWING AMERICAN PSYCHOLOGICAL ASSOCIATION ARTICLES ARE OFFERED AS REFERENCE MATERIAL²

1. Depression and How Psychotherapy and Other Treatments Can Help People Recover

- How Does Depression Differ From Occasional Sadness?
 - What Causes Depression?
 - Can Depression Be Successfully Treated?
 - How Does Psychotherapy Help People Recover From Depression?
 - In What Other Ways Do Therapists Help Depressed Individuals and Their Loved Ones?
 - Are Medications Useful for Treating Depression?
 - In Summary
-

According to the National Institute of Mental Health, an estimated 17 million adult Americans suffer from depression during any 1-year period. Depression is a real illness and carries with it a high cost in terms of relationship problems, family suffering, and lost work productivity. Yet, depression is a highly treatable illness.

How Does Depression Differ From Occasional Sadness?

Everyone feels sad or "blue" on occasion. It is also perfectly normal to grieve over upsetting life experiences, such as a major illness, a death in the family, a loss of a job, or a divorce. But, for most people, these feelings of grief and sadness tend to lessen with the passing of time.

² The American Psychological Association (APA), in Washington, DC, is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. APA's membership includes more than 148,000 researchers, educators, clinicians, consultants and students. Through its divisions in 54 subfields of psychology and affiliations with 60 state, territorial and Canadian provincial associations, APA works to advance psychology as a science, as a profession and as a means of promoting human welfare.

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However, if a person's feelings of sadness last for 2 weeks or longer, and if they interfere with daily life activities, something more serious than "feeling blue" may be going on.

Depressed individuals tend to feel helpless and hopeless and to blame themselves for having these feelings. People who are depressed may become overwhelmed and exhausted and may stop participating in their routine activities. They may withdraw from family and friends. Some may even have thoughts of death or suicide.

What Causes Depression?

There is no single answer to this question. Some depression is caused by changes in the body's chemistry that influence mood and thought processes. Biological factors can also cause depression. In other cases, depression is a sign that certain mental and emotional aspects of a person's life are out of balance. For example, significant life transitions and life stresses, such as death of a loved one, can bring about a depressive episode.

Can Depression Be Successfully Treated?

Yes, it can. A person's depression is highly treatable when he or she receives competent care. It is critical for people who suspect that they or a family member may be suffering from depression seek care from a licensed mental health professional who has training and experience in helping people recover from depression. Simply put, people with depression who do not seek help suffer needlessly. Unexpressed feelings and concerns accompanied by a sense of isolation can worsen a depression; therefore, the importance of getting appropriate help cannot be overemphasized.

How Does Psychotherapy Help People Recover From Depression?

Several approaches to psychotherapy, including cognitive-behavioral, interpersonal, and psychodynamic, help depressed people recover. Psychotherapy offers people the opportunity to identify the factors that contribute to their depression and to deal effectively with the psychological, behavioral, interpersonal, and situational causes. Skilled therapists can work with depressed individuals to:

- ✓ **Pinpoint the life problems that contribute to their depression and help them understand which aspects of those problems they may be able to solve or improve.**

A trained therapist can help depressed patients identify options for the future and set realistic goals that enable them to enhance their mental and emotional well-being. Therapists also help individuals identify how they have successfully dealt with similar feelings if they have been depressed in the past.

- ✓ **Identify negative or distorted thinking patterns that contribute to feelings of hopelessness and helplessness that accompany depression.**

For example, depressed individuals may tend to overgeneralize, that is, to think of circumstances in terms of "always" or "never." They may also take events personally.

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- A trained and competent therapist can help nurture a more positive outlook on life.
- ✓ **Explore other learned thoughts and behaviors that create problems and contribute to depression.**
For example, therapists can help depressed individuals understand and improve patterns of interacting with other people that contribute to their depression.
- ✓ **Help people regain a sense of control and pleasure in life.**
Psychotherapy helps people see choices as well as gradually incorporate enjoyable, fulfilling activities back into their lives.

Having one episode of depression greatly increases the risk of having another episode. There is some evidence that ongoing psychotherapy may lessen the chance of future episodes or reduce their intensity. Through therapy, people can learn skills to avoid unnecessary suffering from later bouts of depression.

In What Other Ways Do Therapists Help Depressed Individuals and Their Loved Ones?

The support and involvement of family and friends can play a crucial role in helping someone who is depressed. Individuals in the "support system" can help by encouraging a depressed loved one to stick with treatment and practice the coping techniques and problem-solving skills he or she is learning through psychotherapy.

Living with a depressed person can be very difficult and stressful on family members and friends. The pain of watching a loved one suffer from depression can bring about feelings of helplessness and loss. Family or marital therapy may be beneficial in bringing together all the individuals affected by depression and helping them learn effective ways to cope together. This type of psychotherapy can also provide a good opportunity for individuals who have never experienced depression themselves to learn more about it and identify constructive ways of supporting a loved one who is suffering from depression.

Are Medications Useful for Treating Depression?

Medications can be very helpful for reducing the symptoms of depression in some people, particularly in cases of moderate to severe depression. Often a combination of psychotherapy and medications is the best course of treatment. However, given the potential side effects, any use of medication requires close monitoring by the physician who prescribes the drugs.

Some depressed individuals may prefer psychotherapy to the use of medications, especially if their depression is not severe. By conducting a thorough assessment, a licensed and trained mental health professional can help make recommendations about an effective course of treatment for an individual's depression.

In Summary

Depression can seriously impair a person's ability to function in everyday situations. But the prospects for recovery for depressed individuals who seek professional care are very good. By working with a qualified and experienced therapist, people suffering from depression can help regain control of their lives.

When do meds make the difference?

For most nonpsychotic conditions, empirically supported therapies and medications yield similarly good results, but therapy is better over the long haul, research finds. Research on depression shows that medications and empirically supported therapies such as cognitive behavioral therapy (CBT) and interpersonal therapy are equally effective, with each modality helping about 60 percent of clients, notes Hollon. Combined treatments produce even better results: In a literature review in the April 2005 *Journal of Clinical Psychiatry* (Vol. 66, No. 4, pages 455–468), Hollon and colleagues found that, in general, combining medication and therapy raised treatment effectiveness to as much as 75 percent. "While that's not a huge increment in terms of the likelihood that someone will get better, you get a faster, more complete and more enduring response when you put drugs and therapy together," Hollon says.

2. DEPRESSION MAY PLAY A BIGGER ROLE IN READJUSTMENT THAN PREVIOUSLY THOUGHT IN TROUBLED VETS³

New Study Finds Vets with Depression Diagnosis Face Increased Risk of Family Problems and Domestic Abuse

SAN FRANCISCO—Depression may be an unrecognized readjustment problem for recently returning veterans of the conflicts in Iraq and Afghanistan, according to a study released today at the American Psychological Association 115th Annual Convention. Researchers working with veterans referred for psychiatric evaluation from a primary care service found that major or minor depression was associated with domestic abuse and other family problems.

The researchers, at the University of Pennsylvania and the Mental Illness, Research Education, and Clinical Center at the Philadelphia VA Medical Center, looked at the family problems of 168 veterans who were referred for behavioral health evaluation and who had served in Iraq or Afghanistan since 2001. More than 40 percent were currently married or cohabiting, some 21 percent were recently separated or divorced and almost 55 percent had at least one child.

Two-thirds of the married/cohabiting veterans reported some type of family readjustment problem or conflict occurring several times a week: 42 percent felt like a guest in their household, 21.8 percent reported their children were not acting warmly or were afraid of them, and 35.7 percent were unsure about their role in regular household responsibilities. Veterans with depression or PTSD were more likely to experience these readjustment problems. The presence of family problems may limit the effectiveness of treatments for depression or PTSD because of the importance of positive family relationships to veterans' recovery. According to the researchers, the results suggest an opportunity to improve treatment for returning veterans by involving family in the veteran's recovery.

In addition, about 56 percent of the patients with current or recently separated partners reported severe conflicts involving "shouting, pushing or shoving," and 35 percent reported that this partner was afraid of them.

The researchers, led by Steven L. Sayers, PhD, of the Philadelphia VA Medical Center, noted that while there has been very little empirical research focused on the family problems of veterans in the first year or two following their return from a major military conflict, family problems among those with partners are common. The rates of problems found in this study were similar to those in longer-term studies of Vietnam veterans diagnosed with PTSD.

³ **APA Presentation:** "Family Problems Among Recently Returning Military Veterans," Steven L. Sayers, PhD, Victoria Farrow, BA, Jennifer Ross, MS, Christine Beswick, BA, Lauren Sippel, BA, Vince Kane, MSW, David W. Oslin, MD. © 2008 American Psychological Association

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“In the current study, however, we did not find that PTSD was associated with overall rates of family problems,” the researchers wrote. “In contrast, depression was most consistently related to the presence of both readjustment and domestic abuse problems.” Many of the veterans at the Medical Center with PTSD were already in treatment in the Behavioral Health Service and so were not part of this primary care sample referred for evaluation.

The researchers found that specific role-related readjustment problems were related both to depression and PTSD. For example, whereas about 20 percent of the veterans reported that their children were afraid of them or did not act warmly, those with PTSD were at greater risk of this experience (36 percent).



Survivor's Guilt, Loss & Grief



Survivor guilt, otherwise known as survivor syndrome, is the mental condition that results from the appraisal that a person has done wrong by surviving traumatic events such as combat, natural disasters, or even surviving a lay-off in a work place. The effect of survivor's guilt depends on the person's own psychological make-up.

Some of our Wounded Warriors will be experiencing survivor guilt because they made it out alive when their buddies did not.

It is a special form of **Depression & PTSD**, this is a deep sense of guilt, combined often with feelings of numbness and loss of interest in life, felt by those who have survived some catastrophe. It was first noticed among survivors of the Holocaust. Survivors often feel that they did not do enough to save those who died or that they are unworthy relative to the perished. It is fairly common among close combat veterans, especially those who were seriously wounded while their buddies died. The Wounded Warriors feels that their buddies who died (KIA) were better persons than themselves and feel guilty about them dying and not themselves.

Most combat veterans were entering late adolescence or early adulthood when they first experienced combat trauma. This is a time of reworking early conflicts and forming a more mature personality. Trauma injected at this time delays or truncates this process. The veterans in combat fear being overwhelmed by the conflict between survival needs and previously established moral and ethical beliefs and understandings of their sense of self. This conflict often produces guilt.⁴

History

Survivor guilt was first diagnosed during the 1960s. Several therapists recognized similar if not identical conditions among Holocaust survivors. Similar signs and

⁴ Professional Psychology: Research and Practice. 1989, Vol. 20, No. 3, 159-165. Copyright 1989 by the American Psychological Association,

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symptoms have been recognized in different traumatic situations in such as combat, natural disasters and surviving significant job layoffs. All have resulted in symptoms, which are now known as survivor guilt or survivor syndrome. A variance of survivor guilt developed in cases of different rescuers who have blamed themselves for not doing enough to help others in emergencies. Along the same ideal, therapists may also feel a form of guilt for their patients' suffering.

CLASSIFICATIONS:

Five types of guilt in response to combat trauma are identified on the basis of clinical experience or accounts in the literature: “survivor,” “demonic,” “moral/spiritual,” “betrayal/ abandonment,” and “superman/superwoman” guilt. Each of the five is described and then conceptualized in cognitive, affective, and behavioral terms.

Survivor's Guilt

Combat veterans carry with them a sense that they should have died, that they do not deserve to live, and that somehow their survival has cheated someone else out of living. Specifically, the tone of survivor guilt is that “someone died so that I can live.” In its more extreme form, survivor guilt includes the convoluted notion that the soldier killed his or her friends so that he or she could live. This orientation is often accompanied with the obligation to live for that other person; if one gets to the point at which one's own life is viewed as a failure, he or she believes that he or she has failed that other person. This can give rise to a painful paradox: One wishes to die in order to give meaning to one's life. This “death to appease another” then conflicts with the inherent will to live.

The soldier frequently experiences a wish or desire to join his dead comrades and is often unable to feel permission to fully join the ranks of the living. A second example, also from Vietnam, is of a soldier who tripped a booby trap, which resulted in his being seriously wounded and the death of the man behind him. He often experiences helplessness that accompanies the need to pay for the other man's death. Not only does he feel responsible for his fellow soldier's death, but he also feels guilt for having “cheated” death and therefore survived.

The veteran conveys a pervasive sense of unworthiness, preoccupation with one or more deceased comrades, and three of the following characteristics:

1. A belief that he or she should have died or does not deserve to live.
2. Feeling like a cheat: Someone died so that the veteran could live.
3. Living primarily for dead persons by concentrating their emotional or psychic energy primarily on/to the dead persons rather than for or to the living.
4. A fear of success or self-sabotage.
5. Dysthymic symptoms.
6. Indifference to living, with episodic life-threatening risk taking behavior.

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7. Self-medicating with drugs or alcohol, or both.
8. Using denial as a primary defense.

✓ Demonic Guilt

Demonic guilt grows out of being aware of, observing, or participating in the most despicable aspect of humanity, warfare ([Lifton, 1973](#)). Being a part of warfare makes the warrior aware of the monster, killer, animal, or devil that can exist in each human being. Demonic guilt may become further entrenched in the combat soldier if he or she experienced joy and power from being engaged in warfare or other aggressive acts, which relieved his or her sense of helplessness in a combat arena. Soldiers who tend to feel demonic guilt may have had experiences that included enjoying killing or observing atrocities or “unnecessary” killings and losing control to the point at which they felt “berserk.”

The veteran's primary affect is a pervasive, angry condemnation of current atrocities committed by persons either known to the veteran or reported by the news media. This is linked with repeated verbalizations of indifference to death and at least four of the following characteristics:

1. Description of one's anger as uncontrollable and of terrifying proportions.
2. Personal isolation and devaluing of relationships.
3. Being sexually dysfunctional, but often describing oneself as otherwise.
4. Feeling inhuman and describing oneself as a “monster,” a “killer,” an “animal,” or a “devil.”
5. Substance abuse that is episodic, if present at all.
6. Extreme fear of loss of control.
7. Paranoid content to verbalizations that are centered on the idea that there is an inherent flaw in humans that eventually leads them to harm him or her.

✓ Moral/Spiritual Guilt

Moral/spiritual guilt grows out of the violation of “normal” human expectations. Warriors, as all others, have been socialized to conform to nonwarfare rules of conduct, including the most obvious one, “Thou shalt not kill.” Combat requires the violation of this and many other social precepts. Therefore, the soldier bears a disproportionate amount of the collective guilt that a society feels for being a part of something evil. That type of displacement is particularly true for the Vietnam veteran, as testified by the poor reception that many received on returning home. In addition, many lost their friends from home because after their return from combat, they had very little in common with their former friends. Therefore, soldiers often ended up feeling forever severed from society. In the most extreme form of moral/spiritual guilt, many feel so alienated from their society, which includes the predominant religious beliefs of Judeo-Christian systems, that they believe that they cannot be forgiven and are therefore condemned to

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hell. Their spiritual connection to Western cultural values has been severed and, with it, so has their avenue for forgiveness.

The veteran feels condemned for his or her behavior believes that he or she should be punished, and evinces four of the following characteristics:

1. Alienation from society and its institutions.
2. Often acting in an apparently sociopathic, corrupt, or uncaring manner.
3. A belief that he or she cannot be forgiven for terrible deeds and may be condemned to hell.
4. A belief that he or she owes an enormous debt.
5. Feeling abandoned by society and God.
6. Intellectualizing anger.
7. Seeming not to have a stable value system.
8. Finding fault with and criticizing all major institutions.

✓ **Betrayal/Abandonment Guilt**

Betrayal/abandonment guilt is one's struggle with the concern that one did not do enough for one's fellow soldiers in combat. The veteran's guilt is embodied in some statement that resembles the notion that "I had it pretty easy, compared to most." The guilt seems to grow out of the overwhelming fear of being abandoned, captured, wounded and left behind, or killed. The overwhelming fear leads to a collective helplessness that generates a disproportionate share of responsibility. [Falk \(1982\)](#) wrote about Israeli soldiers who were hospitalized with serious wounds. They "escaped" from the hospitals and rejoined their units, which were in active combat, because "their consciences" were unrelenting

The veteran feels ostracized from society and feels responsible for his or her status. The veteran appears to be extremely angry and evinces at least four of the following characteristics:

1. A tendency to describe himself or herself as selfish, heartless, and uncaring.
2. A belief that he or she did not do enough in combat.
3. Fears of committing to deep, intimate relationships.
4. Persistently characterizing his or her actions as being cowardly or shameful, even in the face of contrary evidence.
5. Experiencing rage over seemingly trivial social slights and angrily withdrawing from future contact.
6. Often appearing slumped or small because of feelings of shame.
7. Characterizing one's relationships with one's parents as "disappointing."

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✓ Superman/Superwoman Guilt

☞ Superman/superwoman guilt develops most specifically from the helplessness that is experienced in combat. In order to cope, soldiers often develop the notion that they have superhuman qualities: They can see in the dark or smell ambushes, or they have a sixth sense that they are going to get “hit” at a particular time. (Krystal, 1971) reported that this phenomenon also occurs with concentration camp survivors; during that experience, many regress to infantile, omnipotent, magical thinking. Therefore, from the veterans' view, they could have prevented many of the catastrophes that did occur. (Terr, 1983) reported a similar process for the Chowchilla survivors. Ten of the 11 came to believe that they had an omen of the disaster. Terr's interpretation is that they needed to change the event in order to stop feeling profoundly helpless. This was accomplished by their creation of an omen. The survivors are consequently left with guilt for not having acted on the omen. Of course, the victims do not have that view at a rational level (Parson, 1986). As a result, veterans often carry powerful feelings of guilt because they could not muster their superhuman abilities at a time when it was vitally important. Therefore, they carry a profound sense of failing others, as well as themselves. These superhuman feelings can also be bestowed by the military on individuals such as medics, officers, radio telephone operators, or noncommissioned officers. Whether developed or bestowed, the power of belief in prescience leads these clients to feel that they alone are in charge of group safety. Clients with this guilt feel personally responsible but helpless in the face of their human limitations.

The veteran expresses a strong sense of inadequacy and evinces at least four of the following characteristics:

1. Past or present use of magical thinking (e.g., that thoughts caused one's behavior in Vietnam).
2. A belief that one had superhuman abilities in combat.
3. Having experienced omens in combat.
4. A belief that no one, including most other combat veterans, could understand him or her.
5. Avoiding responsibility in current life.
6. A demanding and harsh superego.
7. Over controlling significant others in daily life.
8. Occupation, while in combat, of a leadership or key (e.g., medical) position.

Social responses

After many acute situations, people with survivor guilt may help others with other survival different coping options. Such is evident in the emergency responses and different high paced and stressful occupations. Over time guilt may be displayed indirectly by playing down one's survival because of the guilt of another's death in one acute situation. The questions may continue to go through one's head: "Why did I

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survive?", "Why not me?", "What am I going to do now"? Much of self-blame and depression from survival guilt will affect one's friendships and way of life.

Moral features

Moral features will include the one self-suffering from survival guilt blaming one's self for someone else's death. This sense of guilt may be extremely enhanced if another soldier died while saving the Wounded Warrior's life. An additional example would when a soldier switches a patrol with a friend for a combat patrol. Then during that particular patrol the friend dies, leaving the other friend with guilt of surviving and the thought that it should have been him. Unjustified survivor's guilt occurs in all traumatic situations. Situations such as being put in a place where one wasn't able to revive someone one may have loved, or were forced physically to prevent someone being tragically harmed or killed. Many situations of survival guilt result in a situation where nothing can be done. Treatment and recovery are the same as for PTSD.

Treatment

The idea of preventing survivor guilt is part of the solution process for early disaster intervention and grief therapy. Treatment is a very complex procedure in which the first part of treatment is recognizing the fact of having guilt over a particular incident. After that and thorough in-depth analysis of the circumstance help reveals the ultimate reasoning behind the suffering. After the recognition, the presentation of alternative hopeful views helps to lower the patient's defense barriers. The emotional damage and trauma is then recognized, released and treated. This is to help the survivor build up stronger self-confidence, in hopes to help relieve some of the guilt. The survivor must then come to the realization that the past events were caused by misfortune, not the survivor. Being able to view oneself as a sufferer and not as an executor lets the survivor mourn and achieve a new determined life

LOSS & GRIEF

Grief is a multi-faceted response to loss. Although conventionally focused on the emotional response to loss, it also has physical, cognitive, behavioral, social and philosophical dimensions. Common to human experience is the death of a loved one, whether it be a friend, a family member, or other close companion. While the terms are often used interchangeably, bereavement often refers to the state of loss, and grief to the reaction to loss. Losses can range from loss of employment, pets, status, a sense of safety, order or possessions to the loss of the people nearest to us. Our response to loss is varied and researchers have moved away from conventional views of grief (that is, that people move through an orderly and predictable series of responses to loss) to one that considers the wide variety of responses that are influenced by personality, family, culture, and spiritual and religious beliefs and practices.

Bereavement, while a normal part of life for us all, carries a degree of risk when limited support is available. Severe reactions to loss may carry over into familial relations and cause trauma for children, spouses and any other family members: there is an increased risk of marital breakup following the death of a child, for example. Many forms of what we term 'mental illness' have loss as their root, but are covered by many years and circumstances that often go unnoticed. Issues of personal faith and beliefs may also face challenge, as bereaved persons reassess personal definitions in the face of great pain. While many who grieve are able to work through their loss independently, accessing additional support from bereavement professionals may promote the process of healing. Grief counseling, professional support groups or educational classes, and peer-led support groups are primary resources available to the bereaved. In the United States, local hospice agencies may be an important first contact for those seeking bereavement support.

Stage theories and processes

Some researchers such as Dr. Elisabeth Kübler-Ross and others have posited sequential stages including denial, anger, bargaining, depression and acceptance, which are commonly referred to as the "grief cycle." As research progressed over the past 40 years, many who worked with the bereaved found stage models too simplistic and instead began to look at processes, dynamics, and experiences common to all. John Bowlby, a noted psychiatrist, outlined the ebb and flow of processes such as Shock and Numbness, Yearning and Searching, Disorganization and Despair, and Reorganization. Bowlby and Parkes both note psychophysiologic components of grief as well. Included in these processes are:

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Shock and denial

Feelings of unreality, depersonalization, withdrawal, and an anesthetizing of affect. Unable to come to terms with what just occurred.

Volatile Reactions

"Whenever one's identity and social order face the possibility of destruction, there is a natural tendency to feel angry, frustrated, helpless, and/or hurt. The volatile reactions of terror, hatred, resentment, and jealousy are often experienced as emotional manifestations of these feelings." (see the article entitled [*The Grieving Process*](#) by Michael R. Leming and George E. Dickinson)

Disorganization and despair

These are the processes we normally associate with bereavement, the mourning and severe pain of being away from the loved person or situation.

Reorganization

Reorganization is the assimilation of the loss of something or someone and redefining of life and meaning without the deceased.

Risks

Many studies have looked at the bereaved in terms of increased risks for stress-related illnesses. Colin Murray Parkes in the 1960s and 1970s in England noted increased doctor visits, with symptoms such as abdominal pain, breathing difficulties, and so forth in the first six months following a death. Others have noted increased mortality rates (Ward, A.W. 1976) and Bunch et al found a five times greater risk of suicide in teens following the death of a parent. Grief puts a great stress on the physical body as well as on the psyche, resulting in wear and tear beyond what is normal.

Normal and Complicated GRIEF

Complicated grief can be differentiated from normal grief, in that, normal grief typically involves at least two of Elisabeth Kubler-Ross' 5 grief stages, though not necessarily in any order. Complicated grief typically cycles through these 5 stages (see below) and then some, processing them out of order and often much more rapidly. Some people commit suicide to end the pain and suffering of grief. Examples of complicated grief can often be found in those who have survived a suicide attempt (Hsu, 2002). While the experience of grief is a very individual process depending on many factors, certain commonalities are often reported. Nightmares, appetite problems, dryness of mouth, shortness of breath, sleep disorders and repetitive motions to avoid pain are often reported, and are perfectly normal. Even hallucinatory experiences may be normal early in grief, and usual definitions will not suffice, necessitating a lot of grace for the bereaved. Complicated grief responses almost always are a function of intensity and timing: a grief that after a year or two begins to worsen, accompanied by unusual

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behaviors, is a warning sign, but even here, caution must be used; it takes time to say goodbye.

Complicated grief is usually grief where the story of the loss is in some ways difficult to tell. Deaths such as suicides, murders, car crashes, and almost any other sudden and unexpected death can result in complicated grief simply because they leave people in such shock that they have great difficulty in integrating what happened into their reality. A simple way to describe this is that there is something that keeps the person from being able to integrate the "story" of the loss and therefore it leaves the person struggling with an initial task of simply believing that the loss has occurred. Variables surrounding the death such as expectedness, naturalness, presence of violence, ambivalence, degree of attachment, and others play into the presence of complicated grief. All too often complicated grief can last for years and most people (friends of the mourner) will recoil when hearing that this sort of grief may still be present after several years. This needs to be differentiated from the clinical problem of becoming "identified" with the grief where people are reluctant to release the grief due to the grief having become a static part of who the person sees themselves as being. It takes a good therapist to be able to tell the difference. It is sometimes very difficult for a layperson to tell the difference. Use caution.

Types of bereavement

Differing bereavements along the life cycle may have different manifestations and problems which are age related, mostly because of cognitive and emotional skills along the way. Children will exhibit their mourning very differently in reaction to the loss of a parent than a widow would to the loss of a spouse. Reactions in one type of bereavement may be perfectly normal, but in another the same reaction could be problematic. The kind of loss must be taken under consideration when determining how to help.

***Please pay special attention to the following section on 'Other losses' because this is what you may encounter most often when dealing with Wounded Warriors.*

OTHER LOSSES: Their.....

- Loss may center around the death of their fellow service members
- **LOSS OF SELF IMAGE**: Loss of their image of themselves; a loss of who or what I am, etc.; this is sometimes referred to as the **"anomic syndrome"** from the root word *anomie*—loss of self.

LOSS OF SELF IMAGE:

Loss of their image of themselves (body image because of a missing limb(s), severe scarring, movement restriction because of a wheelchair, loss of who or what I am, etc.); this is sometimes referred to as the “anomic syndrome” from the root word anomie—*loss of self*—where people are confused and frustrated about how to develop and carry on their (new) lives because they have “lost” the old self; where a person no longer has a sense of continuity—a sense of “rootlessness”—disorganization of the “self” We can call this the “Unknown Wound on an Unseen Front”

→ SERIOUS because it is a major cause of suicide.

- Loss of a career (they must choose whether to stay in the military or not and sometimes this choice will not be theirs; they might have to change specialties because their injuries have now placed limitations on what they can do);
- Loss of a Relationship: their spouse or significant other may leave them because they can't deal with this new person so there will be a loss of a relationship, companionship, and love;
- Loss of friendships because others cannot handle their buddy's change, experiences, and others.

This is to give you an idea that grief and bereavement can be more than just the death (loss) of a person. Please take this into consideration if the service member is female and has been disfigured. America is a country that judges women by how they look and not by their character or what they have accomplished. They have an added burden to bear when they have been injured serving our country.

Elisabeth Kübler-Ross - five stages of grief⁵

Again, while Kübler-Ross's focus was on death and bereavement, the grief cycle model is a useful perspective for understanding our own and other people's emotional reaction to personal trauma and change, irrespective of cause.

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Stages	Interpretation
1 - Denial	Denial is a conscious or unconscious refusal to accept facts, information, reality, etc., relating to the situation concerned. It's a defense mechanism and perfectly natural. Some people can become locked in this stage when dealing with a traumatic change that can be ignored. Death of course is not particularly easy to avoid or evade indefinitely.
2 - Anger	Anger can manifest in different ways. People dealing with emotional upset can be angry with themselves, and/or with others, especially those close to them. Knowing this helps keep detached and non-judgmental when experiencing the anger of someone who is very upset.
3 - Bargaining	Traditionally the bargaining stage for people facing death can involve attempting to bargain with whatever God the person believes in. People facing less serious trauma can bargain or seek to negotiate a compromise. For example "Can we still be friends?" when facing a break-up. Bargaining rarely provides a sustainable solution, especially if it's a matter of life or death.
4 - Depression	Also referred to as preparatory grieving. In a way it's the dress rehearsal or the practice run for the 'aftermath' although this stage means different things depending on whom it involves. It's a sort of acceptance with emotional attachment. It's natural to feel sadness and regret, fear, uncertainty, etc. It shows that the person has at least begun to accept the reality.
5 - Acceptance	Again this stage definitely varies according to the person's situation, although broadly it is an indication that there is some emotional detachment and objectivity. People dying can enter this stage a long time before the people they leave behind, who must necessarily pass through their own individual stages of dealing with the grief.

ANXIETY DISORDER

GENERALIZED ANXIETY DISORDER⁶:

The essential feature of ***Generalized Anxiety Disorder (GAD)*** is excessive anxiety and worry (apprehensive expectation), occurring more days than not for a period of at least 6 months, about a number of events or activities. The individual finds it difficult to control the worry. The anxiety and worry are accompanied by at least three additional symptoms from a list that includes: restlessness; becoming easily fatigued; difficulty concentrating; irritability; muscle tension; and disturbed sleep. Although individuals with ***Generalized Anxiety Disorder*** may not always identify the worries as “excessive,” they report subjective distress due to constant worry, have difficulty controlling the worry, or experience related impairment in social, occupational, or other important areas of functioning.

The intensity, duration, or frequency of the anxiety and worry is far out of proportion to the actual likelihood or impact of the feared event. The person finds it difficult to keep worrisome thoughts from interfering with attention to tasks at hand and has difficulty stopping the worry. Adults with *Generalized Anxiety Disorder* often worry about everyday, routine life circumstances such as possible job responsibilities, finances, the health of family members, misfortune to their children, or minor matters (such as household chores, car repairs, or being late for appointments).

ASSOCIATED FEATURES AND DISORDERS:

Associated with muscle tension, there may be trembling, twitching, feeling shaky, and muscle aches or soreness. Many individuals with *Generalized Anxiety Disorder* also experience somatic⁷ (of or relating to the body) symptoms (e.g., sweating, nausea, or diarrhea).

Generalized Anxiety Disorder very frequently co-occurs with Mood Disorders.

**SEE NEXT PAGE FOR DSM IV TR DIAGNOSTIC CRITERIA
FOR GENERALIZED ANXIETY DISORDER>>>>>>>>>>>>>>>>**

⁶ DSM IV TR Diagnostic Code 300.02

⁷ Of or relating to the body, esp. as distinct from the mind. It means 'of the body'—relating to the body. In medicine, somatic illness is bodily, not mental illness.

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DIAGNOSTIC CRITERIA FROM DSM IV TR 300.02 Generalized Anxiety Disorder:

- A. Excessive anxiety and worry (apprehensive expectation). Occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The person finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). **Note:** Only one item is required in children.
 - 1) Restlessness or feeling keyed up or on edge;
 - 2) Being easily fatigued;
 - 3) Difficulty concentrating or mind going blank;
 - 4) Irritability;
 - 5) Muscle tension;
 - 6) Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
- D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in “Panic Disorder”), Being embarrassed in public (as in “Social Phobia”), being contaminated (as in “Obsessive-Compulsive Disorder”), gaining weight (as in “Anorexia Nervosa”), having multiple physical complaints (as in “Somatization Disorder”), or having a serious illness (as in “Hypochondriasis”), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder (PTSD).
- E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- F. The disturbance is 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., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.