Bereavement in Alcoholics: A Multidisciplinary Problem

by

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Alcoholism can complicate the course of grief and impair physical and mental health. It can also increase the risk of suicide.

Where possible bereavement counsellors need to work with medical and other agencies to reduce the risk that problems will become intractable.

In this paper Dr. Blankfield highlights some of the problems from the point of view of a medical officer in an addiction unit in Australia.

The moderate social use of alcohol has long been recognised and accepted. Sometimes, however, when people feel distressed, they may reach out for a glass or so of drink to restore a more settled frame of mind. A summary of the surveys of apparently "normal" bereaved widows noted a trend towards an increased use of alcohol and hypnosedatives and it is the concern of the bereavement counsellor if misuse of these substances is occurring[1, 2].

The cut-off point between a social level of consumption and that which blocks emotional expression of mourning is critical in the bereaved[1]. Escalation of intake increases the risk of an abnormal grief response in the short term, and in the long term the possibility of addiction. There is no absolute safe level of daily alcohol consumption, but recent recommendations provide rough guidelines[3]. The regular pattern of alcohol consumption in men should not exceed 40 grams per day or 280 grams per week. Women should not drink in excess of 20 grams per day or 140 grams per week. The absolute alcohol content differs in various drinks so it is best to establish the concentrations in locally available items.

The continuous (as opposed to the infrequent) use of more than two drinks daily by women and four drinks daily by men, or regular nightly use of hypnosedatives, signal the advisability of a medical evaluation. Sudden cessation of these substances is inadvisable, as an unsuspected depression may flare up or in long-standing situations withdrawal effects can occur. An unknown number of people attribute the onset of their problem drinking to a significant loss, but the majority of alcoholics seen in treatment centres were already problem drinkers at the time of bereavement. The notion that "I drink because . . ." infrequently pinpoints a valid trigger event, but the "cocktail hour" widow deserves more prospective research to clarify further the interaction of alcohol and grief.

Issues Specific to Alcoholics

Alcoholics who required admission to a psychiatric facility shortly after a bereavement have been infrequently mentioned in the literature[1]. The recent trend to admit them to specialised units has stimulated speculative papers on "grief" in addiction which compare attempts to discontinue addictive behaviours to a loss process which has to be resolved by mourning. This article, however, is based on case studies of alcoholics admitted to an addiction unit for rehabilitation. They had spontaneously reported grief related to a significant bereavement[2].

There is difficulty in unravelling the separate effects of grief on alcoholics as many of the psychological symptoms encountered are common both to bereft persons and to alcoholics. These symptoms may overlap in alcoholics who have experienced a recent loss. The contribution of the severe alcoholic state to the production of these symptoms has to be sorted out from the elements of grief. An outline is given here of some of the problems encountered in an alcoholic population. At present, however, insufficient information is available to predict the special risk factors for abnormal responses in established alcoholics.

Alcohol and Alcoholism: The Effect on Self Perception

Alcohol is a chemical substance which can produce vast changes in mood and emotion in any person through its direct action on the brain. This effect can occur irrespective of the occurrence and importance of events in the outside world. In the alcohol-dependent person, maudlin sentimentality about past inter-personal relationships and other lost objects may flood to the forefront of conversation. Where insight is minimal, elements of guilt or denial may emerge as past losses are recounted.

An added problem is the high risk of suicide in alcoholics. Murphy *et al*[4] found that the loss of a close inter-personal relationship through death or separation made alcoholics more prone to suicide. They studied coroner's records of consecutive suicides in alcoholics and interviewed the families of the deceased. In their 1968-9 survey, ten of 31 persons had killed themselves within six weeks or less after the loss. In the 1971 survey the figure was 13 out of 50. In both samples a further half were dead within the year of loss. They noted that the presence of depression was not a sufficient precondition for suicide.

The alcoholic can experience alcohol-induced mood swings and disinhibition, so that impulsive behaviour such as attempted suicide can be an accidental spur-of-the-moment decision or miscalculation. This misfortune can befall the non-alcoholic person as well if they have drunk too much. When the act is premeditated, the client is likely to affirm that life is not worth living, or will appear perplexed, distressed or uncertain. Immediate hospitalisation may be appropriate in these situations.

Withdrawal symptoms in the alcohol-dependent person are noticeable as the level of alcohol

concentration falls in their bloodstream and the tremor in their hands becomes obvious. The bodily symptoms they may complain of include sweating and sleeplessness. Psychological symptoms at this point are numerous and may include anxiety, depression, a paranoid misinterpretation of other people's intentions, and even agoraphobia.

The withdrawal response of most interest to counsellors is a pseudo-grief accompanied by an intense yearning for the departed. These symptoms are transient. They will temporarily disappear after several more drinks, or perhaps fade permanently two to four weeks after the client has been "dried out" provided that heavy drinking is not again reinstated. Further enquiry at this point reveals that mourning had been previously resolved and that grief was an artefact of withdrawal discomfort. People with fictitious or contrived grief are rarely encountered. They are best referred to other support groups and firmly told that a bereavement service is inappropriate to their present mood.

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Bereavement

Bereavement in established alcoholics may have no influence on the course of alcoholism and the amounts consumed may increase, decrease or remain unchanged. A massive increase in intake can either be an abnormal response or an indication that the deceased person had previously controlled the level of intake and was no longer around to exert restraint.

The full range of grief reactions can be encountered in the alcoholic person, from a missed response to a normal resolution through to pathological variants. The latter is a problem of unknown magnitude as alcoholic clients have presented with unresolved grief as long as 15 years after the bereavement.

The style of expression of grief is often related to personality. The more stable and conscientious person sometimes displays severe guilt which may also accompany a severe depressive illness. Self-centred and explosive personalities may demonstrate more flamboyant, even violent behaviours.

Separation from a spouse sometimes creates grief reactions which are as severe and intense as those which arise from loss through death. Separation is a common sequel to alcoholism and the divorced state usually promotes resolution of the extreme interpersonal disturbance to both parties.

Many emotions and bodily feelings are common both to alcoholism and intense grief, but their significance can be sorted out with time and patience. Grief and yearning are topics which alcoholics tend to mention spontaneously when a thorough medical and psychiatric history is obtained from them in a relatively sober state. At this point an atypical grief response can be suspected if death took place unexpectedly or under circumstances of conflict.

Management

A period of drying out or detoxification, usually under medical supervision, permits withdrawal-phase pseudo-grief to be identified and treatable psychiatric illness to be diagnosed when present. This continuing assessment takes up to four weeks, and even longer if the client is dependent on tranquillizers. It is necessary to work with a sober client for meaningful discussion. In addition, psychiatric treatment with appropriate medications can stabilise manic-depressive and other disorders and reduce the patient's impaired perception of the real world. Grief work may realistically proceed at this point, with resolution of mourning, if sobriety is present for a sufficient length of time.

Denial and rejection by the client of the existence of problems, and avoidance of treatment, can produce a highly stressed situation for the family, friends and care-giving professions. With the client's consent, it may be best to have frank discussion with family or other support persons, perhaps together with the client. The situation must be outlined and a choice of options kept open for problem clients and their supportive network

A case study can best illustrate the complexity of assessment and treatment in the established alcoholic, and demonstrate the sometimes protracted though not insurmountable problems which occur. Alcoholics may not present for treatment until months or years after the significant loss. Containment of the alcohol problem may not be possible until after several admissions for rehabilitation[5]. If the sober state is short-lived, resolution of grief may not be satisfactorily completed until a subsequent admission. A lot of patience and perseverance may be required to achieve good outcome to treatment; long-term follow-up studies have shown that the prognosis for alcoholics is not necessarily as gloomy as was formerly believed.

When sobriety is maintained long enough for grief to be resolved during a single course of therapy, the short-term outcome of this intervention on the course of alcoholism can be highly variable and the patient may relapse irrespective of completion of the mourning process.

Case Study

Depression was identified and controlled with medication in a 38-year-old widower. Despite this, he failed to cast off his feeling of severe guilt and distress following his wife's death three years previously. She too had been an alcoholic and had experienced severe physical illness as a result. She refused to allow her husband to call an ambulance when her health further deteriorated. They both continued to drink, and when he emerged from his alcoholic stupor several days later, he found her dead in bed beside him. In therapy he repeatedly told his story with no display of emotion. Eventually a photograph of his late wife was placed in front of him. This action allowed him to cry and enabled him to recount her difficult behaviour and rejection of him in the weeks which preceded her death.

His concealed anger was released with this tactic, and resolution of his guilt and grief began but was intercepted. He took an overdose of his weekend-leave medication, and after discharge to outpatient care he followed a stormy course. His drinking was rapidly reinstated and he was upset by an unsettled daughter.

Eight years later he approached me in the corridor of a general hospital and proudly told me that he was employed there as an orderly and had been sober for five years. He told me that he had been admitted eight times for treatments to different addiction units. Two other counsellors again discussed the death of his wife with him in therapy. He acknowledged that he was an alcoholic before the tragic event and that he needed to hit the Alcoholics Anonymous level of rock bottom before he could remit and remain sober for a sufficient period of time to complete his grief work.

References

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