DIAGNOSIS: I'M NOT BROKEN

The Pathologizing of Grief and Trauma

Merle Meyers

"Grief is not a disorder, a disease, or a sign of weakness.
It is an emotional, physical, and spiritual necessity, the price you pay for love.
The only cure for grief is to grieve."

~ Rabbi Earl Grollman

Trauma and grief are both *normal* and *natural* physiological and emotional distresses, not disorders. They are physiological, in that the body and brain may be distressed, and mental because emotions are deeply involved. Complex trauma and complicated grief, the state of being "stuck," are also normal and natural distresses.

Webster's 1913 Dictionary defines "distress" as extreme pain or suffering; anguish of body or mind; suffering distress from gout, or the loss of friends. Dr. Ted Rynearson, psychiatrist and creator of the facilitated healing process known as Restorative Retelling, in his paper "Accommodation to Unnatural Death," explains Trauma Distress and Separation (grief) Distress:

	Traumatic Distress	**Separation Distress**
Thoughts	Reenactment of dying	Reunion with the deceased
Feelings	Terror	Pining and Sorrow
Behavior	Avoidance of reminders of the dying Protection of self and others	Searching

Common trauma reactions can also include:

- **Post-traumatic stress** – Intrusive thoughts, flashbacks, nightmares, fight-flight-or freeze/survival brain, can't sleep or concentrate
- **Amplified emotions** – Safety, security, and trust undermined, confusion, anxiety, depression, disconnection, unreality
- **Shattering basic assumptions** – About the world's predictability, meaning, fairness, and justice, difficulty trusting others
- **Unable to make sense of, or find meaning** – In the death or other traumatic events; undermining spiritual faith (anger, disillusionment, feelings of betrayal by God)
- **Preoccupation with issues** – Causality, responsibility, and blame (and self-blame about not preventing the death or other traumatic events that happened in the client's own life)
- **Preoccupation with a loved one's final moments and degree of suffering**

Common grief reactions can include 60 or more separate reactions:

- **Physical** – Pain, fatigue/exhaustion/low energy, sleep changes/disruption, appetite changes, shortness of breath, tight or heavy feeling in the chest, stomach upset or pain, tightness in the throat, muscle tension or agitation, clumsiness, among other reactions;
- **Emotional** – Shock/numbness/emptiness, sadness/sorrow, loneliness/longing/yearning, anger/betrayal/resentment, guilt/regret, fear/anxiety/insecurity/helplessness/loss of control, relief, diminished self-concern, desire to join the deceased, emotional rollercoaster, among other reactions;
- **Mental** – Denial/disbelief, confusion/disorientation, diminished focus/attention span, low motivations, dreams/images of deceased, memories of past losses, preoccupation with the deceased and the story of the death, needing to tell and retell the story, among other reactions;
- **Social & Familial** – Isolation/withdrawing from social activities, diminished desire for conversation and interaction, shifting roles in relationships, new responsibilities, hiding/concealing grief, difficulty relating to old friends or those not grieving, losing friends/making new friends;
- **Behavioral** – Crying, carrying mementos/holding onto deceased's belongings, enshrinement, going to the grave/ash scattering site/special places, looking at/avoiding photos or videos of the deceased, avoiding situations that arouse grief, normal social circumstances are intensified/explosive, keeping busy to avoid emotions, assuming mannerisms of the deceased;
- **Spiritual & Existential** – Questions about God/higher power, affirming spiritual beliefs/doubting religious or spiritual beliefs, questions about the deceased: Where are they now? Can they see me? Will I see them again? Questions about mortality/afterlife, existential questions: What is the meaning of my life? What is my purpose now? Sensing the deceased's presence/smell/sounds/dreams/waking life, awe/wonder/mystery.

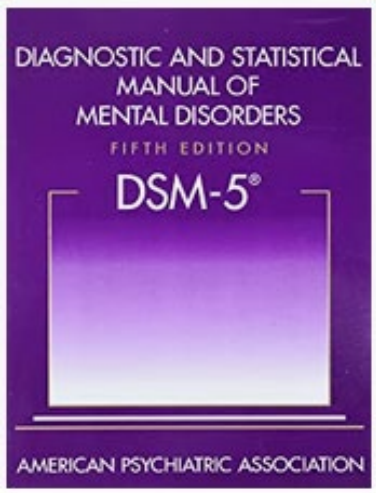
This is a long list of *normal* and *natural* symptoms identified in the multiple categories of trauma and grief reactions. Many of these reactions (symptoms) can and routinely get misdiagnosed as Depression, ADHD, Bipolar Disorder, Border Line Personality Disorder, Disruptive Mood Regulation Disorder, and myriad other "mental disorders," and can involve a combination of other disorders or "labels" for a single patient, including a child.

Misdiagnosed early childhood trauma (e.g., diagnosis of ADHD, Bipolar Disorder) triples the risk of heart disease, lung cancer, and a twenty-year life expectancy reduction. Improper medical screening of children in the examination room and a growing interest in pharmaceutical treatment has resulted in chemical intervention where none might have been appropriate. Note that when this occurs, the child is typically without a medical advocate who understands the implications of a diagnosis and a suggested treatment plan and advocates for the best interests of the child. Physicians should be able to advocate for their juvenile patient. However, a treatment objective to make the child compliant or at least manageable potentially creates a bias for chemical treatment. The objective exists before an actual diagnosis, a very subtle but precarious sequence of events. Contrary to the old Dupont slogan, this is not "Better Living Through Chemistry."

Recommended viewing via the MEDIA tab on our Grief and Trauma Chaplaincy website, or on YouTube, is the TED Talk entitled, *How Childhood Trauma Affects Health Across a Lifetime* by Dr. Nadine Harris Burke.

HOW DID WE GET HERE?

What is the Gold Standard created by The American Psychiatric Association (APA) as the resource to help mainstream medicine arrive at patients' proper diagnoses? ***The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition***, **DSM-5**. The original DSM was not compiled to create diagnoses, but to provide a standardized language for existing conditions, partially for insurance billing consistency. By the fifth edition, this changed, and now the DSM-5 is considered a diagnostic tool.



In his book, ***The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma***, Harvard Medical Psychiatrist Bessel van der Kolk explains the history of psychological trauma, its treatments, the tremendous breakthroughs in neuroimaging technology, successful treatments, applications in care, and the adversarial and harmful wing of mainstream psychiatry, whose dominance has been steadily increasing.

Psychiatric medications (antidepressant, attention, behavioral) are only addressing symptoms associated with the approximately 300 "mental disorders" listed in the 947-page DSM-5.

> *Before the late nineteenth century doctors classified illnesses according to their surface manifestations, like fevers and pustules, which was not unreasonable, given that they had little else to go on. This changed when scientists like Louis Pasteur and Robert Koch discovered that many diseases were caused by bacteria [germs] that were invisible to the naked eye. Medicine then was transformed by its attempts to discover ways to get rid of those organisms rather than just treating the boils and the fevers they caused. With DSM-5 psychiatry firmly regressed to early nineteenth-century medical practice.*

Why is much of modern psychiatry voluntarily taking itself and its patients by the millions back to the medical dark ages? Why go back to treating only the symptoms? Why only treat the symptoms by the numbing of trauma and grief? It's been said when you numb the pain you numb the subsequent joy.

In 1980, the Introduction section of the DSM-3 warned unambiguously that *all categories of this manual were insufficiently precise* to be used in forensic settings or for insurance. But over time, the DSM became a leviathan with insurance companies requiring a DSM diagnosis for reimbursement.

This means with a doctor, psychiatrist, or psychiatric nurse, a DSM-5 diagnosis of a mental disorder, (e.g., Depression, Disinhibited Social Engagement Disorder, Acute Stress Disorder, Separation Anxiety Disorder), or any reactions that can result from grief or trauma, the patient can get medical treatment/medications covered by insurance. The result of these misdiagnoses means that a healthy and normal grieving patient has documented mental illnesses on their medical record, *which they carry with them for life*. How deeply ingrained is the DSM in medical treatment? The APA earned $100MM in sales with the release of DSM-4.

THE EVER-EXPANDING FOOTPRINT

The DSM-5 "Scope Creep" is prevalent with an increasing number of traumatic and grief reactions like Complex Trauma and Complicated Grief, and normal, natural reactions being labeled as "mental disorders" (mental illnesses) like *Persistent Complex Bereavement Disorder* by some doctors and other "medical authority figures."

> ***When Grief is Complicated: A Model for Therapists to Understand, Identify, and Companion Grievers Lost in the Wilderness of Complicated Grief***
>
> **by Alan D. Wolfelt, Ph.D.**
>
> *The trouble is when we give grievers a diagnosis, they believe that something is wrong with them. They believe they're not grieving properly. They think we're the experts on their grief and not them. They feel ashamed. They think, as our medicalized world has taught them, that they need to be treated and "cured." And we often internalize the belief that we are the experts who hold the key to their recovery.*
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> ***Complicated Grief or Clinical Depression?*** *According to the Centers for Disease Control and Prevention, at any given time, one in ten American adults is clinically depressed, and one in 25 meets the criteria for major depression. Throughout their lifetimes, one-fourth of all Americans will experience at least one episode of depression.*
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> *Are these numbers falsely inflated by the trend toward the medicalization of normal existential troubles? Probably. But while I worry that we are diagnosing clinical depression too liberally because we as a culture misunderstand the role of pain and suffering, I am not a depression denier. I do believe that clinical depression is a real physical disorder that may require medical treatment.*

To review, in the DSM-5, Major Depressive Disorder [MDD] can be diagnosed with five or more of the following symptoms a) represent a change from previous functioning and b) have been present for at least two weeks:

1. *Depressed mood most of the day, nearly every day*
2. *Little pleasure in all or most activities*
3. *Significant weight loss or gain*
4. *Insomnia or hypersomnia*
5. *Physical agitation or lethargy*
6. *Fatigue or loss of energy*
7. *Feelings of worthlessness or excessive guilt*
8. *Inability to think, concentrate, or decide*
9. *Recurring thoughts of death or suicide*

Symptom numbers 1 and/or 2 must be present for the depression to be considered MDD, and the patient must also be in "clinically significant distress" or impaired functionally in social, occupational, or other areas.

The trouble for us as grief companions is that depression and grief look a lot alike. Most normal grief symptoms overlap with clinical depression symptoms, let alone complicated grief symptoms, which are even more likely to mimic clinical depression. In fact, in the DSM-5 list above, all nine symptoms may also be present in complicated grief.

When it comes to grief, complicated or not, I (and many other professional caregivers, I will note) object to the two-week time frame in the DSM-5. Previous DSMs excluded newly bereaved people from a major depression diagnosis, but the DSM-5 removed this exclusion. Now, even in normal grief, many grievers would meet the criteria for MDD given this timeframe.

Proponents argue that removing the bereavement exclusion allows clinicians to quickly treat mourners who are clinically depressed and may be suicidal. It's true – sometimes grievers react so dramatically to the death of a loved one that they may be in immediate danger to themselves. In these cases, short-term hospitalization or other interventions may indeed be required, and taking all professionals to help prevent a griever's suicide is a necessary standard of care. I urge you to stay current with the proper resources and protocols in your community for the care of suicidal people.

Still, it is common for grievers, normal or complicated, to entertain passive thoughts of suicide. This usually takes the form of the griever wishing he wouldn't wake up in the morning, wishing he had died instead, or wishing he could fast-forward through the pain and on to his own death before they can choose to live again. But actual suicide is another matter entirely. What we must be on the lookout for in the grievers we companion are suicidal thoughts that take on planning and action.

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Being alert to potential risks is advocacy; "fixing" is not. Grievers need not be fixed because they're not broken. When you see a woman crying, even uncontrollably in a public place because of grief, know that emotionally she is probably the healthiest person in that space.

In our experiences working with the newly bereaved, it is not unusual for our "Dear Ones" (our grievers) to see their loved one physically in the room with them, to have visitations during their dreams, or smell a freshly lit cigarette from the back porch where their loved one used to smoke.

Activities we generally take for granted, like remembering to turn off the burner on the stove, knowing where we are when driving common routes in our local community, comprehending basic written instructions even as simple as cooking directions, become challenges for the griever who may need to apply constant focus. It is not uncommon for us to reach out to the newly bereaved and traumatized who don't remember filling out a contact request online a couple of weeks prior. These, including the common and traumatic grief reactions on pages 1 and 2 are normal. All are reparative efforts to heal. All, as part of the grief process, can happen well after two weeks following their loss.

BETWEEN TWO WORLDS

In the book ***Transitions: Making Sense of Life's Changes***, author William Bridges describes three "perilous stages" in any of life's major transitions. Every story has a beginning, middle, and end. Whether the death of a loved one, a job loss, or a loss through betrayal from a trusted loved one or business partner, there are three similarities people will experience:

1. **An ending** – The world as we know it has changed forever.
2. **The period of confusion and distress (chaos)** – Also a time of extreme vulnerability in this new wilderness journey. Coming to terms with going from "we" to "me," this is the stage where the traumatic and common grief reactions are experienced at their fullest and processed.

   NOTE: If a reaction or symptom is misdiagnosed as a mental disorder and psychiatric medications are taken to numb the symptoms, this will break the connection with the grief emotions, and they won't get processed. What follows is complicated grief or re-traumatization, including problems during future losses, often when elderly, under-resourced, and possibly isolated.

Stage 2 is where we as companions and therapists meet those newly dealing with grief and trauma, those still in liminal space, the fixed threshold between two worlds.

3. **A new beginning** – A new course is charted. This can involve new people, new roles and activities, and a new meaning in life. This can also include Post-traumatic Growth.

So, it begins with an ending and ends with a beginning.

FROM RESILIENCE TO INTEGRATION

In his book, ***Retelling Violent Death***, Dr. Rynearson describes an exercise he calls The 3 P's:

1. ***Pacification*** *is the most primary and refers to the capacity for self-calming or soothing. It is essential as a basis for limiting the primal experience of disintegrating terror.*
2. ***Partition*** *refers to the capacity for self-discrimination. It is essential in establishing a limitation or boundary between the experiential worlds of "me" and "not me."*
3. ***Perspective*** *refers to the capacity for self-transcendence. It is essential in allowing time to penetrate experience so change can be anticipated.*

Psychiatrist Stephen Marmer said, *"If cars didn't have shock absorbers every ride would be a miserable experience. The ride through life without shock absorbers, that is, resilience, would be the same. So, without building resilience, your own internal shock absorbers, it's not possible to lead a happy and productive life."*

Resilience is not a trait bestowed genetically. Babies and children are not at all resilient. Resilience is learned, preferably beginning early in the home. Without resilience, one cannot integrate the pain of one's life into one's story. Resilience makes one's life a beautiful mosaic of both dark and light pieces rather than life being eclipsed by the darkness of experienced pain and distresses. *Resilience* gives way to *integration*, blending the feelings of loss with a positive approach to living forward.