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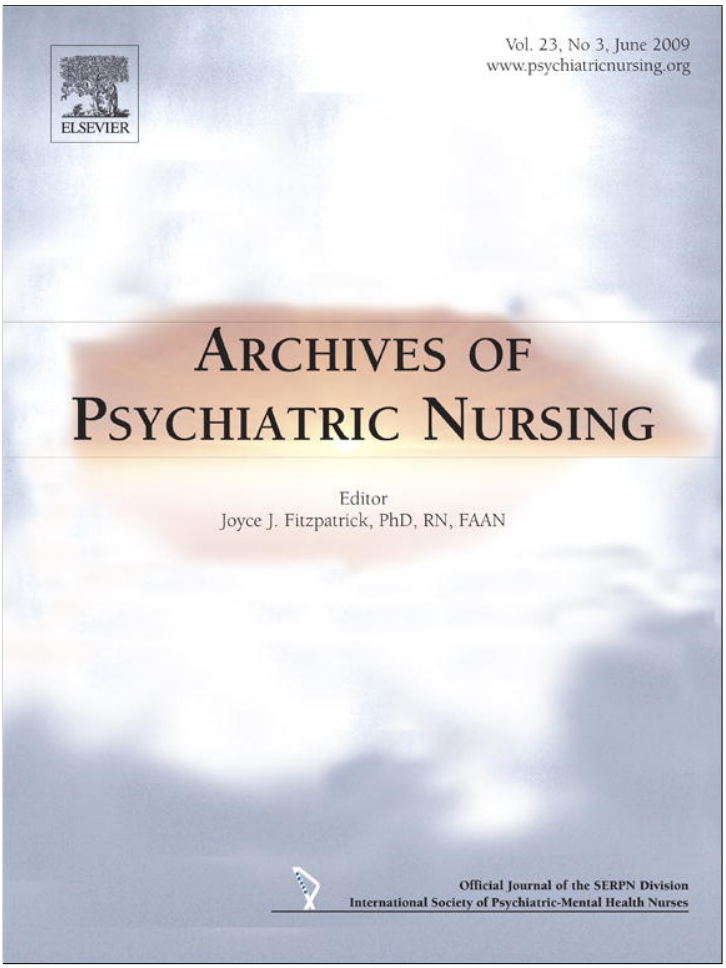

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Loss and Grief in Patients With Schizophrenia: On Living in Another World

Maria Mauritz and Berno van Meijel

Aim: **Schizophrenia enormously impacts the lives of the patients who have this psychiatric disorder. This study addresses the lived experience of grief in schizophrenia.**
Method: **A qualitative study based on the grounded theory was designed. Ten patients were interviewed in depth on their feelings of loss and ways of coping.**
Results: **All respondents experienced significant feelings of loss. Internal and external losses were distinguished. Respondents dealt with their losses by accepting their diagnosis and treatment, identifying with other patients, learning about schizophrenia, and searching for meaning.**
Discussion: **Respondents were able to identify their significant losses and verbalize the accompanied feelings. They went through an intensive grieving process that to a certain extent led to coming to terms. During the interviews, the presence of grief was evident, whereas clinical depression was excluded.**
Clinical implications: **Interventions may be improved by the following factors: (a) optimal assessment and treatment of symptoms; (b) adequate information about symptoms, treatment and its effects, and prognosis; (c) opportunities to identify with other patients; (d) strengthening of social support; and (e) a relationship of trust with care providers based on an accepting attitude.**
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SCHIZOPHRENIA IS A serious psychiatric disorder that deeply affects the lives of patients who have it. The illness and its consequences can substantially impair personal life and social functioning (American Psychiatric Association, 2000; Horowitz, 2002; Lewis, 2004; Lewis & Langer, 1994; Lorencz, 1991; Siris & Docherty, 1990). Living with schizophrenia means losses in several areas of life such as emotional and cognitive functioning, social contacts, study and employment, and daily activities. To come to terms with these losses, a patient must go through a mourning process that may well entail feelings of grief and depression (Appelo, Slooff, Woonings, Carson, &, Louwerens, 1993; Witmann & Keshavan, 2007). The increased risk of suicide among patients with schizophrenia in the first years after the illness manifested itself is indicative of their suffering (Addington, Williams, Young, & Addington, 2004; de Hert & Peuskens, 2000; Lewis, 2004; Mamo, 2007; Pinikahana & Happell, 2003). According to the *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors*, 23%–55% of patients with schizophrenia engage in a suicide attempt at some point in their lives (American Psychiatric Association,

From the Support and Psychosis Programme of the Mental Health Care Unit GGNet in Zevenaar, The Netherlands; Inholland University in Amsterdam, The Netherlands.
Corresponding Author: Maria W. Mauritz, RN, MScN, Manager of the Support and Psychosis Programme, GGNet Zevenaar, PO Box 2003, 7230 GC Warnsveld, The Netherlands.
Precis: This article describes a qualitative study on the experiences of loss and grief in patients with schizophrenia.
E-mail addresses: m.mauritz@ggnet.nl, berno.vanmeijel@inholland.nl
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2003). The lifetime risk of suicide in schizophrenia is estimated to be approximately 5% (Palmer, Pankratz, & Bostwick, 2005). In comparison, suicide accounted for 1.4% of total deaths in the United States in 2004 (National Center for Injury Prevention and Control, 2005). In providing care to patients with schizophrenia, nurses need to be open to these experiences of loss and grief to offer effective care aimed at helping patients come to terms with the fact that they are ill and accept the losses that they feel (Appelo et al., 1993; Glass, 1993; Horowitz, 2002). *Grief* can be defined as a complex but stereotyped reaction pattern to losses, with both psychological and physiological aspects playing a role, such as social withdrawal, restlessness, difficulty in carrying out routine daily activities, fatigue, sleep disorders, and loss of appetite. Feelings are dominated by hopelessness, heavy heartedness, and fear. Aggression and guilt feelings also occur regularly (Clayton, 1990; Worden 2001). The losses experienced by patients can be classified into internal and external losses (Appelo et al., 1993). Internal loss includes cognitive impairments (lack of concentration and memory defects, confusion, and lessened problem-solving ability), low self-esteem, and loss of future prospects. External loss refers to a decline in social contacts and a change in a patient's role and position in society.

It is unclear how grief is expressed in relation to schizophrenia. It is often difficult to distinguish reactions of depression from those of grief (Clayton, 1990) or negative symptoms (Appelo et al., 1993; Lewis, 2004). Apart from some case studies (Horowitz, 2002; Witmann & Keshavan, 2007), no reports have been published of scientific research specifically focused on grief in schizophrenia (Lewis, 2004). This article describes the results of an exploratory study conducted with the objective of gaining better insight into the losses experienced by patients with schizophrenia and the reactions of grief that may follow. Insight into these aspects will enable nurses to better understand the specific losses felt by these patients. This will contribute to nursing interventions supporting patients to cope more effectively with these losses.

The following research question was asked:

How do patients with schizophrenia experience and come to terms with the loss that their illness entails?

METHOD

Grounded theory was selected for the research design (Strauss & Corbin, 1998). This approach is used within the context of symbolic interactionism. Grounded theory aims at understanding how people define their reality via social interactions (Hutchinson, 1993). Loss in schizophrenia has a large impact on the individual's definition of reality and on his or her social interactions. The choice for this design was motivated by the emphasis on the significance that the respondents attributed to their experiences of loss and on how they continue to live their lives based on this newfound meaning. The qualitative method was considered appropriate because of the complexity of the concepts of grief and loss and because of the relatively new scientific articulation of these concepts in schizophrenia (American Psychiatric Association, 2000; Lewis, 2004). After the approval of the institutional review board, the respondents were selected based on the following inclusion criteria: (a) *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* diagnosis of schizophrenia confirmed by the Comprehensive Assessment of Symptoms and History interview (Andreasen, Flaum, & Arndt, 1992; American Psychiatric Association, 2000); (b) between 6 months and 7 years since the first psychosis so that the experienced losses by the patients were relatively recent; (c) engaged in active treatment as day patients or outpatients at the university hospital where the researchers worked; (d) ability to verbalize ideas and experiences; (e) absence of clinical depression according to the clinical judgment of the psychiatrist; (f) absence of overt psychosis; and (g) legally competent adults.

Ten patients took part in this exploratory study, 9 men and 1 woman. The mean age was 26.6 years (range = 21–38 years), and the mean duration of illness was 3.45 years (range = 0.5–7 years). Six lived with their parents at the time of the interview, and 4 lived independently. Six patients received day treatment, and 4 were treated as outpatients. All respondents had previously received clinical treatment in the university hospital and were now in the rehabilitation phase.

Data were collected in 10 semistructured interviews lasting up to 1 hour. On the basis of the literature, the following "sensitizing concepts" were used: internal loss, external loss, and grief (Appelo

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et al., 1993; Hutchinson, 1993; Witmann & Keshavan, 2007). The interview topic list for internal loss consisted of general skills, cognitive functioning (concentration, memory, problem solving, and abstract thinking), self-image, self-esteem, illness symptoms, side effects, effects of hospitalization, and future perspective. External loss addressed relationships (spouse, family, friends, and fellows), time spent during the day (employment, education, and leisure time), and living conditions (dependency, self-supporting, and privacy). The topic list for grief addressed emotions, cognitions, and behavior (Appelo et al., 1993; Lewis 2004; Witmann & Keshavan, 2007). Data collection and analysis were a cyclic process, with the interim analyses forming the basis for subsequent interviews. The first three interviews primarily focused on the way in which respondents experienced their illness and the losses entailed. The subsequent interviews emphasized specific expressions of grief. When speaking about grief, respondents often mentioned that they had come to terms with the losses associated with their illness. Therefore, "coming to terms" was added as concept. In the last four interviews, there was more emphasis on the coping process that leads to coming to terms. The texts of the interviews were transcribed literally and analyzed using Winmax-pro '96 (Kukartz, 1996), a computer program for qualitative text analysis. Biographical and autobiographical data were used as a further source of information.

In the first analysis, the text was coded with labels directly derived from the respondents' words. For instance, one respondent dealt with his loss in a way he called "shut off his feelings." "Shut off" became a descriptive code. After the second analysis, interview fragments were united into bigger wholes, and codes became more interpretive. Shut off can then be explained as a grief reaction or as avoiding stimuli in an adaptive way. Both explanations may be possible at the same time. During the process of coding, the researchers continuously looked for similarities and differences between the interviews based on the constant comparative method (Hutchinson, 1993). The third analysis consisted of uniting the fragments into categories. The final categories of internal loss, external loss, and grief turned out to be quite similar with the original sensitizing concepts. The category "coming to terms" was added.

Ten respondents proved to be a sufficient number to sketch the initial outlines of a theoretical framework. No completely new points of view or new themes came forward in the final interviews.

Methodological objectivity was enhanced by (a) targeted sampling confined to respondents who had recently experienced losses because of schizophrenia (patients were between 6 months and 7 years since psychosis), (b) neutral attitude in asking questions and in orally checking the findings with the respondent, (c) data triangulation of interviews and written autobiographical material, (d) researcher triangulation: minimization of researcher bias by authors independent analyzing and coding interviews, (e) peer debriefing with two neutral psychiatrists and nurses, and (f) transparency and reproducibility emphasized through careful documentation of all steps of the research process. Interviews were tape recorded and verbatim transcribed. The raw material was saved and stored in its entirety to be available for verification purposes.

RESULTS

A particular focus on the experience of loss occurred in the first interviews as all respondents were keenly aware of their loss. Experiences of loss were articulated when answering the question about the impact of schizophrenia on day-to-day life. The experience of loss was initially categorized using the topics corresponding with internal and external losses. The subsequent interviews used grief and coping as central concepts and concentrated more on coming to terms with these losses.

Internal Loss: Living in a Different World

The internal loss suffered by patients as a consequence of schizophrenia is wide ranging and has a large impact on the respondents' daily lives. Psychotic episodes were experienced as highly traumatic because of the frightening feelings and thoughts experienced. Several respondents referred to their experiences as awful or dreadful and used strong terms for psychosis such as *sheer hell*.

> There was the feeling that all sound was focused on me; it was very loud and got louder and louder and I was in more and more pain. It felt extremely oppressive...And I felt that things would get completely out of hand at the end that I would wind up in a straitjacket. And would never get out of

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> it again. Like being in a kind of hell—not the fact that I was there, but that it was me….

The traumatic experience was intensified by unexpected and sometimes involuntary hospital admission and treatment.

In terms of consequences, a psychosis first of all causes respondents uncertainty and self-doubt regarding the workings of their brain and senses. They can no longer rely on their own observations and thought processes. Jarosinski (2006) describes this uncertainty for patients as the theme "Are they who they are?" As the psychotic symptoms subside, respondents become aware that their psychotic perceptions do not correspond with reality. There is incongruence between the picture formed of themselves and the surrounding world. This demands a reorientation as a new reality has to be accepted. Subsequently, respondents fear a new psychotic relapse and the resulting loss of control.

The prolonged presence of symptoms and side effects of medications caused a great deal of distress in their daily lives. Commonly reported perceptions of loss included faulty memories, garbled thinking, and fatigue. As a result, they function somewhere below the level achieved before the illness and viewed themselves as impaired. Feelings of meaninglessness and emptiness resulted from a more or less enforced passivity created by the loss of energy and inability to complete usual daily activities such as work or school that had been previously taken for granted.

Research into the perception of chronic physical illness demonstrates that the life of a person with chronic illness is sometimes described as a life in "two worlds": the normal world and the world of the illness (Grypdonck, 1998; Jarosinski, 2006).

This leads to the experience that the world of the person who is chronically ill is no longer the same as that of others. Living with schizophrenia can therefore mean "living in another world"—the world of the psychotic experience. It is also the world of a person experiencing a chronic illness with long-term symptoms and permanent impairments as the patient's own psychotic reality conflicts with the surrounding reality.

> Because I know you can't tell by looking at me, so at first it won't even occur to people. But that does tend to make life very complicated, and it sometimes makes me extremely lonely. Just this week I had the feeling that I was awake and the rest were asleep. Other people haven't been through any of this, they are sleeping, and they have no idea what it is like to…Do you know what I'm saying? And for me there is no way back.

External Loss: Not Belonging

Loss of cognitive skills and the presence of both positive and negative symptoms often lead to fewer social contacts and a declining quality of interaction with the remaining contacts. This loss of satisfying social contacts intensifies feelings of loneliness and constitutes an external loss. Working, studying, and almost all daily activities can also be greatly affected by the limitations of schizophrenia.

The respondents experienced external losses in all important areas of life. Their social network had become very small. They described the loss of friends, acquaintances, and colleagues and sometimes had not a single friend left in the world. In many cases, it had become extremely difficult if not impossible to enter into and maintain a relationship with a partner. The quality of their remaining contacts had also significantly decreased. Respondents identified that their thought disorder led to communication problems, they deliberately avoided social situations to escape stress, and their friends and acquaintances simply did not understand.

The erosion of a person's social network has many consequences, one of which is the almost total lack of the practical and emotional support ordinarily offered by partners and friends. Respondents are thrown back upon the most basic relationships of all: family ties. Existing relationships change because respondents grow increasingly dependent; they are aware that they are a source of concern and have the feeling that they have failed in their relationships.

> My parents have supported me all these years; they always would come and see me. I have three cats and my father cared for them every time I was admitted to the hospital, even when it lasted two years. They always were behind me…I am their problem child. I don't think they realize that I occasionally don't want to live anymore. I don't want them to know and be afraid.

The theme of "not belonging" is common to all the stories of respondents about the different forms of external loss. It is based on the reality of literally no longer being able to take part and on the feelings of "being different," as described

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under internal loss. This is where internal and external loss meet.

> I don't feel completely safe in the dorm, especially not with what I have. Everything seems to go too fast. I don't fit in because I am not really studying anymore anyway. Writing e-mails, making new friends—it is such hard work. How to put it…I haven't seen them for a year and I just have the feeling that I don't belong. I don't even know if I want to belong.

The literature on grief describes how people who sustain a loss may end up isolated (Worden, 2001). On the basis of the interviews, it may be assumed that patients with schizophrenia experience double isolation: isolation that results from the primary symptoms and isolation due to consequences of schizophrenia.

Expressions of Grief

Several spontaneous expressions of grief occurred in relation to both internal and external experiences of loss. Grief reactions were further discussed in specific questions about thoughts and feelings in relation to the losses. The mourning process starts with the shocking discovery that a person has schizophrenia. The diagnosis offers an explanation for the symptoms and in this sense, it gives clarity. At the same time, it says that the respondent is experiencing a serious psychiatric disorder that has a dramatic impact on daily life and on the future. People view this as a psychological disaster and sometimes describe it in terms of a natural disaster.

> For years I had been going around in a sort of circle. The circle got bigger and bigger; it turned into a cyclone. The storm was devastating, and afterwards you have to pick up the pieces.

A twofold denial often occurs at the beginning of the mourning process: denial of the diagnosis and the need for treatment and denial of the seriousness of the limitations and the adjustments that will be necessary in daily life. Generally speaking, the respondents in our study were well informed about their illness and were able to describe their limitations clearly. However, acting in accordance with this knowledge was difficult for a number of them because this presumed a certain acceptance of the situation. Not looking the loss in the face seems to be one way of not feeling the grief and not being overwhelmed by emotions.

> I would rather run away from all those things; I just can't focus. It's all so painful, a kind of paralyzing sadness. That is what I run away from. I don't want to face it. I prefer not to talk about it.

Mourning the loss is expressed by the emotions of grief, somberness, desperation, guilt, and anger and the behaviors of withdrawal from social contacts and placing blame on self or others. If the mourning process stagnates, the experiences of loss seem to increase. For example, nonacceptance of medication and rules of life can cause symptoms to increase. Symptoms in turn are an obstacle to daily activities and have a negative effect on contacts with others. Feelings of isolation and alienation multiply, and the quality of social contacts declines further. People feel more powerless and become desperate, which may be expressed by a depressed state of mind and suicidal behavior. Respondents directly experience a loss of future prospects. In one of the autobiographical sources, this is put in the following words:

> My illness is a journey of fear, often paralyzing, mostly painful. If only someone could put a bandaid on the wound…but where? Sometimes I feel I can't stand it any longer. It hurts too much, and I'm desperate to feel safe, comforted. (McGrath, 1984 p. 638)

Sufficient comfort and support are needed to grieve constructively. Only then can a person begin to cope with the loss suffered. During the interviews on loss and mourning, several respondents spontaneously mentioned "coping" or "coming to terms." They had learned to cope with "it" or were in the process of coming to terms with "it." These terms were therefore further elaborated in subsequent interviews.

Coming to Terms

Coming to terms is a part of the mourning process aimed at finding a new equilibrium. Grief and coming to terms cannot be separated; they lie on the same continuum (Witmann & Keshavan, 2007; Worden, 2001). Respondents use various strategies to cope with their experiences of loss and to integrate them into their existence. These strategies are described in the next paragraphs.

Coming to terms starts with recognizing the loss as a fact. The respondents expressed this by saying

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that they had accepted their losses to a great extent. This refers to acceptance of the diagnosis and treatment, the wanting to receive help, and the acceptance of their limitations. An incomplete awareness of the illness and poor insight can make it more difficult to accept the diagnosis. Understanding and acceptance are increased by medication efficacy, decline in psychotic symptoms, repeated provision of illness information, and opportunities to identify.

> Strange, isn't it, I had never heard of this illness. First you just don't believe it, but later you start to accept it. After all, the symptoms are all there. Everything they tell you, whatever you read, it all adds up. And you see that others have accepted it. These other patients have it too and they take their medication.

Cognitive coping strategies include nourishing hope, living from day to day, seeking an explanation, and giving meaning to a life with schizophrenia. Nourishing hope is of great importance because it is literally a source of life. Hope was explicitly mentioned in discussions on the positive effects of medication. This included the hope that the illness would take a favorable course and that there would be no new psychotic periods. Hope was also expressed in connection with new or different future prospects of relationships and work.

Finally, respondents gave their life meaning by setting themselves a special assignment in life or believing that God supports them by enduring the pain.

> Sometimes when I have survived a heavy crisis, I feel rich… I belief that if there were no God, I was irrecoverably lost… Just the idea that there is Somebody who meant me to be here, it helps.

Observing others with an illness is an important way of gaining an understanding of the progress of an illness that is difficult to comprehend. It becomes easier to accept the fact that psychotic experiences are not reality if you discover that fellow patients have similar psychotic symptoms. This is an important advantage of group psychoeducation. The combination of identifying with fellow patients and obtaining information helps to make impairments manageable and may even lead to an active way of coming to terms. Respondents also sought help from the members of their own social networks and from professional care providers but did not always receive sufficient support. For some, the study interview was the first time they had talked at length about the personal significance and consequences of schizophrenia. Not being understood and not being comforted can be a heartrending experience.

> An evening like this…
> Tears filled my eyes.
> Nowhere to go
> No one knew what I was thinking
> Nobody who could comfort me
> Nurses having no time,
> the door always locked.
> (Frits Diepeveen, 1990 p. 86)

One respondent told how she tried to comfort herself:

> When I was in the psychiatric hospital I always had a teddy bear on my bed. At a certain point I was holding that bear as if it was a child, and I slept all day with my child on my lap. I knew what I was doing and it was somehow comforting to me…but I felt completely at a loss: there I was, thirty-five years old and walking around dragging a teddy bear, something like: oh you poor thing, isn't it pathetic.

The concepts of loss, grief, and coming to terms can be visualized in the following scheme (Figure 1).

DISCUSSION

The patients with schizophrenia who participated in this study represent a select group. They are young adults, the duration of their illness is relatively short, and all respondents have been treated in a university hospital. To focus on grief specifically, patients with clear depressive symptoms were excluded from this study. Exclusion of negative symptoms was not possible, but the respondents appeared to be well able to formulate their thoughts and verbalize their feelings. The most striking negative symptom during the interviews was the inability to affectively demonstrate sadness. The mentioned considerations should be kept in mind in interpreting the result and the clinical implications. The first aim of this study was to understand how patients with schizophrenia define the reality of the losses they experience during the course of their illness. All the respondents defined their reality as overwhelmingly painful during the psychotic periods. Moreover, they experienced many other severe losses and are well aware of it. Internal loss

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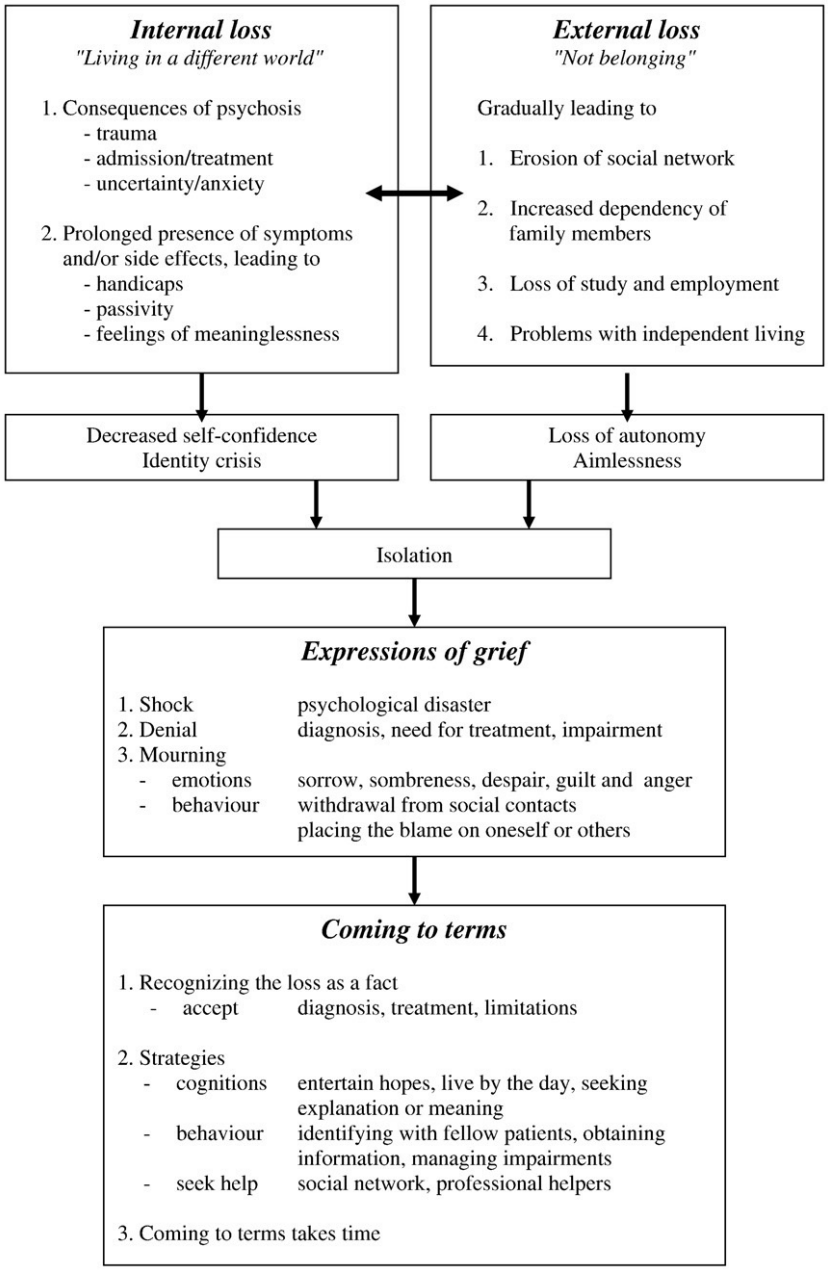

Fig 1. Theoretical scheme for relations between losses, grief, and coming to terms.

includes the traumatic experience of psychosis, loss of cognitive and emotional functioning, and the existence of prolonged symptoms. The traumatic character of psychosis has also been found in other studies. Morrison, Frame, and Larkin (2003) describe that psychosis causes posttraumatic stress disorder in approximately 50% of the patients in several studies. Hospital experiences accounted for an additional 6% of the variance (Frame & Morrison, 2001).

The loss of cognitive and emotional functioning has been referred to as primary loss (Witmann & Keshavan, 2007). This study identified decreased self-confidence and identity crisis as a consequence of the traumatic experiences and the loss of cognitive and emotional functioning. The

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respondents have the experience that they are no longer the same person as they were before illness. As a result, the world has changed forever. This is a dominant theme in the experience of internal loss, which can be characterized as "living in a different world." External loss includes the erosion of the social network, increased dependence on family members, loss of study and employment, and the impossibility of independent living. Consistent with our results, Witman and Keshavan (2007) also mention vocational loss and loss of place in a social milieu as secondary loss. In addition, our respondents experienced loss of autonomy and aimlessness. The respondents characterized the dominant theme in external loss as "not belonging."

Although internal and external losses can be distinguished, they continuously influence each other. For instance, cognitive impairments (internal loss) lead to vocational loss (external loss), which, in turn, contributes to loss of self-esteem (internal loss). Eventually, the experience of "living in a different world" while "not belonging" leads to isolation and severe loneliness.

The second aim of this study was to explore the reactions of patients with schizophrenia to the massive losses they experience in the course of their illness. Although it is difficult to distinguish between grief and depression (Clayton, 1990; Lewis, 2004), it is evident in this study that strong grief reactions, for example, emotional shock, denial, sadness, somberness, guilt feelings, and, withdrawal of social contacts, are present while manifest depression is absent at the same time. Mamo (2007) also describes the occurrence of despair, sadness, and hopelessness in the absence of a depressive syndrome. In the opinion of the respondents, schizophrenia has a disastrous character and causes a severe shock often followed by denial. Lewis (2004) describes the function of denial as an unconsciously motivated psychological defense mechanism to protect against realization of a painful reality. However, denial in schizophrenia is hard to distinguish from poor insight. According to Amador and David (1998), poor insight is probably a consequence of brain dysfunction. Lewis (2004) argues that neurocognitive deficit and motivated denial both contribute to impaired insight. At the time of the interview, most of the respondents showed considerable insight in their illness probably because of the absence of manifest psychotic symptoms and increased acceptance. They were able to reflect on their denial, which was related to diagnosis, treatment, and impairments. The purpose of mourning is to come to an acceptance of a reality that cannot be changed (Worden, 2001). When the respondents said that they had come to terms, they first of all meant the acceptance of diagnosis, treatment, and impairments. Acceptance was mentioned as the opposite of (former) denial, which concerned the same aspects, that is, the acceptance of diagnosis and need for treatment and the recognition of disabilities in daily life. Coming to terms is reached by having cognitive strategies directed at hope and meaning, by identifying with fellow patients, and by obtaining information to manage impairments. In this painful and lengthy process, patients need much support from their social network and professional care providers.

CLINICAL IMPLICATIONS

To limit the internal loss in schizophrenia, it is first of all important to provide optimal treatment. This will reduce serious symptoms and maintain cognitive and emotional functioning as much as possible. Reduction of internal loss will also limit external loss as it is evident that these losses influence each other. External loss can further be decreased by supporting contact with family members and significant others, by providing meaningful ways to spend daytime hours, and by improving independent living. These interventions will limit the risk of isolation and feelings of meaninglessness.

In observing emotions and behavior, it is important to distinguish between symptoms, adjustments to limitations, and grief reactions especially because these will often occur together. Regular assessments of positive and negative symptoms and depression will possibly be helpful in distinguishing these symptoms from grief and contributing to optimal treatment. To increase understanding of patient behavior, it is wise to question patients closely about their emotions and motives to increase comprehension.

Interventions aimed at coming to terms with grief should be geared to the specific expressions of grief that are dominant. If upheaval predominates during the shock period, the presence and availability of care providers are necessary. In this situation, offering structure, building a relationship of trust, and giving adequate information are essential. If

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denial predominates, it must be kept in mind that denial as such may be an effective way to avoid overwhelming pain. On the other hand, it must be kept in mind that denial may represent lack of insight. In both cases, it is important to foster insight by repeatedly providing appropriate and understandable information in small doses.

Some of the interventions and therapies commonly used in mourning do not seem suited to patients with schizophrenia because they require considerable cognitive abilities and thus can be a source of additional stress. According to the respondents in this study, the opportunity to "tell their own story" supported the mourning process.

Patients with schizophrenia have the same emotions as all other mourning people but are usually less able to express these feelings, especially nonverbally. Nurses often have prolonged and frequent contact with patients. This enables nurses to carefully observe their patients and understand their personal reactions to loss. During this process, it is important to find out what provides consolation and hope. It is important for nurses to show involvement and empathy by taking time and listening carefully to patients' stories. This attitude will encourage patients to develop active coping strategies such as identifying with other patients and learning information about symptoms and symptom management.

The respondents and the authors of autobiographical sources stress the importance of consolation given by family and friends. Supporting these significant others by offering them room to express their own concern and sorrow will help them comfort their relatives. If adequate information is provided, it promotes their understanding and can help them comfort the patients.

In conclusion, nurses can use their unique position and regular contacts with patients to support them in their mourning process. Psychiatric nursing requires empathic understanding and courage as it is not easy to face the unimaginable losses of these patients. Nevertheless, real compassion can reduce the suffering and isolation by bridging the gap between "different worlds."

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