Bereavement

Susan Block, MD
Dana-Farber Cancer Institute & Brigham & Women's Hospital, Harvard Medical School Center for Palliative Care

Holly Prigerson, PhD
Director, Center for Psycho-oncology & Palliative Care Research Associate, Dana-Farber Cancer Institute
Professor of Psychiatry, Harvard Medical School

Course Director & Producer: VJ Periyakoil, MD

Self-Assessment Questions

I. All of the following are risk factors for complicated grief except:
   - 1. Multiple losses
   - 2. Ambivalent relationship with the deceased
   - 3. Lack of preparation for the loss
   - 4. Dependent relationship with the deceased
II. Which statement best describes the resolution of grief after a loss?

1. Grieving generally proceeds through a consistent sequence of phases: denial, anger, bargaining, despair, acceptance
2. Most bereaved persons are beginning to find new meaning and purpose by 2–3 months post loss
3. Half of patients experience complicated grief after a loss
4. Hearing the voice of the deceased in the months after death is a sign of complicated grief

Self-Assessment Questions

III. Bereavement increases risk for which of the following:

1. Suicide
2. Death
3. Increased alcohol intake
4. Hypertension
5. Depression
6. Worsening of CHF
7. All of the above

Self-Assessment Questions

Reflective Exercise

• Personal experience with death
• How did this loss change you?
• How did it change your approach to palliative care?
Why is bereavement care important?

Bereavement increases risk for:
1. Psychiatric disorders
   • Major Depressive Disorder (MDD)
   • Generalized Anxiety Disorder (GAD)
   • Post-Traumatic Stress Disorder (PTSD)

Bereavement increases risk for:
2. Physical illness
   • Cancer
   • Hypertension (HTN)
   • Myocardial Infarction (MI)
   • Congestive Heart Failure (CHF)

Why is bereavement care important? (cont’d)

Bereavement increases risk for:
3. Adverse health behaviors
   • Smoking
   • Drinking
   • Eating
Why is bereavement care important? (cont'd)

Bereavement increases risk for:
4. Functional impairment
   • Social
   • Family
   • Occupational

Why is bereavement care important? (cont'd)

Bereavement increases risk for:
5. Quality of life impairment
6. Inappropriate health service use
7. Natural death and suicide

Important to Note

• Grief and Bereavement are self-limited—most patients recover on their own
• Small number of patients develop enduring distress and functional disability—opportunities for preventive intervention
Normal Grief: Phenomenology

- Somatic disturbance (sleep, appetite, energy)
- Anxious, agitated
- Preoccupation with, longing for deceased
- Identification with deceased
- Emptiness
- Reworking last days of life of deceased, and decisions about EOL
- Auditory, visual illusions
- Feeling that one is going crazy

Normal Grief (cont'd)

- 80-90% of survivors experience "normal" uncomplicated grief
- Painful, disruptive, sad, distressing
- Disturbances of appetite, sleep, perception, concentration, hopelessness about future can be profound
- Slow progression towards adaptation
- By 6 months, most patients are on path towards finding new meaning and purpose

Normal Grief (cont'd)

Cardinal symptoms include feelings of:
- Yearning
- Sadness
- Being upset
By 6 months post-loss, patients can begin to:
• Accept loss as reality
• Find meaning, purpose
• Feel future holds potential for fulfillment
• Enjoy leisure, engage in productive activities
• Maintain connections with significant others

By 6 months post-loss, patients can begin to:
• Keep identity intact
• Explore new roles and relationships
• Maintain self-esteem and sense of competence
• Function without significant impairment

Hypothesized Grief Resolution
Adapted from the work of Elisabeth Kübler-Ross
Mean Grief Symptom changes over Time from Loss
Holly Prigerson, PhD and Colleagues

Proposed Diagnostic Criteria for Complicated or Prolonged Grief Disorder
Yearning, heartache +4 of 8 at > 5 months post-loss
- Difficulty moving on
- Numb/detached
- Bitterness
- Life empty without the deceased
- Trouble accepting the death
- Future holds no meaning without the deceased
- On edge, agitated
- Distrust

Distinctive Risk Factors/Clinical Correlates of Complicated Grief
- Dependent relationships to deceased
- Kinship relationships—parents/spouses most adversely affected
- Parental loss, abuse or serious neglect in childhood
- Separation anxiety in childhood
- Preference for lifestyle regularity – averse to change/disruptions
- Lack of preparation for the death
Preparation for Death & Complicated Grief

- Bereaved caregivers who were prepared for death were 2.4 times less likely to have Complicated Grief (CG)
- Among Alzheimer’s caregivers, preparation for death reduced rates of CG, major depression, and anxiety disorder
- Length of time in hospice associated with reduced risk of morbidity and death among bereaved survivors

What not to say

- You’ll get over it…
- It is God’s will…
- If there is anything I can do, give me a call…
- She’s in a better place…

WHO SHOULD BE TARGETED FOR INTERVENTIONS?
Patients with socio-demographic and circumstantial risks

- Mothers, spouses
- Lack of social, financial resources
- Extreme dependency on deceased
- Abuse, neglect or parental loss in childhood
- Traumatic deaths
- Multiple losses
- Lack of preparation for the death

Patients with mental health risks/indicators of poor adjustment

- Suicidal ideation
- Psychiatric disorder (MDD, GAD, PTSD)—current or lifetime
- History of Prolonged or Complicated Grief

Why is Grief Hard? Two Theories

1. Trauma model
   - Grief is a trauma
   - People avoid trauma
   - Treatment = exposure to get over trauma

2. Attachment model
   - Death disrupts attachment
   - Treatment = helping bereaved maintain bonds with deceased, form new relationships
Do medications work for grief?

- Tricyclics, bupropion, benzodiazepines help for depression, sleep disturbance
- SSRIs not tried
- No medication trials demonstrate improvement in grief symptoms

Does Therapy work?

Complicated Grief Therapy

- Psycho-education about normal and CG
- Focus on adjustment to loss & restoration of satisfying life
- Trauma model
- 51% experienced significant improvement with CGT (vs 28% with IPT)
- Faster time to response (p=.02)

Do Support Groups Work?

Evidence Mixed

- Mutual self-help for support groups:
  - Significant improvement in depression, anxiety, satisfaction
  - No effect of type of support group

Mutual self-help groups are as efficacious as group psychodynamic therapy

- Tuckier et al. (1992), Vachon et al. (1980), Barrett (1978), Marmar 1988
RECOMMENDATIONS

A Palliation Education Network Production © VJ Periyakoil, MD

Bereavement Adjustment

Effective interventions

• Stabilization of sleep-wake cycles,
• Routines (e.g., nutrition)
• Exercise

Bereavement Adjustment (cont’d)

Talking generally helps talkers— if there is no one in the patient’s life, support group or therapy may be helpful
More Recommendations

• Goal of “treating” grief is to help patient find ways to hold on, and ways to move on
• There are no down-sides to support groups with an empathic, experienced leader
  - Promote new relationships
  - Provide forum for talking
• If depressed, treat the depression with drugs

Pre-Death Bereavement Care

• Early hospice referral
• Good clinical care for patient (no pain)
• Prepare for death
• Prepare for life after death
• Identify and provide extra support for those at high risk

Pre-Death Bereavement Care (cont’d)

70% of patients improve with treatment
• Strong attachment
• Little sense of self without patient
• Other: sudden, unexpected death, lack of social support, multiple losses
Pre-Death Bereavement Care (cont’d)

Educate

• Not like any other experience
• Far-reaching, overpowering experience
• Minimize alcohol, substances
• Develop new routines and skills to achieve a sense of competence
• Seek company of empathic friends, groups, develop new friendships
• Invite discussion of what happened

Pre-Death Bereavement Care (cont’d)

• Encourage expression—narrative disclosure (keep journal)
• Express sorrow for their loss
  ▪ Telephone call
  ▪ Condolence note
  ▪ Attend wake, funeral, memorial service

Long-Term Bereavement Care

• Survivors often feel abandoned and neglected
• Don’t expect bereaved people to take the initiative
  ▪ Don’t say “Call me.” They probably won’t.
• Go to them
Long-Term Bereavement Care (cont’d)

With permission, contact the bereaved’s primary care physician

Review Coping

High Distress

Mental Health Referral

• Outreach at 4–8 weeks
• Recommend support group
• Reinforce warning re: alcohol, substances
• One-year call
Good Bereavement Care: Outcomes

• Survivors feel their loved one was cared about and honored by the physician
• Gradual disengagement for medical team—avoids the “double loss” phenomenon

Good Bereavement Care: Outcomes (cont’d)

• Survivors feel supported, able to “hold on and move on”
• Reduction of health risks of bereavement for survivors
• Sense of satisfaction, meaning, and peace for the physician

Congratulations!

You have successfully completed the learning material for this module.

Thank you,
VJ Periyakoil, MD,
Palliation Education Network
Thank You!

Please click on the Certification Quiz link on the left task bar to take the self-assessment quiz.

A Palliation Education Network Production © VJ Periyakoil, MD