Life after Death: A Practical Approach to Grief and Bereavement

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This consensus paper describes the essential skills that clinicians need to help persons who are experiencing grief after the death of a loved one. Four aspects of the grieving process are reviewed: anticipatory grief, acute grief, normal grief reactions, and complicated grief. Techniques for assessment and recommendations about interventions and indications for referral are provided for each aspect.

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The dead want nothing of us but that we live.

Richard Powers, *Gain*

Throughout their personal and professional lives, physicians will encounter and experience grief. *Grief* describes a multifaceted response to loss. It may be obvious, as in a colleague who develops depression soon after the death of his wife, or more subtle, as in a widow who presents with fatigue and insomnia during her yearly check-up.

Despite its prevalence in the clinical practice and personal lives of physicians, grief has remained largely outside the province of medicine (1). Yet not all physicians have avoided grief and its management. Benjamin Rush, one of the founders of modern medicine, viewed grief as a profound threat to health and advocated an aggressive course of bleeding and purging (2). While his technique was questionable, his enthusiasm at least should be commended.

Nevertheless, Rush's sense of urgency in dealing with grief has not entered mainstream medical practice, perhaps in part because of uncertainty about whether grief is a natural response or an illness that requires treatment (3). This is a legitimate question, but the discussion it provokes should not distract physicians from the importance of recognizing grief and relieving the suffering that it can cause. Grief may be a significant source of distress and may be responsible for many of

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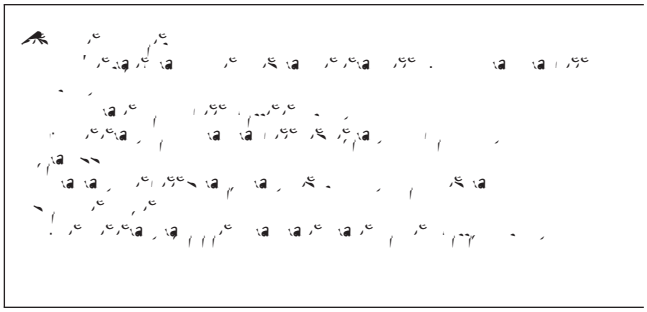
Table 2. **The Brief Bereavement Interview**



bereaved person who reassures the physician that symptoms or behaviors are normal. For example, among the Navajo, grief is often expressed publicly only during the 4 days after death (14), which many non-Navajo physicians may find surprising. When physicians are not familiar with a culture, it is important that they inquire about customs, beliefs, or cultural norms.

In assessing Mrs. Powsand's grief, Dr. Cantor should also identify deficits in social support that are associated with prolonged or difficult grief (15–17). This will require reevaluation even when a physician knows a patient well, because the most robust social support systems may weaken during bereavement if friends and family withdraw or if the bereaved person feels uncomfortable attending social events alone. Dr. Cantor can work with Mrs. Powsand to review and identify sources of support and other coping resources that she has found to be comforting. These may include spending time with family or friends or creating a memorial to her husband in the form of a scrapbook, a charitable donation, or a scholarship in his name.

Finally, Dr. Cantor can also help Mrs. Powsand identify the practical problems that have arisen now that she is alone. These difficulties may be particularly pronounced in elderly couples, who often depend on one another for financial and domestic tasks of daily life, such as balancing a checkbook or paying taxes. Referral to a social worker may be helpful.

Follow-up

Dr. Cantor reassures Mrs. Powsand that the sensation of her husband's presence is normal and does not indicate a psychiatric illness, as long as it is not disturbing to her. Mrs. Powsand says that she was reluctant to return to her bridge club because she thought it seemed inappropriate for her to go out socially so soon after her husband's death. Dr. Cantor acknowledges her concerns but encourages her to continue to draw on the sources of support that she had found helpful in the past. They agree that Mrs. Powsand should return for a routine appointment in 6 months but that she could call sooner.

Complicated Grief

Four months after Mr. Powsand's death, Mrs. Powsand's daughter calls Dr. Cantor to say that her mother has been feeling tired and lethargic since Mr. Powsand's death. These symptoms became much worse 1 month ago but have improved somewhat since then. Mrs. Powsand has been spending most of her time in the house and is still reluctant to return to activities that she had found pleasurable in the past. Her daughter asks Dr. Cantor for "something to help Mom's mood."

Mrs. Powsand is experiencing fatigue and anhedonia and has been withdrawing from her usual activities. These responses may be features of normal grief, or they may be indications of *complicated grief* or depression, which are marked by a failure to return to preloss levels of performance or states of emotional well-being (15). Because both depression and complicated grief are indi-

cations for additional counseling or psychotherapy, Dr. Cantor should arrange a follow-up visit.

At this visit, Dr. Cantor should rule out organic causes of Mrs. Powsand's symptoms and should determine whether her grief is complicated. Because of its implications for treatment, Dr. Cantor should first look for evidence of depression. Overall, estimates of depression in the first year of bereavement range from 17% to 27% (18), and suicidal ideation is present in up to 54% of persons even 6 months after the death (19–21).

Physicians may find it difficult to distinguish grief from depression because feelings of guilt, thoughts of death, and psychomotor retardation can be features of both conditions (22). However, symptoms caused by depression typically begin later, after 1 to 2 months of bereavement (23), and persist for several months after the loss (23, 24). In addition, depression is the more likely diagnosis when symptoms are constant (24). Prominent suicidal ideation, profound changes in appetite or sleep, or substantial decreases in function are also markers of depression. None of these criteria are absolute, but they should prompt consideration of antidepressant therapy or referral to a psychiatrist.

In this case, Mrs. Powsand is unlikely to have depression. Her lethargy and sadness have been present since her husband's death. Furthermore, they are accompanied by few if any somatic symptoms, such as a change in appetite, weight, or sleep. Finally, her feelings of sadness and apathy have waxed and waned over time. It is more likely therefore that Mrs. Powsand's symptoms are due to complicated grief.

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Mourning: The process by which people adapt to loss.

Bereavement: The period after a loss during which grief is experienced and mourning occurs.

Complicated mourning: Delayed or incomplete adaptation to loss.

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References

1. Eliot TD. Bereavement as a problem for family research and technique. The Family. 1930;11:114-5.

2. Rush B. Medical Inquiries and Observations upon the Diseases of the Mind. Philadelphia: Kimber and Richardson; 1812.

3. Engel GC. Is grief a disease? A challenge for medical research. Psychosom Med. 1961;23:18-22.

4. Rando TA. Treatment of Complicated Mourning. Champaign, IL: Research Pr; 1993.

5. Parkes CM. Bereavement: Studies of Grief in Adult Life. New York: International Univ Pr; 1972.

6. Helsing KJ, Szklo M. Mortality after bereavement. Am J Epidemiol. 1981; 114:41-52. [PMID: 0007246529]

7. Theut SK, Jordan L, Ross LA, Deutsch SI. Caregiver's anticipatory grief in dementia: a pilot study. Int J Aging Hum Dev. 1991;33:113-8. [PMID: 0001955206]

8. Buckman R. How to Break Bad News: A Guide for Health Care Professionals. Baltimore: Johns Hopkins Univ Pr; 1992.

9. McCorkle R, Robinson L, Nuamah I, Lev E, Benoliel JQ. The effects of home nursing care for patients during terminal illness on the bereaved's psychological distress. Nurs Res. 1998;47:2-10. [PMID: 0009478178]

10. Bowlby J. Sadness and Depression. vol. 3. London: Hogarth Pr, Institute of Psychoanalysis; 1980.

11. Lindemann E. Symptomatology and management of acute grief. Am J Psychiatry. 1944;101:213-8.

12. Tolle SW, Bascom PB, Hickam DH, Benson JA Jr. Communication between physicians and surviving spouses following patient deaths. J Gen Intern Med. 1986;1:309-14. [PMID: 0003772620]

13. Abrahm JL, Cooley M, Ricacho L. Efficacy of an educational bereavement program for families of veterans with cancer. J Cancer Educ. 1995;10:207-12. [PMID: 0008924396]

14. Miller SI, Schoenfeld L. Grief in the Navajo: psychodynamics and culture. Int J Soc Psychiatry. 1973;19:187-91. [PMID: 0004786022]

15. Prigerson HG, Frank E, Kasl SV, Reynolds CF 3rd, Anderson B, Zubenko GS, et al. Complicated grief and bereavement-related depression as distinct disorders: preliminary empirical validation in elderly bereaved spouses. Am J Psychiatry. 1995;152:22-30. [PMID: 0007802116]

16. Sanders CM. Risk factors in bereavement outcome. In: Stroebe MS, Stroebe W, Hansson RO, eds. Handbook of Bereavement: Theory, Research, and Intervention. New York: (York:)-269.1(CM.)]Tbridge.5(bereaved's)-297.5(psycho-)]TJTlotin

during the early stages of widowhood. Psychiatr Clin North Am. 1987;10:355-68. [PMID: 0003684745]

35. Weinberg N. Self-blame, other blame, and the desire for revenge: factors in recovery from bereavement. Death Studies. 1994;18:583-93.

36. Woof WR, Carter YH. The grieving adult and the general practitioner: a literature review in two parts (part 2). Br J Gen Pract. 1997;47:509-14. [PMID: 0009302794]

37. Parkes CM. Evaluation of a bereavement service. Journal of Preventive Psychiatry. 1981;1:179-88.

38. Cameron J, Parkes CM. Terminal care: evaluation of effects on surviving family of care before and after bereavement. Postgrad Med J. 1983;59:73-8. [PMID: 0006844191]

39. Raphael B. Preventive intervention with the recently bereaved. Arch Gen Psychiatry. 1977;34:1450-4. [PMID: 0000263815]

40. Lieberman MA, Yalom I. Brief group psychotherapy for the spousally bereaved: a controlled study. Int J Group Psychother. 1992;42:117-32. [PMID: 0001563900]

41. Levy LH, Derby JF, Martinkowski KS. Effects of membership in bereavement support groups on adaptation to conjugal bereavement. Am J Community Psychol. 1993;21:361-81. [PMID: 0008311030]

42. Vachon ML, Lyall WA, Rogers J, Freedman-Letofsky K, Freeman SJ. A controlled study of self-help intervention for widows. Am J Psychiatry. 1980;137:1380-4. [PMID: 0007435671]

43. Nolen-Hoeksema S, Larson J. Coping with Loss. Mahwah, NJ: Erlbaum; 1999.

44. Freud S. Mourning and melancholia. In: Strachey J, ed. The Standard Edition of the Complete Psychological Works of Sigmund Freud. vol. 20. London: Hogarth Pr; 1917.

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