Bereavement and loss

Bereavement and loss - Z63 (Clinical term: Grief reaction E2900).

Presenting complaints

An acute grief reaction is a normal, understandable reaction to loss. Patients present in different ways, but typically they:

- feel overwhelmed by loss
- are preoccupied with the loss
- may present with somatic symptoms following loss.

Individual grief experiences vary enormously; they depend on:

- the type of loss (eg a loved one, health, social status and lifestyle through the loss of a job, or the breakdown of a relationship)
- the nature of the loss (expected versus unexpected, traumatic loss, concurrent multiple stressful events, multiple losses)
- the individual suffering the loss (eg coping strategies, age, spiritual health, previous experience of loss) and their social context (eg family systems, access to support, cultural context).

Grief may precipitate or exacerbate other psychiatric conditions. It can also become pathological, eg it can be absent, delayed (grief reaction triggered some time after loss) or chronic (intrusive and fixed emotions of grief). Broadly speaking difficulties arise when the response becomes unusually dysfunctional to the individual and those around them.

Diagnostic features

Besides the emotional response to loss, symptoms resembling depression can occur:

- low or sad mood
- disturbed sleep
- loss of appetite
- loss of interest
- restlessness
- guilt or self-criticism about actions not taken by the person before the death of the loved one
- transient hallucinations of the deceased person such as hearing their voice
- thoughts of joining the deceased.

The patient may:

- withdraw from usual activities and social contacts
- find it difficult to think of the future
- increase his/her use of drugs or alcohol.

Patient presentation can be obvious, but it can also be hidden. Adverse reactions to loss may only be revealed after careful questioning. It may be possible to identify certain individuals who are at particular risk (eg social isolation, history of mental illness, previous unresolved grief). Assessing the impact of the loss and the coping strategies available is important in guiding management. Taking time, perhaps over a couple of appointments, may be necessary.

Differential diagnosis

- Depression - F32# Knowing when to use the medical model for depression can be difficult and it is important not to medicalize the problem. That said, disabling depressive symptoms that become protracted (about 4-6 months) or severe (eg retardation, overwhelming guilt, hopelessness, suicidal ideation) may be helped by treatment for depression.
- Generalized anxiety - F41.1
- Sleep problems - F51.

Essential information for patient and family

- Everybody grieves differently.
- Important losses are often followed by intense sadness, crying, anger, disbelief, anxiety, guilt or irritability.
- Bereavement typically includes preoccupation with the deceased (including hearing or seeing the person).
- A desire to discuss the loss is normal and beneficial.
- Inform patients, especially those at greater risk of developing an abnormal grief reaction, of local agencies, which offer bereavement counselling and aim to help guide people through their normal grief (ref 30).

References

30 Raphael B. Preventive intervention with the recently bereaved. Arch Gen Psychiatry 1997, 34: 1450-1454. (BIII) This work demonstrates that 'high-risk' bereaved people who receive counselling have fewer symptoms of lasting anxiety and tension than those who do not.

General management and advice to patient and family

(ref 31)

- If a loss can be predicted, lead the patient and their family through the challenges facing them with appropriately paced and guided discussion, shared understanding based on the patient's world view and optimal physical care.
- Enable the bereaved person to talk about the deceased and the circumstances of the death. This can provide them with a useful narrative about their loss which will help them in the future.
- Answer questions to enable the bereaved to understand what happened at the time of death.
- Encourage free expression of feelings about the loss (including feelings of sadness, guilt or anger). In bereavement, be prepared to hear and acknowledge any expressions of anger directed at health professionals, including yourself. Sensitive management of this anger can be crucial.
- Offer reassurance that recovery will take time (grief has to run its course). Some reduction in burdens (eg work or social commitments) may be necessary.

- Explain that intense grieving will fade slowly and that reminders of the loss may continue to provoke feelings of loss and sadness.
- Social structures (eg families) are vulnerable at times of bereavement. Group coping strategies can increase or decrease subsequent individual morbidity and group functioning.
- Take into account the cultural context of the loss.
- Listening and giving a sense of 'being there' for the patient may be all that is needed.

There is no 'catch-all' advice for the patient and family but the following might be helpful:

- Do cry if the need is there and don't be surprised if you cry more than normal, even if it is in unusual places.
- Do accept help from others but don't let people pressure you to do things that don't feel right or before you are ready.
- Don't feel guilty if you do not always feel upset. There will be many occasions when you need to carry on with everyday things.
- Do remember that children and young people need to grieve as well. Let the teachers and school know.
- Do remember that people react to grief in different ways; within a family this can be difficult.
- Do take care of yourself and try to eat sensibly and rest.
- Do try and keep life as normal as possible, with some sort of routine. Do, if you can, avoid any major changes in the first year, such as moving house.
- Do take things a day at a time when you are feeling low, but be ready, as time passes, to try new things and meet people.

References

31 Kato PM, Mann T. A synthesis of psychological interventions for the bereaved. Clin Psychol Rev 1999, 19(3): 275-296. (C1) Fourteen studies were analysed. A slight improvement is seen for individual therapies.

Medication

Avoid medication if possible. If the grief reaction becomes abnormal, see Depression - F32# for advice on the use of antidepressants.

Disturbed sleep is to be expected. If severe insomnia occurs, short-term use of hypnotic drugs may be helpful but use should be limited to 2 weeks.

Referral

If the patient is failing to respond to the measures outlined above, or symptoms are severe and persistent, or patients are particularly at risk, then more formal grief counselling may help and can be arranged via:

- practice counsellor
- Cruse Bereavement Care (adult bereaved)
- Compassionate Friends (for those bereaved through the loss of a child)
- hospice bereavement services (for those bereaved of hospice patients)
- Relate (for those who are suffering through the loss of a relationship).

Referral to secondary mental-health services is advised:

- if the patient is severely depressed, threatening suicide (never be afraid to ask), or showing psychotic features
- non-urgently, if symptoms have not subsided by 1 year despite bereavement counselling.

Refer bereaved people with a learning disability to a specialist disability team or specialist learning disability counsellor.

Resources for patients and families

Cruse Bereavement Care 0870 167 1677 (Helpline 9.30am–5.00pm, Monday–Friday)
Email: info@crusebereavementcare.org.uk; website: http://www.crusebereavementcare.org.uk
Offers support, information, training and direct telephone help to anyone who has been affected by a death. Over 150 branches throughout the UK.

The Compassionate Friends 0117 953 9639 (Helpline 10am–4pm, 6.30pm–10.30pm)
Email: info@tcf.org.uk; website: http://www.tcf.org.uk
Organization of bereaved parents offering friendship and understanding to others after the death of a child.

Stillbirth and Neonatal Death Society (SANDS) 020 7436 5881 (Helpline 10am–3pm)
Email: support@uk-sands.org; website: http://www.uk-sands.org
Provides support for parents and families whose baby is stillborn, or dies shortly after birth.

Foundation for the Study of Infant Deaths (FSID) 0870 787 0554 (helpline)
Email: fsid@sids.org.uk; website: http://www.sids.org.uk
National helpline, local parent groups and befrienders to bereaved families who have suffered a cot death.

Papyrus 01706 214 449
Website: http://www.papyrus-uk.org
Self-help for parents of young people who have committed suicide.

Relate 01788 573 241
Website: http://www.relate.org.uk
Counselling for adults with relationship difficulties, whether married or not.

Growthhouse.org http://www.growthhouse.org
This is an **award winning** website for those facing the end of life and bereavement.
Coping with Bereavement. The Royal College of Psychiatrists. Talking Life, 1A Grosvenor Rd, Hoylake, Wirral CH47 3BS. Tel: 0151 632 0662. website: http://www.talkinglife.co.uk
A programme on tape of practical advice and support to people of all ages who have been bereaved.
Leaflets are available from the Royal College of Psychiatrists (http://www.rcpsych.ac.uk): Bereavement, Sleeping well, Bereavement information pack: for those bereaved by suicide or other sudden death.