Grief and abnormal grief

“I don’t think you ever get over it, but I am beginning to see there might be a life out there for me, without John. It’s a very different life to what we imagined together...but there are some things I am starting to feel excited about...”. This was said to me many years ago, by a woman whose husband had died about 6 months previously, shortly after he had retired.

This article is summarised from two BMJ articles which focused on grief and prolonged grief (defined later) (BMJ 2017;357:j2016 and 2017;358:j2854).

Grief is a unique experience for each person, and those in primary care are very used to observing grief and often develop a good sense of what is normal and what is outside the norms.

Models that describe ‘stages’ of grief are inadequate as they imply a series of steps everyone does/should go through on the grief journey, and for most the journey is much more messy than that.

More recent models describe ‘grief tasks’, which need to be achieved, but acknowledge these can and do happen in any order:

- To accept the reality of the loss.
- Experience and process the pain of loss.
- Adjust to a world without the deceased.
- Re-invest in a new reality and new life.

Remember that grief is very culturally bound – make allowances for cultural norms.

The ‘grief tasks’ can also be applied to losses other than bereavement: missing persons, migration (‘cultural bereavement’) and in the context of losses such as new onset physical and mental illness and disability.

‘Normal’ grief

The experience of grief is intense, and often profoundly disruptive of all normal behaviours. People may wonder if their experience is ‘normal’, especially if they experience auditory or visual hallucinations of their loved one, which many people do. No one’s experience is the same as another’s, and one bereavement may not feel like a previous bereavement experienced by the same person earlier in their life.

Acute grief is characterised by:

- Feelings of disbelief, difficulty comprehending the reality of the loss.
- Bitterness/anger/guilt/blame.
- Impaired functioning: within the family, socially, ability to work/go to school.
- Intense yearning and sadness, emotional and physical pain. There may be physical symptoms of anxiety.
- Mental fogginess, difficulty concentrating, forgetfulness.
- Loss of sense of self or sense of purpose in life.
- Feeling disconnected from other people and ongoing life.
- Difficulty engaging in activities or making plans for the future.

Normal grief is often more severe if death has been violent or unexpected.

When listening to a bereaved person talking, look out for the following, which show progress is being made with the ‘grief tasks’ (outlined above) and the integration of the loss/grief:

- Beginning to accept the reality of the death.
- Beginning to imagine a future without the person they loved, in which there might be the possibility of purpose, meaning and happiness.
- Finding meaningful ways to connect to the person who died.

Grief and mental ill health

Remember depression, anxiety disorders, PTSD and alcohol abuse can all occur after a bereavement.

Separating grief from depression can be hard, as many of the symptoms overlap. Look for the following:

- Grief includes longing/yearning for the loved one, which is not seen in depression.
- In grief, positive emotions can still be experienced, whereas in depression, these are often blunted.
- In grief, symptoms are at their worst when the patient is thinking about the deceased person.
- In grief, people often want to be with others, whereas people with depression tend to want to be alone.
When is grief abnormal?

Psychiatrists don’t agree! The International Classification of Disease (ICD-11) and the American DSM-5 have slightly different terms for abnormal grief, however, they share many elements in common, and for us in primary care I do not think the differences are particularly important.

- The US DSM-5 describes ‘persistent complex bereavement disorder’ which can be diagnosed 12m after a loss.
- ICD-11 describes ‘prolonged grief disorder’ which can be diagnosed 6m after a loss.

Throughout this article I will use the term prolonged grief disorder.

What is prolonged grief disorder?

Prolonged grief disorder is diagnosed when there is:

- Marked distress and disability caused by the grief reaction.
- AND the persistence of this distress and disability more than 6m after a bereavement.

Prolonged grief disorder occurs in about 5% of all bereavements in adults.

Suspect prolonged grief disorder when, more than 6m after a loss, there are persistent, distressing and disabling features such as:

- Grief reactions that are out of proportion with or inconsistent with cultural, religious or age-appropriate norms.
- Separation distress (longing for the deceased, intense emotional pain, preoccupation with deceased/circumstances of their death).
- Difficulties confronting reality and the irreversibility of the loss (disbelief/denial).
- Sense of meaninglessness about life without the deceased.

Remember many of these things are normal after a loss, but are transient – if, more than 6m after a loss, they are present more days than not and cause severe distress and impaired functioning, then this is likely to be prolonged grief disorder.

Many of the symptoms are similar to depression, anxiety states, PTSD and adult separation anxiety disorder, and these 4 conditions can coexist with prolonged grief.

Impact of prolonged grief disorder

Prolonged grief disorder is associated with an increased risk of:

- Poor physical health.
- Suicide/suicidal ideation.
- Reduced quality of life.
- Functional impairment.

Who is most at risk of prolonged grief?

- Women.
- Those of lower educational achievement.
- Personality traits: insecure attachment or neuroticism.
- Death of a partner or child as opposed to other relationships.
- Immigrants, refugees and groups displaced/affected by conflict are at higher risk.

Can prolonged grief disorder be prevented?

Studies suggest mixed results from interventions to reduce the risk of prolonged grief disorder and the trials are mainly small.

Treating prolonged grief disorder

- There is some evidence for:
  - Behavioural activation: aims to restore meaningful roles and activities by gradually increasing engagement in activities that are valued (these might be social, educational or occupational) and reduce depressive avoidance and rumination.
  - Cognitive interventions: identify and modify negative thoughts that stop adjustment to loss. For example, looking at negative cognitions about self or the world and, after a violent loss, the world’s safety and predictability.
  - Exposure interventions: designed to reduce avoidance of situations/thoughts and memories associated with loss. Often involves talking/writing about the implications of separation, increasing exposure to places/things that are associated with the loss. After a violent loss, it may also involve exploring the memories of the circumstances around the loss.
  - Antidepressants can and are used to treat co-existing depression.
  - Benzodiazepines are NOT recommended, because of the risk of dependence, but also because they interfere with learning
We make every effort to ensure the information in these articles is accurate and correct at the date of publication, but it is of necessity of a brief and general nature, and this should not replace your own good clinical judgement, or be regarded as a substitute for taking professional advice in appropriate circumstances. In particular check drug doses, side-effects and interactions with the British National Formulary. Save insofar as any such liability cannot be excluded at law, we do not accept any liability for loss of any type caused by reliance on the information in these articles.

Referral

- For all who are bereaved, refer if depression/PTSD occur and impair functioning.
- For those with prolonged grief disorder, consider referral to mental health services if there is impaired functioning.

Children and prolonged grief disorder

- Rates of prolonged grief disorder are around 5–10% in children.
- In children the features are often similar to those in adults, but expressed in an age-appropriate manner – for example, a young child might persist in being obsessed with death-related play.
- In children who have lost a parent, the Family Bereavement Programme (that aims to build resilience in the child) has been shown to reduce immediate and long-term emotional problems.
- CBT has been shown to be beneficial in children with prolonged grief disorder.

Witnessing the distress of a bereaved person can trigger our own memories of past losses and can trigger feelings of guilt if we feel we failed the deceased patient in some way. Do remember to allow yourself time and space to process these emotions and seek help from family, friends, colleagues and professionals if needed. No person is an island...

Grief and abnormal grief

- Everyone’s experience of grief and way of dealing with loss is unique, and it can be hard to decide what ‘normal’ is, especially if a parent has lost a child, or a death has been violent or unexpected.
- Grief can also occur with losses other than death (e.g. ‘cultural bereavement’ can occur with migration).
- After the acute phase of grief, look for positive signs that grief is being integrated:
  - Beginning to accept the reality of the death
  - Beginning to imagine a future without the person they loved, in which there might be the possibility of purpose, meaning and happiness
  - Finding meaningful ways to connect to the person who died.
- Suspect prolonged grief disorder if, more than 6m after a loss, there are persistent, distressing and disabling features which are outside the cultural norms for that person.
- The features might include disproportionate grief reactions, separation distress, difficulties confronting reality of the loss.
- Remember to look for and treat PTSD (especially after a violent death) and depression.
- Consider additional support/referral if function is impaired.

For patients:
Child Bereavement UK:
https://childbereavementuk.org
Cruse Bereavement Care:
www.cruse.org.uk
The Royal College of Psychiatrists has a leaflet on bereavement with a whole host of resources listed at the end:
www.rcpsych.ac.uk/healthadvice/problemsdisorders/bereavement.aspx
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The Effective Consultation Course

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Leeds Fri 16 Nov 2018
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The Medically Unexplained Symptoms Course

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☐ The Women’s Health Update Course (location)............................................................... (date)................................
☐ The Telephone Consultation Course (location)............................................................... (date)................................
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