Why grief matters

Physicians can help patients handle loss

BY KIMBERLY SCHOONOVER, MD

People express grief differently—sometimes with intense emotions and sometimes with mild sadness, sometimes for months to years and sometimes for days to months. As medical professionals, we need to understand how grieving affects people, and how to identify and understand the management of grief and complicated grief.

After the death of a loved one, bereaved people navigate challenging societal expectations and circumstances. Common situations may include:

- Unwanted comments (minimizing the loss of an infant and/or stillborn, for example) and intrusive and uncomfortable questions about the death.
- Stigma, such as after a loved one is lost from suicide.
- Feeling isolated (such as after the sudden loss of an infant in current society where infant death is uncommon).
- Avoidance by other people (others turning away from them at work or in the general public to avoid conversing with the bereaved person).
- Relationship difficulties (which can occur after a child dies and the parents have different ways of expressing grief or of supporting one another).

The way to categorize grief—normal, uncomplicated, pathological, prolonged, complicated—continues to be debated. If grief is an extension of love, how long does someone have the right to grieve? How intensely is one "allowed" to grieve?

There are different theories about the mourning process, or the process of integrating the loss into a new reality.

Stage theory describes adjusting to the loss through stages of shock-numbness, yearning-searching, disorganization-despair and reorganization. The accuracy of this model has been questioned.

Task theory posits that a bereaved person actively engages in the grieving process by accepting the death, processing the pain, adjusting to a world without the loved one and finding an enduring connection with the person who died.

Dual process recognizes that a grieving person oscillates between confronting (loss-orientation) and avoiding (restoration-orientation) the distress related to the death by not focusing on the loss for a period of time. This model recognizes that this is a healthy way of coping with the death of a loved one.

'Normal' vs complicated grief

What makes "normal" grief different from complicated grief is the intensity and/or duration of grief, in addition to impacting familial, social and/or occupational functioning that is different than would be culturally explained. Most people start to integrate the loss of their loved one into their new reality within the first six months (yearning, anger and/or depression tend to reach their peaks by six months). When intense emotional pain and/or yearning continue beyond what typically is experienced and impact the person's level of functioning, complicated grief should be considered. Complicated grief has been associated with worsening mental and physical health and quality of life.

Acute grief may be experienced in many ways, including: anxiety/restlessness, anger and despair, yearning and numbness, "brain fog," fatigue, insomnia, loss of appetite, ruminations about the one who died, a sense of helplessness and unreality, sensing the presence of the one who died, social withdrawal and suicidal ideation. Increased inflammatory markers as well as physical complaints may occur. Depending on the circumstances, such as the death of a child or spouse, the risk of mortality may increase.

The prevalence of complicated grief varies from about 10 percent of the general adult population in non-violent bereavement to higher in those bereaved by a violent death, a death of a child (expected or unexpected) or after a disaster. For example: 57 percent of mothers whose infant had died suddenly and unexpectedly met the criteria for prolonged grief disorder one year after the death and 41 percent met the criteria three years after the death. Risk factors for complicated grief include: being female, over 60, grieving an unexpected loss (including traumatic or violent death or suicide) as compared to a natural death, lack of preparation for the loss, low social support, history of anxiety or depression in the bereaved person prior to the death and the loss of a child. Screening tools can identify persons with complicated grief. These include a self-report Brief Grief Questionnaire and the Inventory of Complicated Grief (ICG), where a score greater than 30 indicates that complicated grief is very likely.

Diagnosing complicated grief

Different terminology and criteria are used to diagnose complicated grief [International Classification of Diseases-11th Revision (ICD)-11 and Diagnostic and Statistical Manual of Mental Disorders (DSM)-5]. It should be noted there are studies that support the idea that while the ICD-11 criteria define prolonged grief disorder (PGD) and DSM-5 criteria for persistent complex bereavement disorder (PCBD) differ on some points (such as 6- vs 12-month requirement), they perform similarly in identifying individuals with complicated grief, although may be less sensitive for certain populations, such as bereaved military family members.

The ICD-11 criteria define PGD by yearning for or persistent preoccupation of the one who died, accompanied by intense emotional pain in addition to impairing one's ability to function in important areas of life for at least six months after the loss (that is outside of one's social, cultural and/or religious norms).

The DSM-5 criteria for PCBD requires the bereaved person to continue to have yearning or intense sorrow or preoccupation with the person who died or circumstances of the death in addition to six out of 12 reactive distress symptoms and/or social and identity disruption (such as difficulty accepting/anger related to the death, emotional numbness, excessive avoidance of reminders of the loss, feeling that life is empty without the person who died), in addition to functional impairment that has persisted for at least 12 months and is not otherwise explained by sociocultural norms.

Anxiety, major depressive disorder (MDD) and posttraumatic stress disorder (PTSD) can co-occur with complicated grief. In both MDD and complicated grief, there are shared symptoms such as rumination, sadness, sleep disturbance, social withdrawal and suicidal ideation. In MDD, the symptoms are more generalized rather than specific to the loss, as in complicated grief. In complicated grief, for example, suicidal ideation specifically relates to the desire to not live without the person who died. While PTSD and complicated grief share similar symptoms, including a sense of shock, sleep and concentration disturbances, intrusive thoughts and images, and avoidance, they differ as well. In complicated grief (where yearning is typically more present than fear), the aim of avoidance is to reduce distress specifically related to reminders of the loss, rather than from a traumatic event; the intrusive memories relate to the thoughts of the death of the loved one rather than to a traumatic event.

Management of grief

Specific management for uncomplicated grief beyond the usual support from the bereaved person's support network (family, friends, others) is usually not necessary and hasn't been shown to be consistently beneficial, with the possible exception of those who specifically request assistance. If the bereaved person has complicated grief, then cognitive behavioral therapy specific for complicated grief can be helpful. If the person has anxiety or depression, antidepressants can be helpful for those conditions, but it is important to recognize that antidepressants are not effective for complicated grief.

While the loss of a loved one will likely occur for most people at some point in their lifetime, the grieving process can be very distressing for the bereaved person as well as for those witnessing the emotional pain of the bereaved person. By understanding grief and complicated grief, health care professionals can be a source of support for those who are grieving by providing condolences, education and reassurance about the symptoms and experiences of grief, and directing those with suspected complicated grief to appropriate resources. MM

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