GRIEF

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Preamble

Today's topic is grief. Exactly do we mean when we talk about grief in primary care?

Grief is the emotional response to an event of loss of any kind. It is an umbrella term and within medicine we discuss a few grief sub-types. "Anticipatory grief" occurs before a loss, like mourning a person's diminishing health. "Acute grief" is the classic experience of loss, and it may last months to years. "Prolonged grief disorder" is when maladaptive responses take over and it describes an intense and disabling form of grief. "Bereavement" is the specific label for when someone loses a loved one. This is the main example we will be using because it is one of the more frequent grief situations encountered in family medicine, and the one clinicians seem least prepared to address.

1. In patients who have experienced a loss, prepare them for the types of reactions (e.g., emotional, physical, varying length) they may have.

This objective requires that we know what quote on quote "normal" grieving looks like.

Let's pause for a second to address a common misconception: the idea that acute grief occurs in discrete steps. This stems from the Kübler-Ross model which puts forward 5 stages of grief: denial, anger, bargaining, depression, and acceptance. Dr. Elizabeth Kübler-Ross was a Swiss-American psychiatrist who recognized the need for better

teaching regarding death and dying in medical school. She studied terminally ill patients and wrote about their experiences.

The original research explored stages of acceptance of one's own death, not grief, but her findings on coping with illness have been appropriated by popular culture as a roadmap for grief and loss. Although grief can manifest many ways this stepwise model has not been supported by further research. It's actually a fascinating story and if you want to learn more about Dr. Kübler-Ross there is a link in the show notes to a Radiolab episode dedicated to this.

Now back to objective 1: we as physicians are supposed to know what normal grief reactions look like so we can guide patients on what to expect, and keep an eye out for deviations from this that can have the potential for harm. Grief reactions are as individual as the relationship that was lost and are influenced by factors like cultural norms, religion, and previous loss experiences.

Some people will present to family physicians because they are alarmed by the symptoms of their acute grief. Although life altering and potentially debilitating it is something that should not be medicalized. Rather, it can be helpful to provide information about grief to promote a better understanding of the experience, and to encourage patients to talk about their loved one.

Let's start with acute grief. Acute in this context is a bit of a misnomer because it can last over a year - more on this later. It can be helpful to think of acute grief symptoms fitting into two main categories,

1) separation responses and

2) stress responses.

1) Separation responses include feelings of loneliness, crying, and yearning for closeness. There may be shame, anxiety, or anger when confronted with reminders of the loss. People can describe somatic sensations of headaches, dizziness, palpitations, chest pain, or GI upset. Persistent or intrusive thoughts and memories of the lost person can lead to disruptions in sleep and appetite, and about 10 to 25 percent of people even experience hallucinations. Social withdrawal and disinterest in other people and activities can happen as well. Significant distress can come from confusion about one's identity and feeling lost or uncertain about the future.

2) Stress responses include disbelief, shock, and numbness. Some people experience impaired attention and concentration. These are things we see in events of psychological trauma, and the trauma of a loss is no exception.

It is normal to experience these separation and stress reactions throughout grief recovery. Most medical resources state that in acute grief the majority of adaptation happens within the first 6 months and that many people heavily re-engaged in their lives by twelve months. Intense emotional reactions can still occur after a year, often flaring at important dates or during emotional or stressful events. It's important to remember that time correlates to recovery but does not erase grief - it's what you do with that time that matters most.

Estimates suggest that in approximately 10 percent of people acute grief does not follow its typical trajectory, instead it can morph into a "prolonged grief disorder." Also known as "complicated grief," with specific criteria listed in the DSM-5, this is characterized by maladaptive thoughts, dysfunctional behaviors, and dysregulated emotions, all of which prevent someone from appropriately coping with loss. Other psychopathologies can develop from acute grief as well, like major depression, anxiety disorders, and even posttraumatic stress disorder.

Keep in mind that unlike previously mentioned conditions, most patients experiencing acute grief don't need any specific interventions, just support and empathy.

2 In all grieving patients, especially those with a prolonged or complex grief reaction:

a) Inquire about depression, suicidal ideation, self-medication, and alcohol and substance use

b) Consider the requirement for additional treatments or referral

Okay, so you suspect your patient may be coping with their loss in a maladaptive way. How do you sensitively and effectively screen for these things?

We here at the GenerEhlist like single item screening tools because they are brief, easy to memorize, and don't require complex scoring. They can be weaved naturally into conversations to avoid the robot doctor stereotype. The following question was validated in a cross sectional primary care study to screen for unhealthy alcohol use:

How many times in the past year have you had five (four for women) or more drinks in a day?

Someone screens positive if the answer is more than zero. A positive test is 82 percent sensitive and 79 percent specific for unhealthy alcohol use.

What about the CAGE questionnaire that we learned in medical school? It's designed to screen for the DSM-IV criteria of substance abuse and dependence, which means it is not as sensitive to the full spectrum of *problematic* use.

For self-medication and drug use you can ask:

"How many times in the past year have you used a drug or prescription medication for nonmedical reasons?"

If patients screen positive to the single item questions you can again continue with DSM-5 criteria to diagnose a substance use disorder and determine the severity.

For people with mild substance or alcohol use disorder the goal in primary care is to encourage abstinence or reduction. Moderate to severe disorders often need more intensive interventions not covered here. We'll have more to say on these points in a future episode dedicated solely to Substance Use and Addiction.

On to depression:

Acute grief and major depression have many overlapping features such as sadness, guilt, dysphoria, and insomnia. There are a few key differences that can help to differentiate the two.

Total time of dysphoria is less important than pattern: in acute grief the main emotion is loneliness and yearning that is often intermittent; people are able to experience positive emotions when not thinking about their loss. In major depression there is no respite from sadness, and the negative emotions are not usually focused on any specific thought.

Guilt in depression will manifest as worthlessness or self-hatred while in acute grief it revolves around thoughts of who or what was lost, having not been able to prevent the loss, or mistakes made in the relationship.

Sleep disturbances in acute grief are more characteristic of anxiety and stress, worrying about what life will be like without the deceased or how things will work out. In depression we typically see more early awakenings or excessive sleep.

Generalized lack of interest in activities is a hallmark of depression, where those experiencing acute grief may want to avoid *specific* reminders of their loss. Additionally, those with acute grief reactions will still be able to imagine themselves as happy if their loss did not occur - those experiencing depression often express hopelessness and find it impossible to imagine being happy.

Suicidal ideation can occur in both acute grief and depression. Whereas in major depression these thoughts stem from negativity towards oneself, environment, and future, in acute grief the goal of suicide is often expressed as a desire to join the deceased.

It can also be the manifestation of feelings that life is not worthwhile without what was lost. Risk factors for suicide include current or prior psychiatric diagnosis, a lack of social support, and grieving someone who died by suicide.

As with anyone where safety is a concern, ask about steps taken, specific plans, and other risk factors to determine how to address suicidal ideations.

So how do we help our patients who may need additional resources?

Well, there is a surprisingly scant amount of high quality research on how to best help patients cope when experiencing complex grief. UpToDate recommends psychotherapy or grief-specific counseling as a first line intervention. CBT is also an option.

Ensure to assess underlying psychopathology if these treatments are seemingly ineffective, as pharmacotherapy may be appropriate. We have a table of resources in the show notes that provide some resources for acute and complex grief.

3 Recognize that grief reactions may vary based on the individual's context and experiences; life cycle and developmental stages; and cultural and family contexts.

Objective three says plainly: grief is not a one-size-fits-all emotion. Concepts of grief are influenced by social group, customs, family, ceremonial rituals, spirituality, and even institutions. Patients may present to family physicians because they are alarmed by the symptoms of their acute grief.

Although life altering and potentially debilitating it is something that should not be medicalized. Rather, it can be helpful to provide information about grief to promote a better understanding of the experience, and to encourage patients to talk about their loved one. If you are unsure what is considered normal within a given culture consider directly asking your patient or consulting a colleague.

If you are concerned about psychopathology, another tool at our disposal is the Cultural Formulation Interview in the DSM-V which can provide sociocultural assessment of a patient's background to help evaluate grief responses.

4 In patients with presentations suggestive of grief reactions without obvious triggers look for triggers that may be unique to each patient (e.g., death of a pet, loss of a job, reactions to anniversary).

The spectrum of losses that leads to a grief reaction can be surprising. Labeling behaviors as consistent with grief may prompt patients to disclose an incident of loss that they have dismissed or are embarrassed to mention.

For example, if someone describes a recent decreased interest in activities and desire for social withdrawal you can ask, “I often see this in people who are experiencing grief from a loss or disappointing outcome. Does that sound like you? I am here to talk if you’d like to explore these feelings.”

Perhaps they will disclose a recent loss, perhaps not. Listen to your instincts and let patients take the lead. Follow up can be helpful if you aren’t able to fully explore grief symptoms in one visit.

5 In patients with unexplained or unresponsive physical or mental health concerns; alcohol or substance use; or functional or behavioral change, ask about loss and/or grief as possible contributing factors.

Our final objective reinforces the immense benefits of getting to know your patients over time.

Exploring unresolved grief as a contributing factor for behavior change requires compassionate inquiry. We know there is significant morbidity and mortality associated with grief.

Asking patients about triggers for their maladaptive behaviors can be a first step in exploring other ways of coping with separation and stress responses which may be attributable to grief.

6. BONUS OBJECTIVE 6: What are the do's and don't of grief in primary care?

1. DO acknowledging a loss, even if it's just to say "I heard about this and am truly sorry. I am here to listen for whatever you need."
2. DO put your patients at ease by being attentive to physical cues including eye contact, active listening, and relaxed body language.
3. DO validate people's emotions.
4. DO encourage adaptive coping responses while screening for maladaptive behaviors.
5. DO reflect on your experiences of loss and death, your way of managing/coping with difficult situations, and try to find your blind spots.
6. DON'T say "I know how you feel," as there are better ways to express compassion that do not center on oneself.
7. DON'T use clichés ("they are in a better place", "everything happens for a reason", "time heals all wounds").
8. DON'T give unrealistic prognostic cures, minimize symptoms, or provide unsolicited advice
9. DON'T medicalize acute grief, normalize it.
10. DO foster genuine compassion, and remember that the role of a physician is to cure sometimes, to relieve often, and to comfort always.

SOURCES

1. UpToDate Article: Bereavement and Grief in Adults: Clinical Features.
2. UpToDate Article: Screening for unhealthy use of alcohol and other drugs in primary care.
3. UpToDate Article: Bereavement and grief in adults: Management
4. UpToDate Article: Prolonged grief disorder in adults: Treatment
5. "The Queen of Dying: Elisabeth Kübler-Ross and the Five Stages", *Radiolab*, WNYC Studios, July 23, 2021
6. Shear MK. Clinical practice. Complicated grief. *N Engl J Med*. 2015;372(2):153–160.
7. STEPHEN T. DUDLEY, DVM, MD, University of Washington School of Medicine, Seattle, Washington. *Am Fam Physician.* 2019 Jul 1;100(1):54-56. “Helping Patients Cope with Grief: Curbside Consultation” https://www.aafp.org/afp/2019/0701/p54.html
8. Pearce, Caroline et al. “Supporting bereavement and complicated grief in primary care: a realist review.” *BJGP open* vol. 5,3 BJGPO.2021.0008. 30 Jun. 2021, doi:10.3399/BJGPO.2021.0008
9. Smith, Peter C et al. “Primary care validation of a single-question alcohol screening test.” *Journal of general internal medicine* vol. 24,7 (2009): 783-8. doi:10.1007/s11606-009-0928-6
10. William E. Cayley Jr., MD, MDiv. *Fam Pract Manag.* 2006 Oct;13(9):74.

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TABLE 1.

Description of Grief-Related Terms

TERM	FEATURES	DURATION
Anticipatory grief	Mourning loss of health in a loved one; worry about what life will be like without that person	Can last for years depending on the health status of the loved one
Bereavement	Experiencing a loss	Often overlaps with grief
Grief	Internal manifestation of loss (e.g., sadness, loneliness, crying, insomnia, lack of self-care, yearning)	Frequently lasts up to one year
Mourning	Personal or public way to grieve (e.g., funerals, wakes)	Months to years
Complicated grief	Abnormally long, protracted, disabling grief	Can last for years

RESOURCES CLINICIANS CAN PROVIDE FOR THE GRIEVING

BOOKS

Getting to the Other Side of Grief: Overcoming the Loss of a Spouse by SJ Zonnebelt-Smeenge, and RC De Vries.

A Grief Observed by CS Lewis

The Grief Recovery Handbook by John W. James and Russell Friedman

It's Okay That You're Not Okay by Megan Devine, Psychologist

Dying Well by Ira Byock, MD

Being Mortal by Atul Gawande, MD

Being with Dying by Joan Halifax

At the Will of the Body by Arthur W. Frank

Mourning Has Broken by Erin Davis

SUPPORT GROUPS

Candlelighters – Childhood Cancer Family Alliance

https://candle.org

The Compassionate Friends – Supporting family after a child dies

https://www.compassionatefriends.org

GriefNet – Community of persons coping with grief, death, trauma, or major loss

griefnet.org