

Virtual Mentor

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ETHICS CASE 3

Treating Bereavement

Commentary by Richard A. DeVaul, MD

On the examining table, Mrs. Greene looked much older than her 41 years. There were dark bags under her eyes, and her hair was tied back in a bun. She was seeing her primary care physician, Dr. Samuel, for a routine physical exam.

“Do you have any pain?” Dr. Samuel asked as he pressed on the patient’s belly.

Abruptly, Mrs. Greene sat up. Tears were overflowing her eyes.

“Dr. Samuel, I’m in a lot of pain,” she admitted. “Since my daughter died, I wake up in the middle of the night thinking I hear her calling out my name. Am I going crazy?”

Mrs. Greene’s 8-year-old daughter had died from leukemia about 7 months before, and since then Mrs. Greene had had trouble falling asleep and staying asleep. She had lost 10 pounds. She was on a leave of absence from her job as an accountant because she couldn’t concentrate on her work.

Dr. Samuel handed her a box of tissues. “My heart goes out to you,” he replied. “I can’t imagine what it’s like for you to lose your child. The grief you’re going through must be terrible.”

“It is terrible,” murmured Mrs. Greene. “It’s been going on for months now. Shouldn’t it have stopped by now? Can’t you prescribe me a pill to take away this pain?”

“Would you be interested in grief counseling?” asked Dr. Samuel.

“I went to a group once, but I couldn’t stand it. All those sad people just made me feel worse,” Mrs. Greene explained. “Can’t you just give me something to stop the pain?”

Dr. Samuel recognized that Mrs. Greene had some symptoms of depression, but he was reluctant to diagnose her with major depressive disorder, given that the loss of her daughter was still fairly recent. Furthermore, he was unsure whether medication was warranted at this point. As terrible as it is, grief is a natural human condition, he mused.

Commentary

The case of Mrs. Greene raises many key issues in the management of acute grief. Bereavement is all too common but is seldom identified or accorded significance in explaining a patient's medical condition. Good for Dr. Samuel for allowing Mrs. Greene to express her emotional concerns and for realizing how important her loss is to her medical presentation.

While uncomplicated grief and clinical depression share characteristics such as crying spells, withdrawn behavior, depressed mood, acute dysphoria, and disturbances of eating and sleeping, they have distinct and very different patterns of clinical presentation. Clinical depression is continuous, involving a constant depressed mood for at least 2 weeks without relief. Grief, on the other hand, is characterized by episodes of intense dysphoria brought on by memories of the deceased. These "ambush episodes" alternate with intervals of relative relief with a decrease in despair and social dysfunction.

Grief is a painful experience that can be lonely as well as scary. Unusual experiences like hearing or seeing the deceased are normal in grief, as are receiving "signs" or messages from them. Similarly, most people underestimate the length of normal grief. While variable, several years may be required to deal with a significant loss. Often patients, friends, and family are impatient to move on rather than continue to work through the loss, but a healthy conclusion requires processing the grief. Unresolved and complicated grief is associated with ongoing personal and medical risks. Dr. Samuel should inquire how Mrs. Greene is doing with her grief at every appointment.

Clinical depression, a syndrome seen in response to a variety of social stresses and medical illnesses, often complicates normal grief, as it appears to have in Mrs. Greene's case. Loss can vary in intensity, but one of the most difficult to confront is the death of a child. It is not surprising that Mrs. Greene is depressed. Her persistent sleep disturbance, inability to work, and weight loss strongly suggest clinical depression. Dr. Samuel could substantiate this impression by: (1) asking the patient if she is depressed (patients know, and a "yes" is greater than 90 percent accurate) and, more importantly, (2) by determining whether her symptoms have been constant or episodic.

Regardless, it is imperative to ask Mrs. Greene about suicidal thoughts and plans. Suicide is a risk throughout the course of depression and occasionally in acute grief when the patient may feel an urge to join the deceased. Simply asking the patient if he or she has thought about suicide will identify a current risk (which may prompt a psychiatric referral). It is also an opportunity to educate the patient about the risk of such thoughts and the importance of calling the physician if they occur.

Dr. Samuel expresses reluctance to diagnose Mrs. Greene with major depressive disorder. The real priority is to identify a depressive syndrome and evaluate suicide risk. Treatment of depression secondary to grief is always indicated. Only if the

patient has a previous history of depressive episodes (or prior diagnosis of major depressive disorder) would a recurrent depressive illness be suspected.

I use antidepressants for patients struggling with grief as well as for those with secondary depression. I think the SSRIs in particular help with the stress of grieving as well as the symptoms of anxiety and depression commonly seen. If Mrs. Greene becomes so depressed that she is unable to care for herself or is acutely suicidal, hospitalization could be indicated. If a patient is very suicidal, ECT can be effective because it treats the depressed mood first and other symptoms such as lack of energy and sleep disturbance last. The opposite is true for antidepressants. This is why the first few weeks of drug treatment may increase the risk of suicide in some patients who still feel suicidal but now have the energy to act on those feelings. It's imperative to warn patients of this risk and monitor the initial weeks of drug treatment carefully.

Individual and group grief therapy can be helpful. Therapy offers structure and support for processing the loss. However it's important to identify people with experience in grief counseling because many therapists are unfamiliar with it. Hospice grief services are usually available to the general community and are a good source for counseling and referral to other community resources.

Dr. Samuel can help the family and Mrs. Greene understand both grief and depression through a brief discussion and by answering questions. Some points to touch on include the length of time it takes to grieve, its episodic nature, and the importance of embracing it. Both grief and depression are typically self-limiting processes, and the purpose of interventions is to shorten their courses. Suicidal thoughts are often experienced in the course of both and should be reported to a physician immediately. It's worth mentioning that special dates, holidays, and anniversaries will be "hard times" in grief, and planning special activities to celebrate the deceased can help make these times more manageable. Many patients express the concern that grieving will mean letting the deceased go and are reassured to learn that grieving actually allows them to become closer to the deceased.

Further Reading

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

DeVaul RA, Zisook S. Psychiatry: unresolved grief. Clinical considerations. *Postgrad Med.* 1976;59(5):267-271.

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