Bereavement and grief in adults: Management

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INTRODUCTION

Bereavement is the situation in which a loved one has died, and grief is the response to this loss [1]. Typical acute grief reactions are often characterized by emotional and somatic distress and impaired functioning, but should not be diagnosed as a psychiatric disorder and generally do not require treatment [2,3]. However, bereavement is also a stressor that can precipitate or worsen psychiatric disorders (eg, unipolar major depression). In addition, acute grief may progress to prolonged grief disorder, which is a unique and identifiable syndrome marked by intense, unrelenting, and functionally debilitating symptoms that require specific treatment [4,5].

Psychotherapy or pharmacotherapy are typically not necessary for acute grief because most bereaved individuals are resilient, and grief is usually transformed and integrated during a natural adaptive process that typically occurs with the support and encouragement of close family and friends, as well as clergy and clinicians.

This topic discusses the management of bereavement and grief. The clinical features of bereavement and grief are discussed separately, as are prolonged grief disorder, palliative care, and hospice:

- (See "Bereavement and grief in adults: Clinical features".)
- (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Prolonged grief disorder in adults: Treatment".)

- (See "Palliative care: The last hours and days of life".)
- (See "Benefits, services, and models of subspecialty palliative care".)
- (See "Hospice: Philosophy of care and appropriate utilization in the United States".)

TERMINOLOGY

The terms bereavement, grief (acute and integrated), mourning, and prolonged grief disorder describe different aspects related to the death of a loved one [1,6-9]:

- **Bereavement** – Bereavement is the situation in which someone who is close dies (rather than the reaction to that loss). (See "Bereavement and grief in adults: Clinical features", section on 'Bereavement'.)

- **Grief** – Grief is the natural response to bereavement, and includes thoughts, feelings, behaviors, and physiologic reactions. Although grief can occur in response to other meaningful, nonbereavement losses (eg, loss of a job, divorce, or migration), this topic focuses upon grief in response to the death of a loved one.

  The pattern and intensity of grief varies over time and evolves as bereaved individuals adapt to the loss. The experience of grief is influenced by personal, cultural, and religious rituals that vary widely, and is unique to each person and each loss. Acute grief can be intense and disruptive but is usually integrated. Progress from acute to integrated grief is often erratic and may be hard to discern as it is happening. (See "Bereavement and grief in adults: Clinical features", section on 'Typical acute grief'.)

- **Mourning** – Mourning is the process of adapting to a loss and integrating grief. Adaptation entails accepting the finality and consequences of the loss and a changed relationship with the deceased, restoring the capacity to thrive, and re-envisioning the future with the possibility for happiness and meaning in a world without the deceased. When mourning is successful, the painful and disruptive experience of acute grief is transformed into an experience of integrated grief that is bittersweet, in the background, and permanent. Like grief, mourning is influenced by personal, cultural, and religious beliefs and rituals that vary widely.

- **Prolonged grief disorder** – Prolonged grief disorder is a form of grief that is unusually intense, protracted, and disabling. The disorder is characterized by maladaptive thoughts, dysfunctional behaviors, dysregulated emotions, and/or serious psychosocial problems that impede adaptation to the loss. The syndrome of prolonged grief disorder is a unique and recognizable condition that can be differentiated from other psychiatric disorders.

Other names that have historically been used for prolonged grief disorder include chronic grief, complex grief, complicated grief, pathological grief, persistent complex bereavement disorder, traumatic grief, and unresolved grief. Prolonged grief disorder is approved for inclusion in the World Health Organization's International Classification of Diseases-11th Revision (ICD-11) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) [10,11]. (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis" and "Prolonged grief disorder in adults: Treatment".)

MANAGEMENT

Overview — Acutely grieving patients can benefit from support but typically do **not** require specific interventions. Social support is a protective factor that helps coping with loss, and clinicians can assist bereaved adults to access support, if they are not doing so on their own through friends, family and/or cultural and religious programs. Primary care clinicians who are not able to provide this assistance can refer patients to a grief therapist. In addition, bereavement is a major stressor, and management should thus include assessment for possible secondary medical or mental health conditions, such as cardiovascular illnesses, depression, substance use conditions, and posttraumatic stress disorder (PTSD).

Clinicians can anticipate that most patients will adapt to bereavement by accepting the reality, consequences, and finality of the loss; altering their ongoing relationship with the deceased in way that psychologically and spiritually works for them; and restoring their capacity for thriving. As patients integrate their grief, they rekindle their interest and engagement in everyday life, and reimagine a future that provides a sense of purpose and the promise of happiness.

Management of bereavement due to coronavirus disease 2019 (COVID-19) is discussed separately. (See "COVID-19: Psychiatric illness", section on 'Family members of COVID-19 patients'.)

Anticipating bereavement — For patients with a terminal illness, clinicians should attempt to involve family members in end-of-life discussions; these conversations can help mitigate the pain of the loss and prevent depression and prolonged grief disorder in the bereaved [12]. Evidence supporting proactive support includes a retrospective study of parents whose child died of cancer; support from clinicians during the illness was associated with a lower levels of prolonged grief disorder symptoms [13].

If families are not present (eg, they reside at a distance), clinicians should try to summon them prior to an expected imminent death (eg, within the next week). If the patient dies at a time when family is not present, it is important to promptly call and inform them, express condolences, answer questions, and offer them the option of viewing the body.

Estimating prognosis for patients who may die soon, communicating this information to patients and family members, and discussing serious news is discussed separately. (See "Communication of prognosis in palliative care" and "Discussing serious news".)

Assessing the bereaved — Following the death of a loved one, grieving individuals may present seeking relief from symptoms such as intense sadness or disrupted sleep. The clinician should first pause, make eye contact, listen, and then offer condolences and validate grief symptoms. In addition, clinicians should assess patients to rule out psychiatric conditions that may be triggered or exacerbated by bereavement, including [3]:

- Anxiety disorders
- Insomnia disorder
- Prolonged grief disorder
- PTSD
- Unipolar major depression
- Suicidal ideation and behavior

Assessment of somatic symptoms and general medical illnesses, which are increased in the bereaved, may also be indicated. Information about psychopathology and adverse medical outcomes associated with bereavement is discussed separately. (See "Bereavement and grief in adults: Clinical features", section on 'Bereavement'.)

Monitoring — We recommend monitoring bereaved individuals until they demonstrate that they are adapting to the loss and grief is diminishing in overall intensity [3]. The frequency of monitoring (eg, every month to four months) depends upon the intensity of grief. Suggested questions include:

- How are you doing with the death?
- How are you experiencing your grief?
- Is life getting more bearable? How so?

Certain grief-related thoughts, feelings, and behaviors can impede adaptation, analogous to an infection that prevents wound healing. The prominence and persistence of these grief elements may foretell prolonged grief disorder. Examples include:

- Imagining alternative scenarios to the death (counterfactual thinking)
- Blaming oneself or others for the death
- Judging one's grief (eg, "I shouldn't grieve so much" or "I need to keep grieving")
- Catastrophizing about the future (eg, "I can't go on without this person")
- Avoiding reminders that activate intense grief, such as prior shared activities
- Focusing excessively on trying to feel close to the deceased person through sensory stimulation, such as smelling their clothes, listening to their recorded voice, or looking at pictures
- Difficulty regulating strong emotions

Information about acute grief, including mental disorders that may be precipitated by bereavement and the differential diagnosis of acute grief, is discussed separately. (See "Bereavement and grief in adults: Clinical features".)

Support — Support from family, friends, clergy, and clinicians is usually sufficient to attenuate the pain of acute grief and promote adaptation to the loss [1,3]. Grieving patients often benefit from an empathic clinician listening to their experience, and virtually all appreciate acknowledgement of the loss, condolences, and an opportunity to discuss the relationship with the deceased person and what the loss signifies [14]. Patients may also appreciate clinicians referring to the deceased by the individual's name rather than relationship (eg, "Your husband") [15].

The intensity and quality of grief may frighten patients and lead them to think something is wrong. Health professionals can help by normalizing grief, validating the patient's unique experience, and providing reassurance about its course while providing empathic, active listening without efforts to fix things [1,3,4,8,16,17]. Primary care clinicians are a natural source of support for bereaved individuals and typically view bereavement care as important and satisfying; however, some clinicians feel inadequately trained or cannot allot the necessary time for adequate grief support and may decide to refer patients to a grief therapist or other source of bereavement support.

If support from family, friends, and clinicians is not adequate or available, referral to peer or faith support groups may be helpful [3,7]. Local hospice organizations can usually help identify community resources. Some groups target specific types of deaths, such as child bereavement, conjugal bereavement, and death due to HIV infection, suicides, or violent crime. Individuals

bereaved by suicide may especially benefit from support groups and/or the opportunity to speak with other survivors, due to the stigma, social isolation, and distress associated with suicide loss. Information for people bereaved by suicide is available at the American Foundation for Suicide Prevention.

Support from clinicians for acute grief includes the following [3,14,15,18-20]:

- Education about grief symptoms, their range and intensity, and their variability and evolution over time as the bereaved adapt to the loss. However, avoid platitudes such as "Time heals all wounds." Patients can be helped by understanding that grief is stressful and it is also a form of love; there is no right or wrong way to grieve. Yearning and longing, and preoccupying thoughts and memories of the deceased are core features. Patients sometimes find certain aspects of grief, such as the intensity or uncontrollability of emotions, especially concerning. As an example, patients without mental disorders may be alarmed by hallucinations of the deceased and can be reassured that this is not a manifestation of psychotic illness.

  Educational material about grief is presented in the following table, which can be printed and given to patients (table 1). In addition, several websites, such as The Center for Prolonged Grief, have helpful information about loss and grief.

  Information about the clinical features of acute grief is discussed separately. (See "Bereavement and grief in adults: Clinical features", section on 'Typical acute grief'.)

- Gentle encouragement to:

  - Talk about the deceased, the quality of the relationship with the deceased, the circumstances of the death, the thoughts and feelings that the bereaved person is experiencing, how the loss has affected the person's life (eg, work and social activities), who is available to provide support and any barriers to accessing it, and challenges with which they are coping.

  - Gradually begin to confront reminders of the loss.

  - Make use of religious and spiritual practices consistent with one's beliefs.

  - Start planning for a meaningful future and developing an identity in the absence of the deceased, even while still experiencing acute grief.

  - Discuss past losses if the patient brings them up; clarify that grief over a past loss might reappear at the time of a current loss and this does not indicate that the

previous grief is unresolved.

- Suggestions to process the grief by alternating (oscillating) between confronting the pain, and then setting it aside to focus on something emotionally neutral or positive. Simple leisure activities such as taking a walk, playing with children or animals, taking a soothing bath, or having coffee with a friend may be helpful. Clinicians can normalize this adaptive process of oscillating between confronting the pain and setting it aside.

- Bereaved individuals often feel disconnected from other people and may thus withdraw and socially isolate themselves. Clinicians can help by validating these feelings while helping the patient to gradually re-engage with their social world.

- Bereaved individuals may forget to care for themselves. If the deceased person lived in the same house, meals can trigger intense feelings of missing the person. Patients may avoid foods that serve as reminders of the loss, or eat food that a loved one especially enjoyed to feel close to the person. Sleep can be disrupted as well (see 'Insomnia' below). Clinicians can support patients to maintain daily activities such as work, and in maintaining or establishing regular patterns of sleep, exercise, and nutrition.

  Treatment of sleep disturbance is discussed separately. (See "Overview of the treatment of insomnia in adults".)

- Encourage the bereaved to explore their intrinsic interests and values and consider how they might recognize and use internal strengths and external resources.

- Certain natural grief-related thoughts, feelings, and behaviors can impede adaptation (see 'Monitoring' above). Most bereaved people experience one or more of these elements during acute grief, but usually recognize them as not helpful and set them aside. If not, patients can be gently encouraged to pause and address these impediments.

- Sometimes social or environmental problems in the aftermath of a loss become the focus of thoughts and behaviors. Examples include a widow who is left with insufficient funds to support herself, her partner's affairs are in disarray, or she is ostracized or blamed after the death of a loved one. These problems require attention and usually take precedence over grieving the loss, and may trigger a depressive or anxiety disorder, or lead to prolonged grief disorder. Clinicians can help the patient problem solve and ensure they have sufficient support to do so effectively.

- Other means of providing support include sending condolence letters, making telephone calls, attending the funeral or memorial service, and making home visits.

Interventions — Acute grief generally does **not** require treatment such as grief counseling or other psychotherapies or pharmacotherapy [2,16,21]. Most bereaved individuals are resilient and acute grief is transformed and integrated during a natural adaptive process that typically unfolds with the support and encouragement of close family and friends, as well as clergy and supportive empathic clinicians [1]. In addition, experiencing and confronting painful emotions may not be essential to adjust to bereavement [22,23]. Some bereaved individuals who experience little distress have been shown to have a benign course [24].

Guidelines from the World Health Organization for bereaved individuals who do not have psychiatric disorders recommend that structured psychological interventions should not be routinely offered [25,26]. Evidence supporting this recommendation includes the following studies, which indicate that grief interventions do not improve outcomes:

- A meta-analysis of 36 studies (sample size not specified) compared grief interventions (usually psychotherapy or counseling) with control conditions (eg, waiting list) for outcomes such as grief, general distress, depression, social functioning, and/or somatic symptoms. The underlying studies included randomized trials and less rigorous observational studies. The analysis found a significant but clinically small benefit at posttreatment that was not maintained at follow-up [27].

- A meta-analysis of nine randomized trials compared interventions (eg, support groups) intended to prevent prolonged grief disorder with control conditions (eg, usual care or minimal treatment) in 1545 bereaved individuals, and found that the incidence of prolonged grief disorder was comparable [28].

- A subsequent randomized trial compared psychoeducation (four sessions, each lasting two hours, administered during home visits) with no intervention in 83 individuals bereaved through suicide; improvement of depressive symptoms (including suicidal ideation) and prolonged grief disorder symptoms in the two groups was comparable [29].

Intense grief — Although acute grief generally does not require treatment, grief therapy or other psychotherapies can help bereaved individuals who request help during acute grief or those who have persistent intense grief that does not meet criteria for prolonged grief disorder [9]. Difficult grief reactions are more likely to occur with especially painful losses, such as death of a life partner or one's child, or deaths by violent or stigmatized means [3,30]. Elements of psychotherapy that may be beneficial include education, stress management, identifying and accepting grief and emotional pain, talking about the deceased person and their death, learning ways to live with reminders of the loss, and decreasing avoidance behaviors, as well as

helping patients to focus upon experiences intended to restore one's life, such as scheduling new activities and re-engaging with others [3,8,31-33]. (See 'Support' above.)

Bereaved individuals, especially those who have lost children, often find it difficult to speak about the loss [34]. In addition to recommending grief counselors for these patients, clinicians may suggest bibliotherapy or internet-based tools. Online programs are designed to help parents or caregivers understand and manage their own grief as well as help them support their grieving children. The programs provide relevant information about grief and adaptation to loss in an accessible format, as well as self-reflection and social interaction activities.

Another intervention that may help managing intense grief is keeping a journal or writing in other ways. Although writing about grief and negative thoughts, as well as positive events and thoughts, does not appear to improve grief or depressive symptoms (eg, anorexia, insomnia, and anhedonia), writing may reduce loneliness and improve positive mood [35].

In addition, mindfulness activities may possibly help managing intense grief [36,37]. Mindfulness approaches include exercises that focus upon self-observation and self-compassion, which may promote awareness and nonjudgmental acceptance of the reality of the loss and associated challenges. Mindfulness approaches are included in treatment for multiple psychiatric disorders, including prolonged grief disorder, anxiety disorders, and unipolar major depression. (See "Prolonged grief disorder in adults: Treatment" and "Complementary and alternative treatments for anxiety symptoms and disorders: Physical, cognitive, and spiritual interventions" and "Unipolar major depression: Treatment with mindfulness-based cognitive therapy".)

For bereaved individuals who do not have mental disorders, we generally do not use pharmacotherapy such as benzodiazepines or antidepressants. Our approach is consistent with treatment guidelines from the World Health Organization [25,26], as well as studies that suggest medications are not helpful:

- A six-week randomized trial compared diazepam (2 mg, up to three times per day) with placebo in 30 individuals who were bereaved within the past two weeks; patients were allotted 20 tablets for the entire study [38]. Outcomes were comparable at the end of treatment and at the six-month follow-up.

- A national registry study found that among individuals with severe losses such as child or suicide bereavement, the risk of psychiatric hospitalization or deliberate self-harm was comparable for those treated with antidepressants within six months of bereavement, and those not treated [39].

However, pharmacotherapy may be indicated for grief-induced insomnia. (See 'Insomnia' below.)

Psychiatric disorders — Bereavement may precipitate or exacerbate suicidal ideation and behavior as well as psychiatric disorders such as major depression, anxiety disorders, and PTSD. In addition, some people may develop prolonged grief disorder. (See "Bereavement and grief in adults: Clinical features", section on 'Associated psychopathology'.)

The decision to treat mental disorders that occur in the context of grief reactions, or to monitor and follow the patient, is a clinical judgment regarding the severity and duration of the disorder [9]. As an example, treatment should be rendered to grieving patients with unipolar major depression that includes suicidal ideation with a plan and severe impairment of functioning. Management of suicidality and mental disorders is discussed separately.

Insomnia — Disrupted sleep is a common symptom of grief. For patients with insomnia, we suggest behavioral therapy, including education about sleep hygiene (table 2) and stimulus and temporal control (table 3) [40]. Patients unresponsive to behavioral therapy often receive additional treatment with nonbenzodiazepine hypnotic medications. However, sleep may be disrupted by several disorders (eg, obstructive sleep apnea), which require assessment for diagnosis (eg, full-night, attended, in-laboratory polysomnography), as well as treatments. Additional information about the clinical features and management of insomnia and sleep disorders is discussed separately. (See "Classification of sleep disorders" and "Risk factors, comorbidities, and consequences of insomnia in adults" and "Overview of the treatment of insomnia in adults".)

General medical illnesses — Bereavement is associated with an increased risk of general medical illnesses (see "Bereavement and grief in adults: Clinical features", section on 'Adverse general medical outcomes'). Separate topics discuss treatment of these illnesses.

One of the illnesses that occur more often in the bereaved than the nonbereaved is cardiovascular disease, and a preliminary study suggests that it may perhaps be possible to mitigate the risk. A six-week randomized trial compared metoprolol (25 mg/day) plus aspirin (100 mg/day) with placebo in bereaved spouses or parents (n = 85) [41]. Physiologic and psychiatric surrogate measures of cardiovascular risk were lower with active treatment than placebo, including systolic blood pressure, 24-hour average heart rate, platelet response to arachidonic acid, and symptoms of anxiety and depression.

INFORMATION FOR PATIENTS

Information for patients about grief and prolonged grief disorder is available in the following graphic that can be printed (table 1), and online at The Center for Prolonged Grief. Information for people bereaved by suicide is available at the American Foundation for Suicide Prevention.

SUMMARY AND RECOMMENDATIONS

- **Terminology** – Bereavement is the situation in which a loved one has died, and grief is the distress that occurs in response to bereavement. Although grief can occur in response to other meaningful, nonbereavement losses, this topic focuses upon grief in response to the death of a loved one. (See 'Terminology' above.)

  Acute grief can be intense and disruptive, but generally is integrated over time. Prolonged grief disorder is a form of grief that is unusually intense, persistent, and disabling; as such, it is a unique and recognizable mental disorder that requires specific treatment. (See "Prolonged grief disorder in adults: Treatment".)

- **Support** – Support from family, friends, clergy, and clinicians is generally sufficient to manage the pain of acute grief. Bereaved patients who seek help from clinicians can typically benefit from support that includes:

  - Empathic listening
  - Education and reassurance about grief including the wide range of symptoms that can occur (table 1)
  - Gentle encouragement to maintain regular patterns of activity, sleep, exercise, and nutrition; reengage with social supports; take intermittent respites from grief; and focus upon ways to connect with meaningful interests and values
  - Reassurance
  - Monitoring

  Telephone calls, attending the funeral or memorial service, and home visits may be helpful as well. If support from family, friends, and clinicians is not adequate or available, referral to support groups may be useful. (See 'Support' above.)

- **Interventions** – Acute grief typically abates with time and usually does **not** require treatment. However, grief therapy can help bereaved individuals who request it or have

difficult, intense grief reactions that do not rise to the level of prolonged grief disorder. In addition, mindfulness activities that include exercises focusing upon self-observation and self-compassion may be helpful.

For bereaved individuals who do not have psychiatric disorders, we suggest not prescribing psychotropic medications such as benzodiazepines or antidepressants (**Grade 2C**). However, patients with insomnia that is unresponsive to behavioral therapy often receive nonbenzodiazepine hypnotic medications. (See 'Interventions' above and 'Insomnia' above.)

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