Life after Death: A Practical Approach to Grief and Bereavement

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This consensus paper describes the essential skills that clinicians need to help persons who are experiencing grief after the death of a loved one. Four aspects of the grieving process are reviewed: anticipatory grief, acute grief, normal grief reactions, and complicated grief. Techniques for assessment and recommendations about interventions and indications for referral are provided for each aspect.

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For glossary of terms, see end of text.

The dead want nothing of us but that we live.

Richard Powers, *Gain*

Throughout their personal and professional lives, physicians will encounter and experience grief. *Grief* describes a multifaceted response to loss. It may be obvious, as in a colleague who develops depression soon after the death of his wife, or more subtle, as in a widow who presents with fatigue and insomnia during her yearly check-up.

Despite its prevalence in the clinical practice and personal lives of physicians, grief has remained largely outside the province of medicine (1). Yet not all physicians have avoided grief and its management. Benjamin Rush, one of the founders of modern medicine, viewed grief as a profound threat to health and advocated an aggressive course of bleeding and purging (2). While his technique was questionable, his enthusiasm at least should be commended.

Nevertheless, Rush's sense of urgency in dealing with grief has not entered mainstream medical practice, perhaps in part because of uncertainty about whether grief is a natural response or an illness that requires treatment (3). This is a legitimate question, but the discussion it provokes should not distract physicians from the importance of recognizing grief and relieving the suffering that it can cause. Grief may be a significant source of distress and may be responsible for many of the physical symptoms that physicians are asked to evaluate (4, 5). In addition, people experiencing grief appear to be at increased risk for health problems, suicide, and death from other causes (6). Physicians should therefore include recognition and management of grief among their clinical skills.

We describe the presentation of grief before, during, and after a person's death. We conclude with a discussion of "complicated" grief. Of note, intervention by the physician need not take a considerable amount of time. Indeed, the vast majority of the support that people receive after a loss comes from friends and family. Nevertheless, there are clear opportunities for physicians to identify and orchestrate mechanisms of support and processes of healing and, in doing so, to make an important difference.

Anticipatory Grief

Mr. Powsand is a 67-year-old married man with severe ischemic cardiomyopathy and inoperable coronary artery disease. He has been hospitalized six times in the past year for exacerbations of heart failure and has required several admissions to the intensive care unit. Mr. Powsand recently completed an advance directive in which he expressed his wish to focus on symptomatic treatment. During the past 2 years, his wife of 29 years has gradually taken over their affairs.

Dr. Wedlich is seeing Mr. Powsand in a routine office visit, and Mrs. Powsand is in the waiting room. Mr. Powsand reports that while he thinks he's doing "fair," he is

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Table 1. **Interventions and Assessments**

Anticipatory grief
Encourage open discussion
Clarify plans for future
Assist with life review
Acute grief
Be present
Acknowledge own sense of loss
Provide time and permission to grieve
Assess immediate plan
Offer follow-up appointment
Early bereavement (<1 month)
Elicit concerns about symptoms of grief
Reassure that manifestations of grief are normal
Assess social support
Assess coping resources
Identify practical or financial problems
Late bereavement (≥1 month)
Assess progress of mourning
Identify depression
Consider referral for counseling
Consider pharmacotherapy

worried about his wife. She seems anxious, and he has seen her crying when she doesn't think he is looking. She has also stopped attending her weekly bridge game. Mr. Powsand asks whether anything can be done to help her.

It is essential to consider the impact of life-threatening illness on people who are close to the patient. In doing so, Dr. Wedlich might consider several possible explanations for Mrs. Powsand's behavior, including depression. However, the first explanation she should consider is *anticipatory grief*, the process by which friends and family come to terms with the potential loss of a significant person. Anticipatory grief is a multidimensional syndrome consisting of anger, guilt, anxiety, irritability, sadness, feelings of loss, and decreased ability to perform usual tasks (7).

The physician's primary goal in the setting of anticipatory grief is to offer support, which Dr. Wedlich can do in several ways (**Table 1**). First, she can ask to talk to Mr. and Mrs. Powsand together to determine what Mrs. Powsand understands about her husband's condition and prognosis (8). Next, she can help the couple talk about the changes that Mr. Powsand has noticed. Often, the most effective response to anticipatory grief is to acknowledge it openly. Such acknowledgment may provide relief to both Mr. Powsand and his wife and should be followed by a careful exploration of Mrs. Powsand's feelings and concerns.

A frank discussion with a physician can be supplemented by life review activities offered by clergy, psychologists, and social workers. The goal of a life review is to develop a sense of closure by reviewing meaningful events that the patient and his or her family have shared. This technique often makes use of pictures or possessions that give a shared sense of the past. Although a life review might be led by any provider, it is usually most practical for physicians to refer to a trained provider who has sufficient time and experience. In the right hands, a life review can help to smooth the dying process and may reduce distress after the patient's death (9). Clergy may use these sessions as an opportunity to provide early spiritual support. A life review may also provide considerable support for patients who, in facing death, are themselves experiencing a profound sense of loss.

Follow-up

Over the next 2 months, Mr. Powsand and his wife meet several times with Dr. Wedlich and a social worker. Mrs. Powsand also meets separately with a minister. Although Mrs. Powsand continues to avoid many social activities, she has resumed her weekly bridge game, and she acknowledges that her friends have become a strong source of support. She continues to have crying spells but is able to discuss with her husband his death and plans for the future.

Acute Grief

Mr. Powsand is admitted to the hospital with an acute myocardial infarction and severe pulmonary edema. He becomes increasingly hypoxic, confused, and combative. Dr. Wedlich meets with Mrs. Powsand and the couple's two daughters. They refer to Mr. Powsand's advance directive and agree that Mr. Powsand would not have wished to undergo endotracheal intubation and hemodynamic monitoring. His agitated delirium is treated with chlorpromazine, and Mr. Powsand dies peacefully several hours later.

Dr. Wedlich is called urgently to the bedside. Mrs. Powsand and her daughters are all in the room. Mrs. Powsand is distraught, sobbing uncontrollably, preventing anyone from touching or moving Mr. Powsand, and repeating: "He's not dead yet, he's not dead yet." The nurses and daughters want Dr. Wedlich to give her a sedative to "calm her down."

Despite the best efforts of providers and careful attention to anticipatory grief, some families will experience dramatic and disturbing acute grief reactions.

Acute grief reactions may include denial, intense crying spells, anxiety, "numbness," a sense of derealization, and somatic symptoms (5, 10, 11) that may be distressing to family and health care providers. The principal challenge that Dr. Wedlich faces is to overcome feelings of awkwardness and to resist the temptation to prescribe a sedative to "fix" a problem. This challenge may be particularly daunting for physicians who are providing end-of-life care but lack an ongoing relationship with the patient.

The most important service that Dr. Wedlich can offer is her presence. Simply by sitting in the room with Mrs. Powsand and being a witness to her expression of grief, Dr. Wedlich is providing valuable support. Spending a few moments with the family in silent contemplation is by far the most important intervention that physicians have to offer at the time of a patient's death.

Dr. Wedlich may wish to gently confirm that Mr. Powsand is dead and acknowledge Mrs. Powsand's grief by saying, "I'm sorry he's gone." She could add that she was honored to have known Mr. Powsand, or that he will be missed. Dr. Wedlich can reassure the family and nursing staff by explaining that Mrs. Powsand's response, while disturbing, is not abnormal, and that Mrs. Powsand does not mean literally that her husband is still alive. Instead, her seeming denial may be her way of expressing the sense of loss that they are all feeling.

Dr. Wedlich might suggest a referral to the hospital chaplain or to Mrs. Powsand's own clergy. She can arrange for Mr. Powsand's family to have time alone with the body to grieve in private. She can also offer "anticipatory guidance" by warning them that the next several hours and days may be very difficult and that they may wish to avoid other commitments. If Mrs. Powsand remains distraught after these interventions, a brief course of a short-acting sedative is sometimes appropriate and could be prescribed by her primary physician.

Before she leaves the unit, Dr. Wedlich should mobilize the unit team to address several practical matters. They should be sure that Mrs. Powsand has a way to get home from the hospital and that she will have a companion for the next several days. They should also arrange a follow-up appointment for Mrs. Powsand in 1 or 2 weeks with her primary care physician.

After she leaves the bedside, Dr. Wedlich should plan a condolence contact in the form of a telephone call or a handwritten note. This brief contact is important and can be a significant source of comfort to the bereaved person (12). Reminder systems may help ensure that contact is made (13). Dr. Wedlich should also consider attending the funeral or memorial service. Although she may feel uncomfortable doing so, her presence may provide an opportunity for personal healing and may offer comfort to the bereaved person. This is a personal decision that depends on time constraints, the physician's relationship with the family, and the family's expectations.

Follow-up

As Dr. Wedlich comforted Mrs. Powsand and her family, Mrs. Powsand gradually became calmer but still refused to allow the nurses to remove Mr. Powsand's body. Dr. Wedlich asked her whether she would be willing to help the nurses wash and prepare the body, and she agreed. This seemed to help her to acknowledge his death, and she allowed the body to be removed. She agreed to see her own physician, Dr. Cantor, in 2 weeks and to spend the night with her younger daughter.

The Spectrum of Normal Grief

Dr. Wedlich contacted Dr. Cantor to explain recent events and to arrange an appointment. During that visit, Mrs. Powsand reports that she has been unable to concentrate on her housework or shopping. She has been staying with her younger daughter for the past 2 weeks and feels "at loose ends." She also describes an unexpected yet comforting sensation that her husband is present in the room with her. When Dr. Cantor asks how she spends her days, she says, "I just sit and look around the room, or I wander around our house, picking things up and putting them back."

At this visit, Dr. Cantor's primary goals should be to review recent events, to define the symptoms and emotions that Mrs. Powsand is experiencing, and to determine whether these symptoms are interfering with her life and preventing her from moving through the processes of mourning. He can do this by asking six open-ended questions (**Table 2**). This line of questioning should pay particular attention to manifestations of grief that might disturb Mrs. Powsand (**Table 3**), such as her perception of her husband's presence; Dr. Cantor can then offer reassurance that such symptoms are normal.

When cultural differences exist, it is sometimes the

Table 2. **The Brief Bereavement Interview**

Responses to grief
"You've faced a lot over the past several weeks. How has that been for you?"
"How have things been different for you?"
"Is there anything that has been especially troubling to you?"
Social support
"Has anyone been particularly helpful to you in the past month?"
Coping resources
"Are there any activities that have made this less difficult for you?"
Practical difficulties
"How are things around the house? With your finances?"

bereaved person who reassures the physician that symptoms or behaviors are normal. For example, among the Navajo, grief is often expressed publicly only during the 4 days after death (14), which many non-Navajo physicians may find surprising. When physicians are not familiar with a culture, it is important that they inquire about customs, beliefs, or cultural norms.

In assessing Mrs. Powsand's grief, Dr. Cantor should also identify deficits in social support that are associated with prolonged or difficult grief (15–17). This will require reevaluation even when a physician knows a patient well, because the most robust social support systems may weaken during bereavement if friends and family withdraw or if the bereaved person feels uncomfortable attending social events alone. Dr. Cantor can work with Mrs. Powsand to review and identify sources of support and other coping resources that she has found to be comforting. These may include spending time with family or friends or creating a memorial to her husband in the form of a scrapbook, a charitable donation, or a scholarship in his name.

Finally, Dr. Cantor can also help Mrs. Powsand identify the practical problems that have arisen now that she is alone. These difficulties may be particularly pronounced in elderly couples, who often depend on one another for financial and domestic tasks of daily life, such as balancing a checkbook or paying taxes. Referral to a social worker may be helpful.

Follow-up

Dr. Cantor reassures Mrs. Powsand that the sensation of her husband's presence is normal and does not indicate a psychiatric illness, as long as it is not disturbing to her. Mrs. Powsand says that she was reluctant to return to her bridge club because she thought it seemed inappropriate for her to go out socially so soon after her husband's death. Dr. Cantor acknowledges her concerns but encourages her to continue to draw on the sources of support that she had found helpful in the past. They agree that Mrs. Powsand should return for a routine appointment in 6 months but that she could call sooner.

COMPLICATED GRIEF

Four months after Mr. Powsand's death, Mrs. Powsand's daughter calls Dr. Cantor to say that her mother has been feeling tired and lethargic since Mr. Powsand's death. These symptoms became much worse 1 month ago but have improved somewhat since then. Mrs. Powsand has been spending most of her time in the house and is still reluctant to return to activities that she had found pleasurable in the past. Her daughter asks Dr. Cantor for "something to help Mom's mood."

Mrs. Powsand is experiencing fatigue and anhedonia and has been withdrawing from her usual activities. These responses may be features of normal grief, or they may be indications of *complicated grief* or depression, which are marked by a failure to return to preloss levels of performance or states of emotional well-being (15). Because both depression and complicated grief are indi-

Table 3. **Manifestations of Grief***

Psychological symptoms
Sadness
Anxiety
Helplessness
Emotional lability
Irritability
Apathy
Disbelief
Impaired concentration
Lowered self-esteem
Hallucinations of the deceased's presence (visual or auditory)
Feelings of unreality
Numbness
Denial
Searching for the deceased
Physical symptoms
Anorexia
Change in weight
Trouble initiating or maintaining sleep
Fatigue
Chest pain
Headache
Palpitations
Hair loss
Gastrointestinal distress

* Adapted from reference 4.

cations for additional counseling or psychotherapy, Dr. Cantor should arrange a follow-up visit.

At this visit, Dr. Cantor should rule out organic causes of Mrs. Powsand's symptoms and should determine whether her grief is complicated. Because of its implications for treatment, Dr. Cantor should first look for evidence of depression. Overall, estimates of depression in the first year of bereavement range from 17% to 27% (18), and suicidal ideation is present in up to 54% of persons even 6 months after the death (19–21).

Physicians may find it difficult to distinguish grief from depression because feelings of guilt, thoughts of death, and psychomotor retardation can be features of both conditions (22). However, symptoms caused by depression typically begin later, after 1 to 2 months of bereavement (23), and persist for several months after the loss (23, 24). In addition, depression is the more likely diagnosis when symptoms are constant (24). Prominent suicidal ideation, profound changes in appetite or sleep, or substantial decreases in function are also markers of depression. None of these criteria are absolute, but they should prompt consideration of antidepressant therapy or referral to a psychiatrist.

In this case, Mrs. Powsand is unlikely to have depression. Her lethargy and sadness have been present since her husband's death. Furthermore, they are accompanied by few if any somatic symptoms, such as a change in appetite, weight, or sleep. Finally, her feelings of sadness and apathy have waxed and waned over time. It is more likely therefore that Mrs. Powsand's symptoms are due to complicated grief.

Complicated grief may be difficult to identify because the experience of grief varies greatly among individuals (25, 26). Even the observation that patients with complicated grief experience more symptoms and grief-related behaviors, while helpful as a guide, is of limited clinical usefulness because of the way in which characteristics of grief evolve over time (27). For example, C.S. Lewis wrote of his own experiences with grief that "One keeps on emerging from a phase, but it always recurs . . . Am I going in circles, or dare I hope I am on a spiral?" (28).

In identifying complicated grief, physicians may find it helpful to first define a patient's risk factors. Grief may be more pronounced and more distressing in younger people (29–31), women (32–34), and persons with limited social support (15–17). Grief may also be slower to resolve if the death was sudden or traumatic (35). Each of these risks factors may increase the pretest probability of complicated grief.

Table 4. **Processes of Mourning and the Complicated Bereavement Interview***

Avoidance
Recognize the loss
"Tell me about your husband's/wife's death."
"How was it for you after he/she died?"
Confrontation
React to the separation
"How has his/her death changed your life? How are you different?"
Recollect and reexperience the deceased and the relationship
"Tell me about your husband/wife."
Relinquish the old attachments to the deceased
"What do you feel you've lost since he/she died?"
Accommodation
Readjust
"What have you done to help you cope with your husband's/wife's death?"
"How has your life changed since he/she died?"
Reinvest in the future
"What do you think the future holds for you?"
"What will tell you that you're coping well?"

* Adapted from reference 4.

However, it is more important that Dr. Cantor examine the course that the bereavement is taking and Mrs. Powsand's progress through "processes" of mourning (4) (**Table 4**). Initially, Mrs. Powsand must recognize the loss of her husband. She can then begin to adjust her life accordingly and confront the loss emotionally. Later, she can seek new relationships and pursuits as she adapts to her loss and begins to rebuild her life. Of note, the result of these processes is accommodation, not "acceptance" or "recovery." Grief changes people, and failure to return to one's baseline is therefore not a sign of abnormal grief. Instead, a more realistic aim is an altered life in which the person has adapted to the loss (4).

These mourning processes have two crucial implications for Mrs. Powsand's care. First, she should not expect to "recover" within a defined period of time, and Dr. Cantor should reassure her and her daughter that continued symptoms are not abnormal if she is making progress in other ways. Second, to assess Mrs. Powsand's progress, Dr. Cantor must define the time course of her grief and how it has changed. Dr. Cantor may find that asking focused questions that assess these processes of mourning may aid his assessment (**Table 4**).

Although accurate predictions of easily identifiable

"milestones" are usually neither possible nor helpful, two guidelines may be useful. First, Dr. Cantor should have noted some progress within the first 1 to 2 months. He might also expect to see clear improvement in at least some areas by 4 months. In this case, Mrs. Powsand's feelings of sadness and lethargy have persisted with little improvement, and it seems likely that her mourning has not progressed substantially.

For people whose grief does not progress, several therapeutic options are available. The option with the most evidence is counseling. Overall, data suggest that a variety of interventions may offer benefit (36). For instance, individualized counseling by a trained volunteer may be effective (37, 38), as is individualized professional counseling (39). Other options include a peer-led support group or a support group with a leader in which members share experiences (40–43). As in anticipatory grief, clergy and social workers can be important resources as well. In discussing counseling, Dr. Cantor should describe several options and might suggest that Mrs. Powsand participate in a session with several groups or therapists before making a decision.

Dr. Cantor might also consider prescribing antidepressant therapy. Although data do not support use of pharmacotherapy in the absence of depression, many clinicians find tricyclic antidepressants or selective serotonin reuptake inhibitors to be beneficial in persons with complicated grief. Given this possible benefit and the benign side effect profiles of most of these agents, a trial of pharmacologic therapy is reasonable.

The choice of therapy will depend largely on the personality and goals of the bereaved person. Referral for counseling will also depend on the availability of services in the bereaved person's community. It is reasonable to describe several treatment options, including both pharmacologic therapy and counseling.

Dr. Cantor should also continue to follow Mrs. Powsand at monthly or bimonthly intervals until her course has become clear. For bereaved people who experience uncomplicated grief, a single follow-up visit is usually sufficient. However, additional follow-up visits are required for complicated grief.

Follow-up

After Dr. Cantor and Mrs. Powsand discuss several therapeutic options, Mrs. Powsand chooses to see a psychologist whom her minister recommended. At her next visit to Dr. Cantor 2 months later, Mrs. Powsand feels less fatigued. She still misses her husband very much and still feels his presence occasionally. However, she is looking forward to the impending birth of their first grandson, who will be named after Mr. Powsand.

CONCLUSIONS

The care of bereaved persons is challenging because few data and landmarks distinguish normal grief from abnormal grief. In addition, the course of bereavement usually fails to follow a traceable trajectory and leaves the bereaved person and physician unsure of the future. For all of these reasons, as well as the discomfort and uncertainty that can accompany conversations about death and dying, bereavement poses challenges that physicians may find daunting.

But care of the bereaved offers opportunities as well. Familiarity with grief may help physicians to understand that the wounds of loss and grief can heal with time. Armed with this knowledge, physicians are better able to take on the challenges of end-of-life care and to take care of themselves and their colleagues—after all, grief does not afflict only the families and friends of patients who have died. Physicians, nurses, and other health care workers often mourn the loss of a patient, and their grief can be profound. Physicians who can recognize grief in themselves or their colleagues will be able to seek support and to offer it to those in need.

Attention to bereavement offers a valuable opportunity to participate in healing in its purest form. It is an opportunity to leave technology behind and to heal with listening, words, and gestures. Physicians have few opportunities to touch lives as profoundly as they can by being present at a patient's death. It is a rare chance to be a doctor, in the original sense of "teacher," and to help patients and families through a difficult time of tragedy and personal growth.

GLOSSARY

Definitions are based on references 4 and 44.

Grief: The psychological, behavioral, social, and physical reactions to loss of someone or something that is closely tied to a person's identity.

Anticipatory grief: A grief reaction that occurs in anticipation of an impending loss.

Mourning: The process by which people adapt to loss.

Bereavement: The period after a loss during which grief is experienced and mourning occurs.

Complicated mourning: Delayed or incomplete adaptation to loss.

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Personae

In an effort to bring people to the pages and cover of *Annals*, the editors invite readers to submit photographs of people for publication. We are looking for photographs that catch people in the context of their lives and that capture personality. *Annals* will publish photographs in black and white, and black-and-white submissions are preferred. We will also accept color submissions, but the decision to publish a photograph will be made after the image is converted to black and white. Slides or prints are acceptable. Print sizes should be standard (3″ × 5″, 4″ × 6″, 5″ × 7″, 8″ × 10″). Photographers should send two copies of each photograph. We cannot return photographs, regardless of publication. We must receive written permission to publish the photograph from the subject (or subjects) of the photograph or the subject's guardian if he or she is a child. A cover letter assuring no prior publication of the photograph and providing permission from the photographer for *Annals* to publish the image must accompany all submissions. The letter must also contain the photographer's name, academic degrees, institutional affiliation, mailing address, and telephone and fax numbers.

Selected Personae submissions will also appear on the cover of *Annals*. We look forward to receiving your photographs.

Christine Laine, MD, MPH
Senior Deputy Editor