ECHO IDAHO

Behavioral Health in Primary Care

Grief and Bereavement: Psychiatric Interventions

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Deep Thoughts...

Learning Objectives

- Define uncomplicated grieving process
- Define Prolonged Grief Disorder (PGD)
- Differential diagnosis of PGD
- Identify pharmacological interventions
- Identify when to intervene and to what degree

Definitions

- Bereavement
- Grief (Uncomplicated)
- Mourning
- Prolonged Grief Disorder (PGD)
  - Previously known as Complicated Grief (CG)

Prolonged Grief Disorder (Complicated Grief)

- Occurs in about 10% of bereaved people
- Failure to transition from acute to integrated grief
- Associated with negative outcomes that result in higher risk of all-cause mortality
- Higher risk for suicidal ideation and behaviors (even when controlling for MDD and PTSD)
- General health impairments
  - Cancer and health problems
  - Increased substance use
- Identified using Inventory of Complicated Grief (ICG)

TABLE 1. *ICD-11* and *DSM-5-TR* prolonged grief disorder criteria

ICD-11 prolonged grief disorder criteria[a]	Proposed prolonged grief disorder criteria for *DSM-5-TR*[b]
History of bereavement after the death of a partner, parent, child, or other loved one	The death, at least 12 months ago, of a person who was close to the bereaved individual (for children and adolescents, at least 6 months ago).
At least one of the following symptoms: A persistent and pervasive longing for the deceased; a persistent and pervasive preoccupation with the deceased	Since the death, the development of a persistent grief response characterized by one or both of the following symptoms, which have been present most days to a clinically significant degree: intense yearning/longing for the deceased person, and preoccupation with thoughts or memories of the deceased person (in children and adolescents, preoccupation may focus on the circumstances of the death). In addition, the symptom(s) have occurred nearly every day for at least the last month.
At least one symptom of intense emotional pain: sadness, guilt, anger, denial, blame; difficulty accepting the death; feeling one has lost a part of one's self; an inability to experience positive mood; emotional numbness; difficulty in engaging with social or other activities	Since the death, at least 3 of the following symptoms have been present most days to a clinically significant degree: identity disruption (e.g., feeling as though part of oneself has died) since the death; marked sense of disbelief about the death; avoidance of reminders that the person is dead (in children and adolescents, may be characterized by efforts to avoid reminders); intense emotional pain (e.g., anger, bitterness, sorrow) related to the death; difficulty reintegrating into one's relationships and activities after the death (e.g., problems engaging with friends, pursuing interests, or planning for the future); emotional numbness (absence or marked reduction of emotional experience) as a result of the death; feeling that life is meaningless as a result of the death; intense loneliness as a result of the death. In addition, the symptoms have occurred nearly every day for at least the last month.
The disturbance causes significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.	The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Time and impairment: persisted for an abnormally long period of time (more than 6 months at a minimum); following the loss, clearly exceeding expected social, cultural, or religious norms for the individual's culture and context	The duration and severity of the bereavement reaction clearly exceeds expected social, cultural or religious norms for the individual's culture and context. The symptoms are not better explained by major depressive disorder, posttraumatic stress disorder, or another mental disorder, or attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

[a] Source: Killikelly and Maercker (30).
[b] Source: Moran M, "Board Approves New Prolonged Grief Disorder for *DSM*." *Psychiatric News*, published online Oct 28, 2020 (https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.11a12).

Simon, N.M. Treating Complicated Grief. JAMA. 2013 July 24; 310(4):416-423

Box 1

Risk Factors for the Development of Complicated Grief

Pre-loss Risk Factors

- Female sex
- Preexisting trauma (particularly childhood trauma)
- Prior loss
- Insecure attachment
- Preexisting mood and anxiety disorders
- Nature of the relationship[15–18]

Loss-Related Factors

- Relationship and caretaking roles: spouses, mothers of dependent children, caretakers for chronically ill
- Nature of the death itself: violent, sudden, prolonged, due to suicide[15–22]

Peri-loss Factors

- Social circumstances
- Resources available following the death
- Poor understanding of the circumstances of the death event: ie, lack of information about the death
- Interference with natural healing process: inability to follow usual cultural practices of death and mourning, alcohol or substance use, low social support[23–28]

PGD and Suicidality

- ASK!!
- Associated with:
  - High rate of suicidal ideation
    - 40-60%
    - May be more common after death of loved one by suicide than other causes
    - Join the person who died
    - Take unnecessary risks
  - History of suicide attempts and indirect suicidal behavior
    - Not explained by comorbid MDD

PGD and Suicidality continued

- 9% Suicide attempts
- Elevated rates of lifetime suicide attempts in bipolar patients
- Isolation
- Guilt

Neurobiology of PGD

- In PGD evidence of more activation in the nucleus accumbens when reminded of the deceased
  - Suggests heightened reward activation associated with the deceased that may impair adjustment to the loss
- Prefrontal regions may be disrupted during emotion processing
- Whole brain volume and cognitive function may be different for those with PGD versus uncomplicated grief
- Recent study found higher oxytocin levels among PGD compared with MDD
- May have implications for immune activation and cortisol responses
  - Morning cortisol levels were lower for PGD suggesting possible dysregulation of the hypothalamic-pituitary-adrenal axis
- More research needed!

Differential Diagnosis

- Acute Grief
  - Feelings of shock or disbelief
  - Yearning
  - Waves of sadness or other intense emotions
  - Feeling disconnected from others
  - Desire to disengage from roles or responsibilities
- MDD
  - ***Sadness***
  - ***Crying***
  - Social isolation and withdrawal
  - Sleep disturbance
  - ***Worthlessness and guilt***
  - Suicidal ideation

- Prolonged Grief Disorder
  - ***Yearning*** for reunion with deceased as well as proximity seeking
  - ***Avoidance*** of painful reminders of the permanence of death
    - Isolation
    - Functional impairment
    - Avoiding friends or activities that previously shared with deceased
  - ***In contrast with general withdrawal and low motivation***
  - Suicidal ideation
- PTSD
  - Intrusive thoughts or images of death
  - Avoidance related to death
  - Emotional numbness
  - Sleep disturbance
  - ***Fear***
  - ***Intrusive thoughts related to trauma***
  - Avoidance due to safety concerns or reducing potential threat

Comorbidity

- PGD often accompanied by comorbid psychopathology
- PGD symptom severity and functional impairment are great in patients with comorbidities
- May initially present seeking treatment for a comorbid disorder
- Prevalence:
  - MDD 50%
  - PTSD 30-50%
  - Anxiety Disorders
    - GAD 20%
    - Panic 1-20%
  - One study showed comorbidity with PTSD and MDD was 36%
  - Medical
    - Acute coronary syndrome
      - metoprolol study
    - Range of diseases
      - Upper GI symptoms
  - Substance use (discussed in previous ECHO talk)

Complicated Grief Treatment (CGT)

- Targeted intervention
- Better outcomes than standard psychotherapy in treating PGD
- Combines CBT with aspects of interpersonal psychotherapy and motivational interviewing
- Dual focus on coming to terms with the loss and on finding a pathway to restoration
- Exposure
- Some evidence of increased outcomes when combined with SSRIs

When Does Psychiatry Intervene?

- Don’t want to pathologize grief
  - Most grief doesn’t require intervention
- So when do we prescribe medications?
  - PGD
  - Sleep disturbance
    - 80% of PGD experience long-term poor sleep
- What medications have shown benefit
  - Antidepressant medications can decrease the intensity of emotions and somatic symptoms and improve cognitive functioning
    - Nortriptyline
    - Paroxetine
    - Escitalopram
      - Less likely to drop out of care and/or complete CGT
    - Bupropion

When Does Psychiatry Intervene continued

- When do we hospitalize somebody?
  - Suicidal ideation
  - Functional deficits
- What about benzodiazepines?
  - No indication
  - Can result in psychological and physical dependence and may interfere with learning and memory
  - Especially problematic in older adults

Key Points

- Importance of understanding uncomplicated grieving process
- Importance of assessing for suicidal ideation
- Differential Diagnoses
- Treatment options

References

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