



# Ian Anderson Continuing Education Program in End-of-Life Care

## Module 13

# Grief and Bereavement: A Practical Approach



Authors:

S. L. Librach MD, CCFP, FCFP

W. Gifford-Jones Professor in Pain Control and Palliative Care, University of Toronto  
Director, Temmy Latner Centre for Palliative Care, Mount Sinai Hospital

Pauline Abrahams, BSc, MBChB, CCFP

Staff Physician, Temmy Latner Centre for Palliative Care Psychosocial Spiritual  
Program, Mount Sinai Hospital

Lecturer, Dept. of Family & Community Medicine, University of Toronto

# Case Scenario – Adrienne Macpherson

## Scenario 1

Adrienne is a 68-year-old woman. She lives with her husband Andrew, age 79, in a modest bungalow in a rural area about 10 minutes from town. Andrew was diagnosed with lung cancer with metastases to liver and bone 10 months ago. Andrew had been feeling unwell for several months before seeking medical attention. He now is very weak and spends most of his time in bed. He has pain that is poorly controlled and eats very little. At times, he is quite confused.

Adrienne and Andrew have been married for 46 years. This is Adrienne's second marriage. She was married for two years to Pierre, a soldier in the army who was killed in Korea. Adrienne was left with one child, a daughter Isabel now age 50. Three years after Pierre's death she met Andrew at work and they married two years later. Adrienne and Andrew had three children, a son Alistair now age 43, a son Jean age 36 and a daughter Anne who died in a motor vehicle accident 10 years ago at age 24. Isabel lives in town nearby but Jean lives in Seattle.

Adrienne worked as a clerk in a department store for many years before retiring 10 years ago because of health problems, rheumatoid arthritis. Andrew was an accountant with his own small firm. They now live on their small pensions.

## Scenario 2

"Doctor? Sorry to bother you but this is Isabel, Andrew Macpherson's stepdaughter. First of all, I would like to thank you for the care you gave my Dad. He died very peacefully at home thanks to you. It meant a lot to all of us and we still miss him a lot. Oh, well life is like that isn't it?"

"Why I called you as well was to talk about my Mom, Adrienne. It has been about six months since Dad died. She really is not getting any better. I am really worried about her. I try to see her every day now if I can. She is just sitting there in a corner chair most of the time. She eats very little and the house is a mess. She just doesn't seem to care any more and that is not like her at all. When I talk about my kids, she occasionally brightens up but then she begins to cry. I have asked her to go and see you but she hasn't made an appointment. I finally called and made her an appointment to see you next week. I just wanted to fill you in. My brothers and I are very concerned."

"Thanks for filling me in, Isabel. Are you coming with her? I think that would be helpful."

## Module Objectives

1. Define grief & bereavement
2. Describe some of the models of grief
3. Describe factors influencing grief
4. Describe complicated grief
5. Describe a practical approach in the management of grief

## Introduction

Grief is a normal phenomenon common to all of us. As we go through life, we experience a wide variety of losses for which we grieve. It is not possible to go through life without suffering losses. Grief is the response to any loss and is therefore a common human experience. Grief is a common but often unrecognized part of life cycle changes. Many of the difficult situations we have faced in our lives have been situations where there has been loss & subsequent grief.

We often see grief as interfering with life, rather than being intrinsic to life. Subsequently we may not mentor our children concerning this aspect of life. On the contrary, we try to protect them, not only from death, but often also from the little losses that happen throughout our lives and which can prepare us for greater ones. Often avoided or unacknowledged throughout much of our life, grief is allowed legitimate (if somewhat curtailed) expression in connection with illness and especially life threatening disease, dying and death. At these times many past sorrows or a history of harm that have been suppressed, either consciously or unconsciously, may be re-activated at a subliminal level, fueling our responses to the current situation with a lifetime of unexpressed grief and unexamined losses. We are overwhelmed, not only because of our present loss, but because we arrive at this point of our lives without the benefit of having learnt anything useful from our previous losses.

A terminal illness or indeed any chronic illness is replete with successive losses and consequent grief. Losing your own life i.e. dying is associated with grief. Losing a loved one is also associated with grief. Who feels the grief -all ages, all persons and often care providers. Grief starts with the symptoms of illness and the diagnosis of any illness.

Good end-of-life care has incorporated the concept of good grief (*i.e. a healthy expression of our life force*) as part of a good death. This module is a brief exploration of the issues of grief and its management in providing good end-of-life care.

Grief is:

- a life experience to be lived
- a mystery to be entered
- a stimulus for compassion and kindness
- a reminder of who and what we have loved
- a longing for relatedness

## Definitions

**Grief** is the process of spiritual, psychological, social & somatic reactions to the perception of loss.

**Mourning** is the cultural response to grief.

**Bereavement** is the state of having suffered a loss.<sup>1</sup>

**Grief work** is the work of dealing with grief, requiring the expenditure of physical, emotional and spiritual energy.<sup>2</sup>

## Models and Theories of Grief

There have been a number of models proposed for grief in the past. Recently, however, as a result of clinical experiences, those in the field of grief counseling and therapy as well as grief counselors in palliative care, have begun to question the standard models of grieving. Briefly the components of the older models include:

1. An identifiable, normal psychological process of mourning with standard characteristics or stages.
2. The function of mourning is conservative and restorative – “to get back to normal”.
3. Mourning is a private, intrapsychic process, its affect arising spontaneously from within the individual.
4. Mourning is only painful and sad.
5. The central task is detachment, the relinquishing of attachment to the deceased.
6. The normal process leads to full resolution.
7. The symptoms are the issues to pay attention to.

Newer theories and ideas of grief challenge many of those beliefs, stating:

1. There is a personal reality of death and loss that is different for each individual, culture, subgroup etc “grief happens within the context of a life story”(Rando).
2. The function of grief is transformative, “we relearn ourselves, we relearn the world” (Attig)

3. Mourning is fundamentally an inter-subjective process and many problems arising from it are due to the failure of others to engage with the bereaved person (Hagman).
4. Grief involves a full range of affect including humor and joy.
5. Grieving involves the creation of continued symbolic bonds with the deceased person "relationship in absence".(Attig)
6. Grief is open-ended and evolving, being continually transformed throughout the lifecycle as we encounter new losses.
7. It is the meaning behind the symptoms that are important for the individual, leading to "an increased appreciation of the possibility of life enhancing post traumatic growth as one integrates the lessons of loss" (Neimeyer).

Grieving is:

- active
- healing
- skillful
- transformative
- connective
- social

## Background Issues and Factors in Grief

1. A single loss will precipitate other losses. For example the physical loss of a breast through a mastectomy for breast cancer will cause losses in the areas of body image, sexuality, role, good health and independence.
2. Characteristics of the bereaved influence grief outcomes:
  - There is inconclusive evidence that men do more poorly than women but there are differences in the way grief may be handled.
  - There are more consequences in children especially if grief is not managed well.
  - Older persons in general may have less intense & fewer reactions but this depends somewhat on the relationship to the deceased. *Often overlooked is the intense grief subsequent to the loss of adult children.*
  - Poor physical health may limit the ability to expend the necessary physical and psychic energy to *integrate grief into our lives.*
  - The use of drugs such as psychotropic agents.
  - A previous history of psychiatric problems or addictions like alcoholism.
  - There are few conclusive studies about the influence of personality variables and the course and outcomes of grief.
  - Patterns of coping.
  - Past or current experiences with grief.
  - Current other psychological or social problems or crises.
  - Culture, ethnicity & religion.
3. The relationship to the deceased influences the course of grief:
  - There is a unique nature to each relationship.

- The role that deceased had in family e.g the power authority in the family.
  - The amount of unfinished business in the relationship.
  - Families who have had long-term dysfunctional patterns of interactions will react in their usual patterns of coping.
4. The nature of the death may be a factor in grief course and outcomes:
    - There are no studies indicating significant differences between acute vs. chronic deaths as far as outcomes are concerned but many of studies have not been done in populations receiving good palliative care.
    - Violent deaths such as those secondary to crime or accidental deaths.
    - Suicidal death.
  5. Characteristics of the deceased:
    - The age of the deceased particularly if young will affect the course and outcomes of grief.
    - The type of person the deceased was.
    - The timeliness (e.g. at retirement, around the time of an important event such as the birth of a grandchild, a marriage of a child, etc.) may influence the course and outcome of grief
  6. The adequacy of social support:
    - Persons lacking or withdrawing from support may have worse outcomes.
    - Remarriage or other close or intimate relationships protect.
    - Culture.
  7. There are gender issues that may influence the expression and course of grief:
    - Staudacher in her book “Men and Grief” indicates that men may have different coping styles than women:
      - To remain silent.
      - To engage in solitary mourning or “secret” grief.
      - To take physical or legal action.
      - To become immersed in activity.
      - To exhibit addictive behaviour.
  8. Children & Grief
    - Children of all ages grieve & grief is particular to age groups.
    - Children should not be protected from grief, funerals or issues of death & dying.
    - They need to be educated in terms they can understand.
    - Parents must be involved in the education.
    - Children cope with grief according to their developmental stage and may re-visit a grieving situation as they reach new developmental stages; for example, a death witnessed as a toddler can resurface and need to be addressed again in a 7-year-old.

## Psychological Phases of Normal Grief

Does grief have distinct phases? Quite a number of authors have defined phases and tasks of grief. The issue is that these may not be chronological phases but really

concurrent processes that may be more active at certain times in the grief process. Grief is also an individual experience.

There also has been discussion of whether there is an entity such as “anticipatory grief”, the grief felt in anticipation of a loss. Many of those involved as grief counselors feel that anticipatory grief is just grief and that by giving it another name tends to trivialize somewhat the depth of emotions during the time of anticipating the loss.

The following is blend of some of the ideas about phases and the psychological reactions to loss.<sup>3</sup> These are to be interpreted not as sequential but more likely concurrent processes through much of the grief experiences that change and remit over time until healing occurs.

### **Acute or Self Protective Phase:**

- ❑ Initial shock, denial and disbelief.
- ❑ May feel dissociated from the world around them
- ❑ If family well prepared, there may not be the same amount of shock or avoidance.
- ❑ May sometimes initially see an intellectualized acceptance (e.g. “Well, he was old in any case.”) without an emotional component as an initial denial of the loss, rather than a necessary self protective mechanism.

### **Confrontation:**

- ❑ Most intense experience of grief.
- ❑ Emotional extremes common-an emotional “roller coaster”.
- ❑ Rapid and large swings in emotion often cause fear & more anxiety.
- ❑ Anger is a common component including anger that may be directed towards physicians and other health care team members.
- ❑ Guilt, inwardly directed anger, confronts the bereaved with questions of “What if I had....?”, “Did I do enough?”, “What did I do wrong?” “What did I do to deserve this?”
- ❑ Survivor guilt. “Why wasn’t it me?”
- ❑ Sadness & despair.
- ❑ Inability to concentrate or process information.
- ❑ Preoccupation with the deceased.
- ❑ Over time the extreme emotional swings lessen.
- ❑ Intermittent denial may also occur.
- ❑ Social manifestations of this phase include:
  - Restlessness & inability to sit still.
  - Lack of ability to initiate & maintain organized patterns of activity.
  - Difficulty completing or concentrating on tasks at work.
  - Withdrawal from the very people who may be able to help.
- ❑ Physiological or somatic manifestations of grief:
  - Common in this phase.



- Often these complaints bring the bereaved into physicians' offices.
- The elderly bereaved are a group vulnerable to new illness and exacerbations of symptoms of old illnesses and physical symptoms must be addressed appropriately.
- Symptoms may include:
  - Anorexia & other GI disturbances.
  - Loss of weight.
  - Sleep disturbances.
  - Fatigue & weakness.
  - Palpitations.
  - Anxiety states.
  - Shortness of breath.
- Spiritual issues:
  - The basic search for meaning and value in life become questions that have to be dealt with by the bereaved, i.e. "who am I?"
  - Not a synonym for religion but religion is one form of expression of spirituality.
  - The feeling of abandonment by G-d/higher power.
  - The feeling of anger towards G-d/higher power.
  - Fear of the unknown.
  - Finding a secular framework to face the unknown – the mystery of death.

### **Reestablishment:**

- Grief gradually softens to an "acceptance" of the reality of the loss.
- Gradual decline in symptoms as grief becomes integrated into life.
- Grief is compartmentalized but periods of grief may arise at specific times such as holidays, birthdays, etc.

## **Complicated Grief**

A number of terms have been used to describe grief experiences that do not seem to be "normal"-abnormal, atypical, unresolved, difficult and complicated. The term "complicated grief" will be used here to describe grief that does not proceed to good healing.

1. **Delayed or absent grief.** Those who are bereaved seem to carry on without much evidence of grieving. Caution must be used in over-interpreting personal ways of coping as delayed or absent grief. Some people will not discuss or reveal their emotions in public. Others exhibiting delayed grief may be involved in settling other issues before they can openly grieve. It often takes some unrelated event, often another loss, to bring out the flood of emotions. Totally absent grief may be a sign of complete denial and it is quite rare.

2. **Conflicted grief.** This is a distortion or prolongation of one of the phases or grief or one of the phase components. The commonest are extreme anger or extreme guilt.
3. **Chronic grief.** For those who suffer from this complicated grief, it is like the grief is fresh all the time. This may be indicative of a relationship with the deceased that was very problematic, had a lot of unfinished business or was quite dependent in nature.
4. **Psychiatric disturbances associated with grief.** Grief can be the cause of major psychiatric illness especially depression. This may of course delay the resolution of grief.
5. **Physical illness associated with grief.** The development of significant intercurrent illnesses in those who are bereaved may delay the resolution of grief until the illness has passed. If the illness is very serious, grief reactions may deepen.

## The Tasks of Grief and Mourning

Dealing with grief requires some work on the part of those who are grieving. These tasks begin for members of the family and for the patient early on in the illness. Worden initially wrote about the tasks of mourning and the goals of grief counseling. These have been reproduced in the box below with some modifications to reflect an approach that begins during the illness.

### The Four Tasks of Grief & Mourning (Worden)

To accept the reality of the loss.

To experience the pain of grief.

To adjust to an environment of change & prepare for the death.

To withdraw emotional energy & eventually reinvest it in other relationships.

### Grief Counselling Goals

To increase the reality of the loss.

To help those who grieve deal with both experienced & latent affect.

To help families discover & deal with impediments to readjustment.

To encourage the bereaved to make a healthy emotional withdrawal from the deceased & reinvest energy into other relationships.

## Helping the Patient and Family Deal with Grief

### Basic Issues

1. Begin grief counseling if possible while the patient is still alive. This will often help reduce a patient's suffering and make the bereavement phase easier on

- the family. Focus on issues such as life meaning, the contributions of the dying person and the legacy left behind.
2. The family is the unit of care and grief counseling before and after the patient's death should be focused on the individual and family. The goal is to build stable and positive family environments in the face of loss.
  3. Grief is a normative process and requires much listening and often not a lot of intervention on the part of the counselor. Just explaining the normal aspects of grief is reassuring and supportive. Explain that grief is a unique process in each individual and there is no right way. Build and practice concrete skills to support healthy families.
  4. Allow sufficient time to grieve. No definite time but most people resolve to a level of functioning around one year. Some individuals and families will accomplish the tasks of grieving in two years. Families that have received adequate palliative care often will do this well within a year. Advocate for sufficient time off from work for the bereaved especially in the first few weeks of bereavement. Discuss the fact that grief spikes continue for life through events, holidays and "anniversary" reactions.
  5. Emphasize the role of the funeral and of memorial service. Encourage families to bring children to these rites. Community expression of grief helps the family. Attend these services if the patient and family have been close to you. Your grief is important too and needs some closure to relationships. Consider having memorial services in hospitals, agencies and palliative care programs for bereaved families and for staff.
  6. Encourage the family to begin to deal with the deceased's personal possessions. Suggest that some of these can be gifts to family members to remember the deceased or gifts to charity so that there is a sense that the deceased continues to contribute and has a continuing legacy.
  7. Medications, particularly tranquilizers and antidepressants are usually not needed for any sustained period of time. Avoid medications unless there is substantial evidence of depression or severe anxiety states that are retarding resolution of grief.
  8. Contact the bereaved at regular intervals. This can be facilitated through volunteers but a call or card from the physician about one month after the death is often very helpful to families. Definitely monitor any families with high risk for grief problems.
  9. Identify concurrent problems that may interfere with normal grief.
  10. Use resource books and Internet sites that deal with grief to help the bereaved.
  11. Monitor children at school for grief problems manifesting as school problems.
  12. Investigate to see what types of bereavement programs exist in your community. Hospice palliative care programs often have associated bereavement groups.
  13. Ask for expert help if you sense there is complicated grief.

## **The Nature of Grief Work**

Much of the nature of grief work in palliative care is geared to be:

- a) Family (friendship) orientated:
  - The ability to accept loss is at the heart of all skills in healthy family relations (Walsh and McGoldrick).
- b) Relational
  - Opportunities for resolution, forgiveness, gratitude.
- c) Intergenerational
  - How we want to be remembered.
  - Legacy work e.g. what are we leaving behind as a legacy.
  - Healthy and effective parenting model.
  - Mentorship re: coping skills with children.
  - Decreasing fear in future generations.
    - Teaching children.
    - Learning from children.
  - People die, relationships don't.
- d) Psycho educative
  - Anxiety about the unknown
  - What changes to expect:
    - Forewarned is forearmed.
    - Physical
    - Emotional
    - Changing family dynamics/roles.
- e) Harm reductive/preventative.
  - Identifying destructive coping mechanisms. i.e. alcohol/drug use.
- f) Community oriented.
  - Looking at the larger social interaction e.g. in school or workplace.
- g) Active:
  - What we need to do in order to integrate how we are changed?
- h) Narrative.
  - Richly descriptive in elucidating personal meaning-‘Tell me what it is you see death or this loss as?’
- i) Supportive
  - Facilitating the safe containment of emotional space.
- j) Intrapsychic:
  - Facilitating connection to our own deeper wisdom and ability to heal ourselves.
  - An affirmation and validation of our own humanity and mortality.
- k) Spiritually supportive.
  - We are dealing with the unknown, with life's mysteries.

## Grief in Children

Grief in children depends on their developmental stage, relationship with the deceased and the circumstances of the death. Children definitely express their feelings of grief differently than adults:

- They often do not display their feelings as openly as adults.

- ❑ They often can immerse themselves in their usual activities while still having strong feelings of anger and continuing fears of abandonment and death.
- ❑ Their grief while appearing more intermittent and brief, it usually lasts longer and requires constant support and monitoring.
- ❑ As children grow and develop, they often revisit their grief at significant life events.
- ❑ They may express their grief through extremes of behaviour-from being aggressive to being very passive

Children's understanding about death depends on their developmental stage (13):

- ❑ Children 0-3 do not have clear concepts of death. The emotional expression and dependable presence of loved ones are more important than the words used. Since these children may equate death with sleep, explanations that compare death to sleep should be avoided. Otherwise abnormal fear of sleep or nighttime may occur. Children in this age group may sense the grief in others and protecting them from the pain of grief may lead to physical and emotional changes such as weight loss, anorexia, sleep disturbance, listlessness and other changes in activity.
- ❑ Children 3-6 often consider death as a reversible event. They often have images from television cartoons that death is temporary. They also may express "magical thinking" believing they in some way that they caused the death or that they can reverse the death. They may regress and show disturbances in eating, sleeping and toileting.
- ❑ Children 6-9 may be more aware of the finality of death but do not believe it is universal. In their grief they can become aggressive or overly clingy.
- ❑ By age 9 or 10, most children understand that death is final and universal.

The child should be told about death in language that is appropriate for their development often using age specific resources such as books, films and videos.

Children's attendance at funerals is also important. They can participate and observe the family and community grief responses. They need to be prepared ahead of time for what they are to see and can be encouraged to participate in the service if they are old enough and if that participation fits with family values and culture.

Indicators in children of atypical grief may include:

- ❑ Continued denial of the death.
- ❑ Prolonged anger.
- ❑ School problems that are not resolving.
- ❑ Behavioural problems that did not exist before.
- ❑ Persistent physical symptoms such as sleep disturbances, eating disorders, etc.
- ❑ Social withdrawal.
- ❑ Disabling or persistent regression.

Children displaying any of the above should be referred to experienced counselors for management since unresolved grief may lead to serious emotional and psychological problems and even suicide.

## Summary

Grieving is the active way by which we incorporate grief into our lives and discover how we are changed by it. It is open-ended and is continually transformed as we go through life and experience further losses. As caregivers we need to be self-aware and develop a respect for our own grief and for another's grief. If we cannot bear our own grief, it will be hard to work in the presence of another person's grief.

Soygal Rinpoche says, "If you are in a position to help others, it is through your own suffering that you will find the understanding and compassion to do so". And Rilke writes, "The protected heart that is never exposed to loss, innocent and secure, cannot know tenderness".

The sparrow digests food by eating gravel, it helps grind up the food the body needs to survive. Is grief the gravel that helps us digest/integrate life's pain? Is grief the gravel for our soul's survival?

## Case Scenario – Adrienne Macpherson

### Scenario 1

Adrienne is a 68-year-old woman. She lives with her husband Andrew, age 79, in a modest bungalow in a rural area about 10 minutes from town. Andrew was diagnosed with lung cancer with metastases to liver and bone 10 months ago. Andrew had been feeling unwell for several months before seeking medical attention. He now is very weak and spends most of his time in bed. He has pain that is poorly controlled and eats very little. At times, he is quite confused.

Adrienne and Andrew have been married for 46 years. This is Adrienne's second marriage. She was married for two years to Pierre, a soldier in the army who was killed in Korea. Adrienne was left with one child, a daughter Isabel now age 50. Three years after Pierre's death she met Andrew at work and they married two years later. Adrienne and Andrew had three children, a son Alistair now age 43, a son Jean age 36 and a daughter Anne who died in a motor vehicle accident 10 years ago at age 24. Isabel lives in town nearby but Jean lives in Seattle.

Adrienne worked as a clerk in a department store for many years before retiring 10 years ago because of health problems, rheumatoid arthritis. Andrew was an accountant with his own small firm. They now live on their small pensions.

### Scenario 2

"Doctor? Sorry to bother you but this is Isabel, Andrew Macpherson's stepdaughter. First of all, I would like to thank you for the care you gave my Dad. He died very peacefully at home thanks to you. It meant a lot to all of us and we still miss him a lot. Oh, well life is like that isn't it?"

"Why I called you as well was to talk about my Mom, Adrienne. It has been about six months since Dad died. She really is not getting any better. I am really worried about her. I try to see her every day now if I can. She is just sitting there in a corner chair most of the time. She eats very little and the house is a mess. She just doesn't seem to care any more and that is not like her at all. When I talk about my kids, she occasionally brightens up but then she begins to cry. I have asked her to go and see you but she hasn't made an appointment. I finally called and made her an appointment to see you next week. I just wanted to fill you in. My brothers and I are very concerned."

"Thanks for filling me in, Isabel. Are you coming with her? I think that would be helpful."

## Detailed Case Scenario

Adrienne is a 68-year-old woman. She lives with her husband Andrew, age 79, in a modest bungalow in a rural area about 10 minutes from town. Andrew was diagnosed with lung cancer with metastases to liver and bone 10 months ago. Andrew had been feeling unwell for several months before seeking medical attention. He now is very weak and spends most of his time in bed. He has pain that is poorly controlled and eats very little. At times, he is quite confused. There is a suspicion that he has brain metastases but his wife and family feel there is no need for further investigations. His physicians agree.

Adrienne was born in Montréal and she has several brothers and sisters still in Québec. Adrienne and Andrew have been married for 46 years. This is Adrienne's second marriage. She was married for 2 years to Pierre, a soldier in the army who was killed in Korea. Adrienne was left with one child, a daughter Isabel now age 50. Three years after Pierre's death she met Andrew at work and they married two years later. Adrienne and Andrew had three children, a son Alistair now age 43, a son Jean age 36 and a daughter Anne who died in a motor vehicle accident 10 years ago at age 24. Isabel lives in town nearby but Jean lives in Seattle. The Macphersons have 8 grandchildren.

Andrew has been a heavy smoker for many years. He has had hypertension and ischemic heart disease for about ten years. He was a heavy drinker for a number of years but he stopped when Adrienne and he separated for a brief period of time. He does not drink alcohol now. He worked as an accountant with his own small office serving small businesses and doing income tax work. He is Scottish and has two brothers in Scotland. He and Adrienne used to visit them frequently. He is worried about how Adrienne will cope after he dies.

They live on their pensions now.

Adrienne has had rheumatoid arthritis for many years but was able to continue working as a department store clerk until about 10 years ago when she had a flare-up of her disease. She is on multiple medications but has been able to do normal activities of daily living reasonably well with Andrew's help especially with household tasks. She is concerned about how she will be able to cope without Andrew's help. She does not want to bother her children for help. She has had to cope with the death of her first husband and her beloved daughter Anne and feels that she cannot cope with another death in the family.

Their marriage has been quite strong despite the one brief separation. For two years after the death of their daughter Anne they grieved quite openly and they recovered slowly. Their children have been very close despite two of them living far away. They are both Roman Catholic and have attending church fairly regularly.



## **Scenario 1 Teaching Tips**

1. Distribute the case scenario. Allow participants a couple of minutes to read the information or ask one of the participants to read the scenario.
2. Ask what learning issues there are for participants. Have them written on the flipchart.
3. Identify case scenario issues as outlined above.

### **Case Issues Scenario 1**

1. Issue of multiple losses for Adrienne-physical, family, spousal loss.
  2. Physical health.
  3. Potential anger with Andrew for his smoking and lack of attention to his health.
  4. Worry about how she will cope with his dying.
  5. Fear of what will happen to her after.
  6. Need for home care support?
  7. Need to explore family involvement and support.
4. Ask participants how they would address each of these issues. What resources exist within the community to help?
  5. What resources need to be developed within their community and/or practice that will help their grieving patients? Who can they identify to lead these efforts?

**Teaching Tip:** Share your own experiences, other models of support that you know of. How did you or others develop these resources? What obstacles did you encounter and how did you overcome them? Who can help? Are their web-based resources you can provide?

6. Review the learning issues that have not been dealt with and assign tasks.

### **Scenario 2**

Adrienne seems very frail. She has lost weight. She responds to questions very slowly. She admits to crying frequently. She says she is very depressed. Her joints are bothering her more than usual. She is eating poorly because her appetite has decreased.

Doctor? Sorry to bother you but this is Isabel, Andrew Macpherson's stepdaughter. First of all, I would like to thank you for the care you gave my Dad. He died very peacefully at home thanks to you. It meant a lot to all of us and we still miss him a lot. Oh, well life is like that isn't it?"

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“Thanks for filling me in, Isabel. Are you coming with her? I think that would be helpful.”

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### **Scenario 2 Issues**

1. Diagnosis and management of depression and atypical grief.
  2. Family support.
  3. Physician patient confidentiality
  4. Coping at home or some other alternative needs to be explored.
  5. Follow-up.
  6. Interdisciplinary approach.
4. Ask participants how they would address each of these issues. What role is there – if any – for antidepressants/ anti-anxiety medications?
  5. If there is a role, what would you prescribe? For how long? How would you follow her?
  6. When would you refer her to a psychiatrist – if ever?
  7. What resources exist within the community to help with these issues?
  8. What resources need to be developed within their community and/or practice that will help their grieving patients? Who can they identify to lead these efforts?
  9. What role does physician-patient confidentiality play in this scenario? What would happen if Adrienne did not want to discuss how she was feeling/ coping? What would happen if Isabel refused to come into the office or if Adrienne refused to allow her to accompany her? How would you raise the topic?

**Teaching Tip:** Share your experiences in practice. What did you say? What would be a better way of raising the issue? If she refuses to discuss what can you do or say?

10. Can you use information provided by the daughter and not tell your patient where it came from? What information can /should you share with the family regarding your concerns re Adrienne? What would you say to Isabel regarding her concerns?

**Teaching Tip:** Share your experiences in practice. What did you say? What would be a better way of raising the issue? If she refuses to discuss what can you do or say?

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## References

<sup>1</sup> p.15 Rando TA. Grief Dying and Death: Clinical Interventions for Caregivers. Research Press. Champaign Illinois. 1984

<sup>2</sup> Lindemann E. Symptomatology and management of acute grief. Am J. of Psychiatry 1944. 101:141-148.

<sup>3</sup> p.29. Rando TA. Grief Dying and Death: Clinical Interventions for Caregivers. Research Press. Champaign Illinois. 1984