Bereavement and Grief During the COVID-19 Pandemic

Ahmed Saeed Yahya, MRCPsych,[a,*] and Shakil Khawaja, MRCPsych[a]

As of May 6, 2020, there were a total of 245,150 confirmed coronavirus disease 2019 (COVID-19) deaths and 3,557,235 cases since the start of the outbreak worldwide.[1] Many families have experienced unexpected bereavement, and, for some, the virus has taken away multiple loved ones. The quality of death is affected with limited provision for ritualistic or spiritual support. Many are expected to experience anticipatory grief, which is natural mourning that occurs for both the patient and family when death is expected.[2] During these uncertain times, many will worry about their loved ones becoming infected, which may exacerbate anticipatory grief reactions.[2]

Disenfranchised Grief

Due to social distancing policies, many have not been present before and during the time of death of their loved ones.[3] As a result, these individuals have been unable to say their final goodbyes. Funeral services are restricted, with a small number of people allowed to be present. Those who have had recent contact with the deceased are expected to self-isolate and are unable to attend. Social networks and connectivity have been affected, with many working from home. Individuals may experience disenfranchised grief as a result of these various processes.[2] Disenfranchised grief is conceptualized as grief, which is not publicly, socially, or culturally expressed.[2]

Identification and Management of Pathological Grief

Grief is an idiosyncratic and natural mourning process. It consists of emotional, cognitive, behavioral, spiritual, and physical responses.[4] However, for many, the confluence of destabilizing factors is likely to affect the natural mourning process[5] with adverse psychological consequences. Evidence indicates that the risk of a pathological grief reaction is amplified with some of these factors. Prior to the COVID-19 crisis, a systematic review and meta-analysis[6] indicated that 10% of bereaved adults were at risk of pathological grief. Eisma et al[7] reported findings on another natural disaster and stated that 1 year after the Sichuan earthquake, 50% of bereaved individuals experienced prolonged grief symptoms and 25% also had symptoms of posttraumatic stress disorder (PTSD).

It is important for clinicians to identify features of pathological grief given the associated adverse physical and psychiatric outcomes.[6] Pathological grief can coincide commonly with major depressive disorder, PTSD, generalized anxiety disorder, and adult separation disorder.[6] Pathological grief is described in the *DSM-5* as a persistent, complex bereavement disorder with symptoms of 12 months duration and in the *ICD-11* as prolonged grief disorder of a duration of 6 months.[6] Clinicians may also consider the diagnosis of depression in those who present with characteristic symptoms 2 weeks after their bereavement.[6] The physician would need to decide whether an intervention is required at this stage[6] or a further period of assessment is warranted. This decision would depend on the degree of distress, associated impairment, and the outcome of a risk assessment.

To meet the criteria for pathological grief in the *DSM-5* or *ICD-11*, the symptoms should be experienced on most days, causing persistent and pervasive distress with impairment or disability in important areas of functioning.[6] Symptoms can include social withdrawal, lack of purpose, and not accepting the loss. There also may be persistent and recurrent intrusive ruminations, negative thinking, and thoughts that life is no longer worth living.[2] Clinicians should screen for symptoms of coexistent depression, suicidal ideation, and PTSD in such patients and consider referral to specialist psychiatric services.[6]

Certain features may assist in identifying those who are at greater risk of experiencing pathological grief. Individuals may have had an insecure attachment or predisposing neurotic personality traits or be socially isolated.[6] The loss of a child or marital partner is an associated risk factor.[8] The evidence indicates that women and individuals with lower levels of education may be more vulnerable.[6] Those with existing or previous psychiatric conditions including mood, anxiety, alcohol, or substance use disorders are at increased risk.[8] Depression early in bereavement may also be an indicator of future risk of pathological grief.[8]

The first-line treatment for pathological grief is usually tailored cognitive-behavioral therapy (CBT).[7] CBT would promote adaptive change by targeting negative cognitions and behaviors. Iglewicz et al[8] report that CBT has been successfully delivered in a group format. Internet-based CBT was also found to be effective in a number of small randomized controlled trials. These methods of delivery warrant further investigation because of the large number of individuals likely to be affected.

[a]Waltham Forest Older Adults Mental Health Team, North East London Foundation Trust, Red Oak Lodge, London, England

*Corresponding author: Ahmed Saeed Yahya, MRCPsych, Waltham Forest Older Adults Mental Health Team, North East London Foundation Trust, Red Oak Lodge, London, England E11 4HU (a.yahya@nhs.net).

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Box 1. Bereavement Resources

The Center for Complicated Grief: https://complicatedgrief.columbia.edu/professionals/complicated-grief-professionals/overview/
ASSIST Trauma Care (offers therapeutic support after traumatic bereavement): http://assisttraumacare.org.uk/
Cruse Bereavement Care: https://www.cruse.org.uk/
American Psychological Association: https://www.apa.org/topics/grief
Royal College of Psychiatrists: https://www.rcpsych.ac.uk/mental-health/problems-disorders/bereavement
UK Bereavement Advice Centre: https://www.bereavementadvice.org/
Free helpline telephone number: 0800 634 9494

Pharmacotherapy may be considered with selective serotonin reuptake inhibitors (SSRIs) to treat coexistent symptoms of depression or PTSD.[6] Boelen and Smid[6] included details of studies on the efficacy and safety of antidepressants for pathological grief disorder and depression related to bereavement. The authors[6] summarize 2 studies that investigated escitalopram and 1 clinical trial that reviewed the effects of paroxetine. The results from a large-scale controlled study indicated that citalopram optimized the effects of psychotherapy on co-occurring depressive symptoms but not on pathological grief. Citalopram by itself did not benefit the depressive symptoms.[6]

Preventive Strategies

It is essential that measures are implemented so that patients have a dignified passing.[9] Communication via digital platforms should be facilitated with loved ones for those patients identified at higher risk of mortality and most importantly during their final moments. Digital devices may also be used in funeral services so those unable to attend have the opportunity to process and accept their loss.[8]

It remains important for clinicians to be prepared to have difficult conversations with patients and loved ones. These conversations may involve discussion of advanced care planning and the implementation of appropriate end-of-life care. For patients, effective symptom control is required, while effort should also be directed toward addressing holistic and spiritual needs. Good communication is imperative with validation of the emotional responses that may arise from anticipatory grief reactions. Expert palliative care services can assist with this challenging process.[10] These timely discussions may ameliorate some of the burden and guilt later experienced by individuals.

Appropriate aftercare and support[9] may be required for those who have experienced bereavement during the COVID-19 pandemic. This care can include checking on their well-being and addressing individual needs and concerns. Most people will follow the natural process of mourning and can be reassured with appropriate validation of their experiences. Advice should also be provided regarding general well-being, good sleep hygiene, exercise, nutrition, and abstinence from excess alcohol and illicit substances. Individuals should be encouraged to maintain social networks[6] and access their desired level of support via bereavement resources and organizations (Box 1). A follow-up meeting may be arranged and relevant contact details provided should these individuals need access to further support outside of working hours.

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