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Understanding Bereavement: What Every Oncology Practitioner Should Know

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Introduction

Bereavement deserves special attention in oncology practices because of the frequency with which providers, patients, and their families encounter death. The biological, psychological, and socio-cultural demands of a potentially terminal illness such as cancer put all involved parties at risk for experiencing grief at many points throughout the continuum of care, both before and after death. Grief may develop before a death as patients and their families experience the loss of physical abilities and roles, activities, relationships, or a sense of a future (1). These losses may heighten a person's sense of loneliness, fear, anger, sadness, helplessness, and hopelessness (2). Although grief typically decreases over time, the onset and expression of distress following a loss may vary among individuals, families, and cultures (3).

A vast body of research has examined grief in terms of risk factors, clinical presentations, and treatment options. In this literature, many terms have been employed to discuss these aspects of the experience of loss. Typically, "bereavement" refers to the death of a significant other (4, 5). Grief represents the psychological reaction to the death and has been described as a feeling of "wanting what you cannot have" (6). Grief encompasses the distress, including related feelings, cognitions, and behaviors which occur as a result of this loss (1, 5). Finally, "Prolonged Grief Disorder" (PGD) refers to a severe and protracted reaction to loss which manifests as extreme emotional distress and mental or functional impairment (7,8, 9). Due to the unique relationship that often exists between a patient, their family and the oncologist, providers have an opportunity to assist patients and families in adjusting to the many losses both will encounter. In particular, by encouraging the development of acceptance prior to the loss, providers may give family members a sense of predictability and comfort which helps them to understand the dying process and decreases their distress (1, 10-11). This paper is designed to address the practical needs of oncologists

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who are likely to encounter various presentations and morbid outcomes of grief and bereavement. We include a review of major theoretical models of grief, risk factors, clinical presentations (including pathological reactions), special circumstances, and conclude with a discussion of how oncology staff can best help patients and their family members by considering their losses holistically, in terms of their unique constellation of biological, psychological, and socio-cultural traits.

Theories of Grief

Grief has been examined extensively in terms of a variety of factors which impact an individual's psychological, biological, and socio-cultural identity. Theoretical models of bereavement offer different perspectives on the development, maintenance, and treatment of grief. Understanding these models in conjunction with an appreciation for the uniqueness of various patient-family dynamics may contribute to a more refined approach to assisting individuals struggling with grief or in providing an appropriate outside referral. Putting these theoretical models to use in clinical care requires providers to remain open-minded about the various aspects of an individual's life which may help or hinder his ability to cope with the death of a loved one (12).

One of the most widely acknowledged paradigms of loss is Bowlby's attachment theory. According to Bowlby (1980) (13), the loss of a loved one may be the most devastating experience a person can endure in his/her lifetime. His theory is based on the concept of attachment, the idea that early on, children form intense bonds with their caregivers in order to receive the care and nourishment they require to survive. A stable and consistent bond is referred to as secure, while a less reliable relationship is termed insecure. Bowlby suggests that insecure attachment styles may be related to difficulties later in life including emotional distress, personality disorders, anxiety, depression, and emotional detachment (13) and others have suggested that insecure attachments may contribute to greater difficulty in dealing with loss later in life, including a greater risk for severe grief reactions (9,14). Individuals with secure attachments, however, may internalize memories of the deceased in a way that allows them gradually to accept the loss of a physical connection with that person.

Psychodynamic frameworks for understanding grief also focus on the importance of early mother-child relationships as internalized schemas for individuals' abilities to handle separation. In object relations theory, the initial separation between a child and his/her mother is seen as the foundation of reactions to emotional separations later in life. As with the attachment theory, a constant and reliable early relationship will impact an individual's ability to separate from a lost loved one in an autonomous, healthy manner. However, those individuals with more unpredictable early relationships may experience more distress in separating from the deceased (15).

According to interpersonal theories of grief, the quality of relationships of those experiencing loss are significant. This theory is based on the concept that the way in which individuals interact with one another becomes a part of how they define themselves, regulate their emotions, and develop a sense of appropriate social roles. These interactions may impact their ability to recover and move on after losing a loved one (16).

Other researchers suggest that cognitive processes are the key to understanding how individuals cope with loss (3, 8). Bereaved individuals may experience intrusive thoughts, frequent distractions, or catastrophic beliefs about the world (8). In particular, cognitive behavioral theories are based on the idea that a loss must be incorporated consciously into the bereaved individual's understanding of the world and his/her place in it (8). Integrating a loss is often very challenging and may result in maladaptive thoughts, feelings and

behaviors which prolong the period of grief. Specifically, individuals who have this difficulty accepting the loss as a reality may also have particularly negative beliefs about the world, misinterpret their own reactions to the loss, and/or display anxious and avoidant strategies (8). According to cognitive behavioral theories, although individual personalities and mental health may play a role in a bereaved person's ability to cope with grief, maladaptive cognitions and behaviors may contribute to the development and maintenance of more serious grief reactions (8).

Some models of grief focus on the sociological and cultural implications of an individual's background on his/her ability to handle loss. Rosenblatt (2001) (12) suggests that although the experience of grief may be common to all humans, there is no universal way of encapsulating the thoughts, feelings, and rituals of coping with grief. He suggests that clinicians and researchers who encounter or study grief must become familiar with the language and practices of people in a variety of societies in order to best understand and assist them.

Stroebe and Schut's dual process model (1999) (17) is one of the most comprehensive theories of grief and suggests that bereavement consists of two kinds of coping: loss-oriented coping and restoration-oriented coping. Loss-oriented coping involves ruminating about the loss and yearning for life with the deceased, which may bring on both positive and negative emotions. Restoration-oriented coping centers on adjusting to life without the deceased person. As with loss-oriented coping, restoration-oriented coping may result in a variety of emotions. For example, a person may experience anxiety about creating a new lifestyle as well as pride or relief at succeeding at various tasks or accomplishments. The vacillation between rumination about the loss and conscious attempts to redefine life contribute to recovery from grief (17).

Recent functional neuroimaging studies have begun exploring the neural basis of grief, identifying brain regions activated during the elicitation of grief with the ultimate goal of improving psychopharmacotherapy for PGD (18, 19, 20). Grieving individuals exhibit increased activation of several brain regions involved in the processing and regulation of emotional pain, including the anterior cingulate cortex, insula, and amygdala. Freed et al. (19) also identified differential patterns of activation between two symptoms commonly seen in PGD – intrusive and avoidant thoughts. Intrusive thoughts were associated with activations of the ventral amygdala and rostral anterior cingulate, while avoidant thoughts were associated with deactivation of the dorsal amygdala and dorsolateral prefrontal cortex. Extending neuroimaging research toward PGD, O'Connor et al. (20) found that while subjects with normal and prolonged grief exhibited similar activation of emotional pain-related regions, only those with PGD demonstrated activation of the nucleus accumbens. The increased activity in the nucleus accumbens correlates with higher levels of self-reported yearning for the deceased. Overall, these results suggest grief is mediated by pathways involved in emotional pain, but PGD may involve abnormal activation of neural reward pathways that ultimately interferes with adaptation to the loss. While future studies should further explore these findings, the potential association between PGD and abnormalities in reward neuro-circuitry holds significant implications for treatment.

Clinical Presentations

Healthcare professionals should recognize that grief may present in a variety of forms and at various times during a patient's illness and beyond. Grief may develop at the time of diagnosis (referred to as anticipatory grief), during and through death, and for months or even years after the loss. Recognition of grief symptoms in family members and caretakers

may lead to earlier interventions which may relieve suffering and prevent the development of pathological grief reactions.

Anticipatory Grief

Anticipatory grief describes grief symptoms experienced by both patients and their loved ones prior to death (21). Although anticipatory grief symptoms may be similar to those experienced following loss, the term is useful in describing the grief which may begin far before death, when the patient and family first recognize the terminal prognosis of an illness. For some, the very diagnosis of cancer may be equated with terminal illness,¹ and anticipatory grief is often a normal response to the realization of major changes forthcoming. Patients and their families may experience fears regarding the loss of independent functioning and changing roles within the family. As a result, some families may encounter increasing dysfunction and conflict as family members react with hostility, anger, and poor expressiveness (22). On the other hand, anticipatory grief may also be a positive experience. Families may become more cohesive through shared hardships, and anticipation of death forthcoming may offer patients and their loved ones time to emotionally prepare for the loss.

Predictors of anticipatory grief include female gender, adult children, high perceived stress, and difficulty coping (23,24). Gilliland and Fleming (1998) found that spousal anticipatory grief was actually more intense and characterized by higher levels of anger and loss of emotional control as compared to grief following death. Similarly, adult children experiencing anticipatory grief were likely to report better adjustment to the death of their parent (25). However, these improved symptoms post-loss may reflect relief from intense emotional and social turmoil surrounding the patient's illness, and relatively little is known about the association between anticipatory grief and abnormal post-loss grief reactions. Nevertheless, it is important that oncologists understand anticipatory grief and recognize symptoms may begin in both patients and family members at the time of diagnosis. Anticipatory grief may produce intense emotional symptoms and holds key implications for post-loss grief. It is critical for oncologists to deliver news with sensitivity and attempt to recognize dysfunctional reactions so that appropriate psychosocial resources can be made available (26).

Grief surrounding time of death

A strong, trusting relationship among physician, patient, and family members is crucial at the end-of-life and promotes healthy adjustment for those who grieve. Informational materials regarding what to expect during these final moments may help alleviate anxieties and provide guidance for the upcoming hours or days. When death appears imminent, family members should be notified promptly and with utmost sensitivity. The healthcare staff should be patient and respectful in taking time to adequately answer all questions.

Clinicians should also offer support and encourage emotional expression rather than making efforts to minimize the loss (27). Cultural and religious practices should be respected, and chaplaincy services may be offered when appropriate. Shortly following death, the clinical team may provide further assistance via psychosocial support and guidance regarding funeral arrangements. Moreover, clinicians may want to send a letter of condolence or make a phone call to the family to express sympathy for their loss and offer a debriefing meeting for the family (28). Indeed, 50-70% of bereaved caregivers of advanced cancer patients desire bereavement support after loss (29, 30), but the rate of bereavement follow-up reported by physicians remains low (31, 32, 33). In one study, 33.3% of medical oncologists, radiation oncologists, and palliative care specialists reported that they usually or always make a telephone call, send a condolence card, or attend a funeral after a patient's

death (33). Families are often extremely appreciative of the care and support the oncologist has provided during the course of illness, and a consoling message provides a sense of closure both for families and clinicians (34).

Maladaptive Responses to Bereavement

Although some form of sadness and anxiety are common particularly right after the death of a loved one, most people tend to recover from their feelings of grief. However, extreme forms of distress which result from grief that is prolonged and causes functional impairment is not considered normal (2). Some individuals may develop separation anxiety, Generalized Anxiety Disorder, phobias, or somatic symptoms (1). In trying to understand the impact of grief on mental health, some researchers have suggested that bereavement-related depression does not differ from depression due to other stressful life events (35). As a result, many patients may receive a diagnosis of Major Depressive Disorder based on symptoms such as psychomotor retardation, feelings of worthlessness, extreme guilt, or suicidal ideation (9). However, a variety of risk factors may increase the likelihood that grief will result in clinically significant cases of depression, anxiety, or Prolonged Grief Disorder (PGD). It is important to distinguish between sadness in the early months following a loss and more severe, protracted distress.

Prolonged Grief Disorder

Although many individuals come to terms with loss over time and begin to feel a renewed sense of stability in their lives without the deceased, about 10-20% demonstrate a severe and prolonged grief response (7, 9). Researchers have studied this potentially debilitating response to loss and developed empirically supported diagnostic criteria for PGD. Though PGD, anxiety, and depression may co-occur, an isolated set of symptoms specific to PGD have been identified. Bereaved individuals with PGD are “stuck” in and unable to move on from their grief (9). The experience of these individuals includes symptoms such as intense longing or yearning for the person who died, a sense of bitterness regarding the loss, rumination about the loss, social isolation, intense sorrow or regret, and a feeling of meaninglessness (9). Many of these symptoms and the impairing nature of the disorder may result from an unwillingness or inability to accept the loss of the deceased and to move toward a life without that person. This may contribute to the notion that an individual with PGD is “stuck” in a state of chronic mourning, unable to let go of the past shared life and picture a purpose or meaning in the world that can carry him/her forward (9). Although symptoms may become evident at the time of death, one important feature of PGD is that a diagnosis cannot be determined until at least six months have elapsed since the loss. Given that normal grief tends to dissipate in six to 13 months (36), this time period is critical for clinicians to distinguish between individuals who are suffering and in need of treatment from those whose grief will likely resolve naturally (7).

Research has offered evidence for the significant presence and distinct clinical picture of PGD as compared to depression and Post Traumatic Stress Disorder (PTSD) (37). PGD has been linked to an increased risk for broad negative mental and physical health outcomes, life-threatening conditions, hospitalizations, symptoms of depression, increased stress, negative health behaviors, functional impairment, and suicidal thoughts (6, 38, 39, 40). Given the empirical evidence for PGD as a distinct mental illness, as well as the grave health outcomes which its symptoms predict, bereavement researchers have made the case for including PGD in the next edition of the *Diagnostic and Statistical Manual of Mental Disorders* (9). Although other terms, such as “complicated” or “traumatic” grief have been employed in past research, Prigerson, Vanderwerker, and Maciejewski (2008) (9) suggest that the use of the word “prolonged” is the most clear and accurate, as well as the least pejorative way of describing this severe reaction to loss. Although previously discussed

evidence exists for the uniqueness of the syndrome, some suggest that both “normal” and “abnormal” grief symptoms fall on a continuum which, if pathologized, may contribute to increased stigmatization or medicalization of the grieving process which many view as a trying, but expected part of life. Prigerson and her colleagues maintain however that recognizing PGD as a distinct disorder will allow for more consistent and earlier recognition of bereaved individuals who require assistance and treatment (7, 9, 37). In addition, among bereaved individuals who met criteria for PGD nearly all of them said they would be receptive to treatment; their families would be more understanding of their distress and relieved to know they had a recognizable syndrome (41).

Risk factors for PGD

In a majority of individuals, the feeling of intense distress following a loss will gradually subside over the subsequent months. For certain individuals, this is not the case. Numerous risk factors for negative grief outcomes have been identified. Some factors relate to personal psychiatric vulnerabilities such as insecure attachment styles (42, 43) childhood abuse or neglect (44), and history of psychiatric illnesses such as depression or childhood separation anxiety (14). Other risk factors for experiencing extreme distress following a loss include the level of family cohesion and social support in the community. Moreover, the conditions of the death itself may also predispose individuals to pathological grief, depending on the family members’ perceived preparedness (11).

Although many risk factors for a PGD are difficult to change, early identification of the subset of individuals at risk for PGD is an important task for family members, oncology staff, psychiatrists, and primary care physicians. Modifiable risk factors may be addressed and optimized early on. In addition, healthcare professionals may be in a unique position to recognize family members at high risk for pathological grief outcomes. Providing early psychosocial support for these individuals may prevent subsequent development of PGD and its sequelae (4).

Specific Circumstances

Loss of a child

Childhood cancer is relatively uncommon and generally carries an encouraging prognosis, with 5-year survival rates of 81.5% (45). However, when a child is lost to cancer, the grief reaction of parents is often more intense and prolonged than the grief which results from the loss of a spouse or a parent (46, 47). Parents may experience extreme feelings of guilt and failure as well as a sense that the natural order of the world has been upset when they have outlived their child. Kreicbergs et al identified increased rates of anxiety and depression in parents who have lost a child to malignancy compared to non-bereaved parents, with a prolonged effect lasting 7-9 years post-loss (48). Parents with unresolved grief experience increased physical and psychological morbidity, including disturbances in sleep, increased sick leave, and increased healthcare utilization (49). A Danish national follow-up study on child death from all causes found bereaved parents to have an increased risk for psychiatric hospitalization that was most pronounced during the first year post-loss and significant for up to 5 years after the child’s death (50). The same group also found bereaved mothers to have increased overall mortality rates from both natural and unnatural causes throughout follow-up as well as increased mortality from unnatural causes in fathers at 1-3 years post-loss (51).

The physician-parent relationship is a critical aspect of care of the terminally ill child and may ultimately promote healthy grief resolution. A Swedish national survey of parents 4-9 years following loss of a child to cancer found those who had access to professional psychological support during the last month of their child’s life were more likely to report

satisfactory grief resolution (52). Higher degrees of grief resolution were also seen in parents who felt the healthcare team was taking initiatives to offer counseling during the child's illness and when parents had the opportunity to discuss their child's condition with the attending physician. Oncology staff should be aware of the importance of communication with patients and their families and offer psychosocial services at the end-of-life. Studies have found parental perceptions of high-quality care to be associated with physicians providing news with care and sensitivity, giving clear information on what to expect during the end-of-life, and preparing the family for the circumstances surrounding the child's death (53). In addition, the physician should also make attempts to communicate directly with the child, if he or she is old enough (53). When psychiatric services are necessary, family-focused grief therapy may be effective in promoting support between parents and any remaining children (54).

Bereavement during childhood

Loss of a parent during childhood often creates a void in the child's life, a void that may begin long before the parent's death as the remaining parent is occupied with caretaking activities. Household responsibilities are likely to change drastically as a result of parental loss, and children may experience fears about their own health and their security in the world (55). Multiple studies have confirmed that children who experience parental death are at increased risk for anxiety and depression both later in childhood and as adults (56,57,58). Bereavement during childhood represents a critical period during which clinicians and caretakers should be vigilant toward symptoms of depression, dysphoria, and conduct issues. Unfortunately, few studies have examined specific interventions in childhood grief. One recently published randomized controlled trial, discussed the effects of a Family Bereavement Program entailing 12 group sessions for caregivers and youths and found this intervention to significantly reduce rates of externalization and internalization of problems as well as lower rates of depression at six years follow-up (59). Additional studies may better evaluate the efficacy of other supportive psychotherapies indicated for children after parental loss.

Adolescents and young adults

Adolescents and young adults (AYAs) (individuals from 15 to 39 years old) live in a transition period characterized by a unique set of psychosocial factors (60), which may affect their ability to cope with distress. The major task of adolescence involves the formation of a coherent and personal identity (61) while still retaining a connection to the family (62). This process often continues into early adulthood, and as a result, loss of a loved one – particularly a parental figure – during this period is an aberrant life event that may disrupt identity formation. While clinicians and family members may typically interact with AYAs as adults during the grieving process, studies show that this group experiences an intensified set of emotions relative to older adults in grieving parental loss (63). Similar to grief during childhood, grief during adolescence is a risk factor for chronic anxiety and depression (64). Uniquely, AYAs may experience the necessity or guilt to return home during the terminal phase of illness and following death. On the other hand, AYAs who may have been the primary caretakers of the deceased may experience both grief as well as a sense of relief following the death. These responses may further trigger guilt and distress during an already fragile period. While empirical data are relatively sparse, current research suggest that AYAs represent a distinct psychosocial group who may benefit from more specific interventions directed at addressing their specialized needs.

Interventions and Treatments for Grief

Although oncologists are likely to encounter patients or families experiencing various presentations of grief on a frequent basis, research on how to help these individuals has been mostly inconclusive. Several authors offer methodological arguments about why a large body of research on psychotherapeutic interventions has been inconsistent and difficult to interpret (65, 66, 67) and why most researchers have found small to moderate treatment effects. Some suggest that small effect sizes for bereavement interventions are a result of “diluting” the sample with less distressed bereaved persons from the start and the reduction of bereavement distress that occurs with time alone (68). Some studies do indicate that those individuals with particularly severe grief symptoms may benefit from psychotherapeutic interventions (23, 65), and/or psychopharmacological treatments.

Clinical support from hospital staff

There are many ways in which clinic staff members may offer support to individuals and families after a death. This may be particularly helpful and appreciated when the staff has developed a close relationship with a patient’s family prior to the loss. While the effort required may be as small as offering condolences over the phone or sending a sympathy card, or more involved, such as visiting the family’s home, attending the funeral, or developing an annual commemoration service for the deceased and his/her family, preserving the connection that often develops during treatment may affect the loved ones’ experience of loss (1).

Psychodynamic and Interpersonal Treatments

Psychodynamic treatment approaches tend to be long-term and revolve around attempts to utilize knowledge of childhood experiences, object relations, and unconscious conflicts as a framework for understanding a patient’s grief response. Patients who would likely benefit most from psychodynamic therapy are those who have unresolved issues related to conflict and insecurity in their early relationships (1). Interpersonal therapy (IPT) is one specific form of psychodynamic treatment which is manualized, time-limited, and focuses on relational conflicts which are purported to maintain symptoms of distress. IPT was developed to treat depression, but has since been utilized as a treatment for a variety of psychological disorders (1, 65). An inventory of relationships is developed to determine which of four common issues (grief, disputes, transitions, or deficits) contributes to the patient’s struggles. Once this target area has been identified, the therapist works with the patient to improve communication and problem solving abilities in order to alleviate the stress of relational conflicts. While some studies offer evidence for the effectiveness of IPT (1, 65), other results indicate that IPT alone does not significantly reduce bereavement-related major depressive episodes (69).

Cognitive Behavioral Therapy

Broadly conceptualized, cognitive behavioral therapy (CBT) focuses on isolating and modifying automatic thoughts and catastrophic beliefs which are often reinforced by maladaptive and/or avoidant behaviors. When considering grief in a cognitive behavioral framework, Boelen and colleagues (8) suggest that individuals have a hard time accepting a loss as real and a difficult time integrating the experience of the death into their internal self-narrative. Treatment within this conceptualization of grief may be especially helpful when individuals are experiencing excessive guilt or anger which may be caused by distorted cognitions regarding the circumstances of the death or the relationship to the deceased (1). Additionally, the behavioral component of CBT may be used to help bereaved individuals decrease their avoidant tendencies which would result in a healthy interaction with reminders of the deceased and a recommencement of day-to-day activities (8).

Group-oriented Therapeutic Approaches

One of the most beneficial aspects of group therapy is that participating individuals can provide informed support to each other because of shared experiences. Group members can offer validation and normalization to one another regarding emotions and behaviors related to coping with the loss. Additionally, participants can share ways in which they have learned to cope with their grief. Studies have indicated that patients with PGD who were more extroverted, open, and conscientious with a history of social support and secure relationships would benefit most from group therapy (54, 70, 71).

Family Therapy

The understanding of a family's dynamics that often develops throughout the course of the deceased's treatment may lead clinicians to recommend family therapy. The aim of Family Focused Grief Therapy (FFGT) (22) is to prevent unhealthy responses to bereavement by examining a family's ability to communicate, feel close to each other, and resolve conflict before a loss. The therapy is brief, focused, and time-limited. Families are screened before the patient has died and if they demonstrate moderate struggles with communication, cohesion, or conflict resolution, therapy begins at this time and continues after the loss. Beginning therapy before the patient's death gives clinicians both the opportunity to view the way the illness impacts the family's functioning as well as to provide a sense of continuity of care after the loss. Research has indicated that FFGT has been modestly successful in reducing distress about a year after the loss, but was most beneficial to families who were characterized as "intermediate" and/or sullen (22). Identifying families before a loss who are already struggling to cope with the stress of cancer may provide clinicians with a valuable opportunity to intervene and help prevent additional distress.

Internet-based Therapy

Treatment interventions for grief found on the Internet have been demonstrated to be effective in reducing distress in the form of avoidance and depression (72). There are a variety of reasons that Internet-based interventions may be successful and appealing to patients: these interventions are cheaper, may be accessed in the comfort of an individual's home, may provide a greater sense of anonymity, and may allow the bereaved to avoid medical settings that remind him of the deceased's treatment and death (1). Additionally, symptoms of psychiatric disorders (e.g. PGD, depression, and PTSD) may be reduced through internet-based interventions (73, 74).

Combined psychopharmacological treatments

Bereavement-related depression may be treated with a combination of antidepressants and psychotherapy, similar to the treatment of Major Depressive Disorder. Both selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) have shown efficacy in reducing depressive symptoms in the context of grief (66, 75, 76). One open-label study found the SSRI paroxetine (Paxil, Pexeva) and the TCA nortriptyline (Aventyl HCl, Pamelor) to be equivalently effective in reducing symptoms of both depression and complicated grief (73). Other studies have found success in combining pharmacotherapy with psychotherapy. The most compelling evidence for this combined approach involves a double-blinded randomized control trial of nortriptyline and interpersonal psychotherapy, which reduced depressive symptoms in 69% of treated patients following a median of 6.4 weeks of treatment, compared to 56% in nortriptyline alone and 29% in psychotherapy alone (73). In contrast to the open-label trial of paroxetine, however, the latter study found that neither nortriptyline nor interpersonal psychotherapy significantly reduced the symptoms of complicated grief. Therefore, while it appears that standard pharmacotherapies may be

combined with psychotherapeutic approaches in treating bereavement-related depression, the intensity of grief symptoms may remain unchanged.

Treatments for PGD

Due to the complex nature of PGD, the disorder does not always respond effectively to typical treatments for bereavement-related depression (9, 37). Boelen et al. (2007) (77) compared a CBT intervention for PGD to supportive counseling, and found that CBT was more effective in decreasing the pathological symptoms of PGD. Additionally, Shear et al. (2005) created Complicated Grief Treatment (CGT), which combines psycho-education with CBT methods. A randomized controlled trial found that patients responded more and more quickly to CGT than IPT (78) .

Effects of hospice care

Hospice organizations and palliative care specialists are adept in the management of physical pain and emotional suffering at the end of life, and hospice staff may be able to play an important role in helping family members cope with loss. In addition to promoting a “good death,” most hospice programs also provide grief and bereavement support for family members after the death, which may be helpful in reducing the severity of prolonged grief reactions. One prospective cohort study found that caregivers of patients enrolled in hospice for three or fewer days were at significantly increased risk of developing major depressive disorder when compared to those with longer hospice enrollments (79, 80). This effect was found at six months and 13 months post-loss after adjusting for confounding factors such as baseline Major Depressive Disorder and caregiver gender, age, relationship to the patient, and burden. More importantly, a retrospective matched cohort study found hospice use at the end of life to be associated with reduced mortality during bereavement among widowed spouses (81). Additionally, hospital deaths relative to hospice heightened risk of PGD in bereaved family members (82).

These studies suggest hospice enrollment may be a preemptive intervention for those at risk for pathological grief, and enrollment status may be further used to identify those at risk for complicated grief. Additional research is certainly warranted to tease out the relationship between hospice use and post-loss morbidity and mortality in caregivers. The available data suggests that physicians should consider engaging with the patient and family in a detailed discussion regarding the resources available through hospice organization.

Conclusion

Although considerable government and private resources have been devoted for many years to finding a cure for cancer and many dramatic advances have been made, a significant proportion of the population is diagnosed with cancer every year. Many of these patients will not survive. The loss of a loved one can be, for many, one of life’s most devastating experiences. While the experience of grief after a death may be thought of in terms of attachment, relationships later in life, intrusive thoughts, avoidance behaviors, or cultural background, oncology providers are likely to experience the suffering of their patients’ loved ones on a regular basis. Many of the theories of grief contain overlapping elements. These elements may be considered and integrated from within a biopsychosocial framework which takes into account the biological, psychological, and socio-cultural ramifications of losing a loved one.

Many treatment models have been proposed for grief, and although the literature still suggests mixed results, further research into specific sub-groups of bereaved individuals may be helpful in developing reliable and valid targeted interventions. Researchers will

continue examining how therapies can help patients resolve conflict from early relationships, diffuse conflict in current relationships, and/or help patients accept the reality of the loss as part of their life story. Treatments which begin before the patient's death, both for individuals and families, may help facilitate greater acceptance and ability to deal with often inevitable role shifts and new responsibilities. Although some controversy about the treatment of grief exists in relation to the discussion of PGD as a distinct disorder, the empirical support for the distinctiveness of this disorder is strong and convinced the DSM-5 to recognize grief as an Axis I disorder, a form of an Adjustment Disorder. We expect this development to stimulate research in epidemiology, neurobiology and treatment of PGD.

Overall the literature indicates that the role of oncology staff in helping families cope with grief is immeasurable. Medically and psychologically, clinicians are well positioned to reach out to patients and prevent post-loss suffering. Patients and their families members often develop very close relationships with hospital staff and may benefit greatly from feeling as though their interactions with staff do not end the moment their loved one dies. Continuity of care, particularly in discussions of grief, must be continued even after the loss of a patient.

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