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Pathological Grief: Causes, Recognition, and Treatment

SUMMARY

Although the incidence of pathological grief does not appear to be high, the morbidity and mortality of sufferers is significant. Because of attitudes about grieving and the reluctance to experience grief, patients may avoid sharing grief with the family physician, who may then fail to recognize pathological grief. This article discusses clinical manifestations and situations which can lead to pathological grief. The types of pathological grief—chronic, inhibited, delayed, and atypical—are also discussed, along with personality variables which predispose some people to difficult grieving. Failure to grieve may also lead to a higher incidence of physical disease and various forms of mental illness. In order to manage grief, the physician must encourage the patient to express all his feelings of sadness, anger, and guilt; reassure him that his anger and guilt are a normal reaction to loss; and later, give him permission to stop grieving. (Can Fam Physician 1984; 30:914-924).

SOMMAIRE

Bien que l'incidence du deuil pathologique ne semble pas élevée, la morbidité et la mortalité de ceux qui en souffrent sont significatives. À cause des attitudes entourant le deuil et la répugnance à vivre le deuil, les patients peuvent éviter de partager leur deuil avec le médecin de famille qui, alors, n'aura pas les indices pour reconnaître le deuil pathologique. Cet article discute les manifestations et les situations cliniques pouvant engendrer le deuil pathologique. Les différents types de deuil pathologique—chronique, inhibé, retardé et atypique—sont aussi discutés, de même que les variables de la personnalité prédisposant certaines gens à un processus pénible de deuil. L'absence de manifestations de deuil peut mener à une plus grande incidence de maladie physique et différentes formes de maladie mentale. Pour faciliter le management du deuil, le médecin doit encourager le patient à exprimer tous ses sentiments de tristesse, de colère et de culpabilité; il doit le rassurer que sa colère et son sentiment de culpabilité sont une réaction normale à la perte; et, par la suite, lui donner la permission de terminer la période de deuil.

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THE PURPOSE OF this paper is to discuss how pathological grief states can be better recognized and treated. Having an interest in this area, I have been struck by the number of cases of undetected pathological grief that I see in consultations referred by family physicians. Generally these cases are depressed patients who have not shown improvement with antidepressant drugs, and at times present with other psychiatric conditions. Only through questions directed at how the patient reacted to major losses in his life is the unresolved grief revealed.

I believe that there are various reasons for this. Society's attitudes are that grieving is a private matter and not something to be readily shared with others. Employers take the attitude that employees need only two to three days off work after a bereavement. Often the bereaved themselves are reluctant to grieve openly; evidence of this is the number of people wishing to take tranquillizers to dampen their grief at the time of the funeral. Sometimes people pride themselves over not crying at the funeral and see this as evidence of strength. Grieving is also not considered a legitimate state requiring time

to overcome it. Many years ago mourners were entitled to wear black clothing or black armbands, marking them as mourners. The public acceptance of a state of mourning meant that mourners could withdraw from social obligations for up to six months.

Very often people fear to discuss a past bereavement for fear of re-experiencing grief. For example, a 54-year-old Italian business man was referred to me for psychiatric help because of depression. He dated the onset of depression to about nine months earlier, and failed to recognize why he had become ill. His wife revealed that his mother in Italy had died about a year earlier and that the patient felt unable to return to Italy for the funeral because of financial and time restrictions. This man showed no overt grief at the time, but his wife reported that he gradually withdrew and became depressed. With reluctance, this man began to grieve his loss, but he tended to discuss it at an intellectual level rather than to experience it at an emotional level.

Another factor which discourages discussions of unresolved grief states is the feeling of shame bereaved people often experience when they have not been able to overcome their grief. The inability to resolve the grief state in a certain period of time is felt to be a failure to live up to a self imposed standard. Along with this there is often a feeling of guilt which leads to the suppression of grief.

A Definition of Mourning

A simple definition of mourning is sadness appropriate to a real loss. Normal mourning includes hostility, sadness, remorse towards the deceased, and a painful feeling of emotional loss and emptiness. Although mourning is associated with discomfort and loss of function, usually it is not considered a morbid condition requiring medical treatment. Mourning is a "normal phenomenon, normal in the sense that it is a necessary part of the response to loss".[1] If a person has lost his spouse, it is clear that the process of mourning or 'grief work' has a function, which is to free the individual from his ties to the lost person. When the grief work has been done, the individual is again free to establish new relationships and begin new activities. This is a painful process which is often actively suppressed. There is a wide range of variability in normal mourning, and mourning varies from one culture to another. Again, the degree of mourning depends on the nature of the relationship to the deceased—how meaningful and intense it was.

Loss occurs in many ways. There can be a real loss when a significant person is lost. Threatened losses are situations where we deal with impending loss. Symbolic losses are the loss of an ideal, belief, way of life, or country. Another major loss involves physical health. Loss of physical strength, disease, or surgical procedures resulting in amputation are major losses.

I will not describe the phases of mourning or typical manifestations of grief, but will keep to the title of my paper. In pathological mourning "the individual has been unable to come to terms with the loss, either to acknowledge it consciously, or to give up yearning for the person".[1]

When Is Grief Pathological?

The incidence of pathological grief is difficult to evaluate. Clayton et al.[2] found that 98% of those suffering from bereavement did not seek psychiatric help. Of this group, 81% began to improve six to ten weeks after their loss. Recovery from grief may be difficult to determine, as many people who appear to have recovered may develop pathological grief reactions. Volkan[3] found that at any one time in a 38-bed inpatient unit, at least one or two patients' natural process of mourning had been blocked.

Parkes[4] described a significant increase in patients' visits to their family doctor in the first six months after bereavement. A wide variety of symptoms may develop after bereavement, and hypochondria is frequent. Patients complain of insomnia, diarrhea, precordial pain and aching limbs. De Vaul et al.[5] described how failure to mourn can "lead to chronic illness behavior and hypochrondriasis". These patients are described as being preoccupied with health and unable to invest interest in social relationships. "They consult numerous physicians, undergo countless medical workups generally with negligible findings, and take medications and treatments with no relief of symptoms".[5]

Other patients may show an exacerbation of previously existing psychopathology in bereavement. Lehrman[6] said variants of pathological grief are "obsessive compulsive neurosis, anxiety states, hysteria, manic depressive psychosis, or schizoid state".

Parkes[7] has shown that medical illness can also be a response to bereavement. During the first year of bereavement, the death rates for the bereaved are considerably higher than for matched populations of the same age and sex who still have a spouse.

Another group at risk are divorced people who have a physical illness.[7] During the first year after divorce, they visit physicians much more frequently than matched married controls.

Clinical Manifestations Of Pathological Grief

I will attempt to outline some of the symptoms manifested by patients suffering from pathological grief and/or situations leading to this condition. The following symptoms will alert the family doctor that the patient is struggling to overcome his loss.

In his study of bereaved psychiatric patients, Parkes[8] found that three features were seen most frequently. These patients had "difficulty in accepting the fact that the lost person was dead", and they expressed "ideas of guilt and self blame". Also frequently seen was "hostility towards others associated with the loss". These findings confirm that an ambivalent love-hate relationship is more difficult to resolve.

For example, a patient was referred to me because of pathological grief. She was a 57-year-old spinster whose mother died in November 1982. She continued to want to believe that her mother was alive, although she attended the funeral, and could not discuss her loss for fear of "breaking into pieces". This patient felt severe guilt because she gave permission for her mother's leg to be amputated a week before her death. She blamed the medical staff for neglect and herself because she was not present when her mother died. As her depression worsened, she had to take a leave of absence from her job and a hospital admission was precipitated by the drowning in her swimming pool of one

of her pet dogs. She also blamed herself for this death. Therapy was directed towards helping this patient to talk about her loss, to recognize that her hostility towards her mother was displaced to hospital staff, and to see that her repressed hostility caused guilt and self blame.

Misdirected hostility

All grieving individuals report irritability and a feeling that the world has become unsafe. The degree of hostility experienced varies, but is probably seen in all grieving people. Parkes[9] reported that caretakers such as physicians, the clergy, or family members may be perceived as having offended the bereaved in some way, and hostility is directed towards them.

Hostility is pathological if the person withdraws socially and avoids family members. The grieving person who feels critical and hostile often fears that he will antagonize others, and he then fears their hostility. Melges and De Maso[10] said that hostility directed at the self or at others is a defense against acknowledging ambivalent feelings toward the deceased.

Guilt and self blame

The wish to cry or rage at the loss may be coupled with an inability to do so. Melges and De Maso[10] described patients who try not "to fall apart" at the time of the loss, and fail to grieve later because grieving seems inappropriate. The inability to cry generally indicates severe guilt and self blame. These people may describe themselves as "too hurt to cry" and, although there is little affect displayed, they are suffering intensely. Lindemann[11] described bereaved persons who struggle with hostility and attempt to hide it by becoming wooden and formal. The patients' face may be like a mask, and his movements are formal and stilted. Lindemann said these patients go through the motions of living, do not verbalize any warm feelings, and admit that they would be angry with everybody if they did have feelings.

Persistent yearning for the deceased

Melges and De Maso[10] described this as evidence of searching for the lost object, and said that the bereaved person may manifest this by talking of the deceased in the present rather than the past tense. Photographs, jewellery and the deceased person's personal items are often examined and touched in order to maintain the hope for reunion. People who tend to develop a pathological grief reaction have great difficulty in accepting the fact that the lost person is dead.

Yearning may also be manifested in grieving people's dreams, in which the wished-for reunion with the deceased person occurs. The deceased interacts with the grieving person, but at the same time there is evidence that something is wrong, and the dreamer often awakes suddenly, feeling very anxious.

Characteristics of Those Suffering Pathological Grief

Self detrimental behavior and lost social interaction

Lindemann[11] described these people as lacking initiative, and being indecisive and restless. They look to others for direction and want to be included in social activities; when they are, they feel grateful. However, they are apathetic and cannot make up their minds to do anything on their own. Nothing brings satisfaction, and it appears that they carry out many daily routines out of habit. Patients may show self punitive behavior without being aware of guilt feelings. Such people may give away belongings, be lured into foolish financial dealings and act stupidly, damaging their reputations and losing their friends or professional status.

Overidentification symptoms

The bereaved person may develop symptoms resembling those suffered by the deceased in his last illness. This may take the form of hypochondriasis, hysteria, or vague symptoms for which the patient seeks reassurance from his physician. Parkes[8] described a man of 42 who had modelled himself after his father. After his father died of a coronary thrombosis, this man developed left-sided chest pain with palpitations about three months later and was convinced that he had heart disease.

Drug abuse

Skolnick[12] described how drug dependency can develop as a means to ward off painful awareness of loss. If the reality of loss is too difficult to accept, a pathological mourner can achieve chemical relief. When the effect of the drug wears off, emerging pain necessitates further drug use. The abuse of alcohol and drugs is a manifestation of pathological grief.

Severe psychopathology

Severe functional somatic symptoms such as persistent insomnia, anorexia and weight loss indicate that the bereaved person is not resolving his loss. Patients with pathological grief may develop an agitated depression, with all of the characteristic symptoms and signs. Along with other symptoms is the tendency for self accusation, feelings of worthlessness, pessimism and a wish for self punishment. These patients can be suicidal and require psychiatric intervention.

There are also certain situations or variables which contribute to the development of a pathological grief reaction. Some of these are circumstances affecting the grieving individual. Others are personality variables, which determine the individual's capacity to work through the grieving process.

Situations Leading To Pathological Grief

Situations that may lead to pathological grief are described below.

Untimely death

With a sudden death there is usually surprise, shock, and no preparation. By way of contrast, the death of an aged person might be expected. With an aged person, some of the grieving work has already been completed, and ties to the aged person have loosened.

Volkan[3] found in his study of 23 patients suffering from pathological grief that all of them experienced the death of a loved-hated one as a sudden death.

Lehrman[6] pictured an untimely death as occurring in a "relatively young person". The death may be sudden, as in an accident, or a "pronouncement of incurability"[6] in cancer patients, which serves as a death sentence and causes the reaction.

For example, a 32-year-old woman was referred to me because of frequent anxiety attacks. Eight years earlier her husband had been killed suddenly in a construction accident, and because his

body was badly mutilated it was arranged that his brother identify the body. She never visualized his body after death, and although she attended the closed casket funeral and grieved, she found it hard to accept that he was actually dead.

Some months later she began having anxiety attacks and became fearful that her children might come to harm if they were any distance from home. News of a school bus accident caused her to panic.

Through psychotherapy, this patient came to realize that some of her anxiety about her children was based on her resentment over increased responsibility as a widow and the feeling of being abandoned.

Krein[13] described the reaction following Sudden Infant Death Syndrome as an intense, disruptive, almost unbearable grief reaction. These parents may become very fearful and reluctant to conceive further children, to have a baby in the house, or to check a sleeping baby's room. It is likely that the loss of children almost always predisposes parents to intense grief reactions. It is estimated[1] that 75% of marriages of parents who have lost a child become dysfunctional, leading to divorce or high rates of alcoholism, depression, and sexual difficulties.

Suicide

After a suicide, relatives have a strong tendency to feel guilt and self blame.

Herzog and Resnick[14] studied parental response to adolescent death by suicide. They described the parents as refusing to think of the death as a suicide, and preferring to think of it as an 'accident'. The researchers said that the parents feel hostile towards others who designate the death as suicide, and they feel longlasting guilt about the suicide. Hostility towards others manifested itself in the researchers' difficulty in arranging interviews with families of suicide victims; only half the families cooperated.

In my practice, I saw a 44-year-old woman in psychotherapy whose 17-year-old son had shot himself. Two years later she continued to show inhibited grief and explained that she "had to see the death as an accident or she couldn't handle it". At the time of the death the patient cried very little, appeared numb and distant, and talked of how she had to be "the strong one in the family". She showed a dogged determination to return to her teaching position a week after her son's death, and did so. The patient was afraid the "coroner would want an inquest", revealing her fear that her guilt would be exposed. She felt much self blame because she herself had attempted suicide years earlier. Her fantasy was that she had transmitted something bad to her son. Recognizing that her need to deny the suicide was a primitive defense, I did not challenge her. I wanted to avoid more severe regression.

Other Factors That May Affect Grieving

Altered life situation

An altered financial situation which leads to feelings of insecurity can also lead to resentment towards the deceased. Bereavement causes anxiety and generally a sense that the world has become a dangerous place. Volkan[3] described situations where loss of money, property, or status in the community caused increased resentment.

Earlier losses

Earlier losses that were not mourned can sensitize people to later losses. These can be further complicated by the fact that some losses are not socially recognized.

Spontaneous abortion: Stack[15] has outlined some of the problems facing a woman after a spontaneous abortion. The woman may be embarrassed to mention that she aborted, and may feel guilt if she had suppressed wishes to terminate the pregnancy. The abortion gratifies this wish, leading to guilt feelings which she may be unable to verbalize.

Also, a women cannot identify with this lost person, and can only fantasize about the size, sex and personality of her lost child. There is no funeral, and her family and friends may encourage her to avoid crying and acting like a bereaved person.

Stillbirth: Lewis and Page[16] described the problem facing women who have given birth to a stillborn child. As with abortions, there is guilt and shame and no known person to mourn; the event is seen as an empty tragedy. Most of these women's fantasies concern what they think or felt caused the death, as exemplified by the following example.

The second child of a 34-year-old woman was stillborn. The woman had openly expressed her resentment about the pregnancy during the first three months, and after the stillbirth her husband blamed her, telling her that she "didn't want the baby anyway". Many years later she remained preoccupied with the death and felt guilt.

Lewis and Page[16] described how a stillbirth can cause considerable anxiety if the child was macerated or malformed. If the woman rejected the pregnancy, she may unconsciously feel she damaged the fetus.

Divorce: Divorced people may have initiated the divorce action, find the divorce a relief, and yet have to work through the loss, which society may not recognize as a loss.

Kitson et al.[7] compared divorcees to widows, and found that the divorcees reported a sense of alienation, restrictions in relationships, and often a feeling of being stigmatized. The status of widows tends to be higher, with an accepted period of mourning during which the widow can grieve and avoid social obligations.

Wise[8] also described the disturbed mourning process in some white, middle to upper class divorced women and their families. These women had been married from nine to 14 years. All had children, and although they maintained well-run homes and took good physical care of their children, all was not well. These mothers had difficulty in tolerating sad affect in their children and refused to recognize the children's distress. The women's guilt made it difficult for them to mother adequately, and they often felt weighed down by too much responsibility. The divorce failed to end marital conflicts and often they continued to be ambivalent toward their former husbands.

The mourner's age

Most investigators agree that mourning is inhibited in the young and elderly. There has been some controversy as to how old children must be before they can mourn. This area has been investigated by various researchers, who have come to varying conclusions.

Furman[19] believed that mourning can occur quite early in childhood, and the preconditions are the acquisition of a concept of death and the ability to maintain a mental picture of another

person when separated from that person (object constancy). Before object constancy is attained, a child readily forgets the absent person. Only when the child can remember the absent person can he work through the loss.

Although both these conditions can be attained by age four, Wolfenstein[2] believed that these conditions are not enough for an immature person to tolerate the work of mourning. It is her opinion that children and adolescents are mentally unready for the work of mourning. She has said[20] that after a parent's death there is an inhibition of crying, which begins after a short time, and that sad feelings are suppressed. She believes that adolescents deny reality and avoid grieving because they fear the emergence of an unbearable panic state. She discovered that adolescents continue to have a more or less conscious expectation of the deceased parent's return. Adolescents' response to death is similar to pathological forms of mourning in adults.

Children think of death as abandonment or separation, and De Vaul et al.[5] described how death has been conceptualized as similar to sleeping or taking a trip. This concept implies that death is reversible. Children begin to understand the concept of death before they are ten, but do not believe in their own mortality. In children, grief may find expression through somatization, behavior disturbances and social problems.[5]

Parkes[8] has said that middle-aged widows under age 60 are predisposed to chronic grief. Inhibited grief is also seen in geriatric patients who show little affective disturbance following bereavement. Stern et al.[21] described grief in the elderly. There is an absence of grief, much somatic illness, and displaced hostility towards living people. These characteristics are associated with advancing age of the mourner, in response to the death of an older person. It is suggested that grief is channelled into somatic symptoms.

Psychological makeup

The psychological makeup of a person is another factor in the etiology of pathological grief. Well integrated personalities who have mutually satisfying relationships with others are better able to give up their love objects. People who have an ambivalent relationship, where feelings of hatred tend to overshadow feelings of love, are in a much more difficult position. Fenichel[22] said extreme ambivalence towards the lost love object leads to pathological grief. "The death of a person for whom one had previously wished death may be perceived as a fulfilment".[22] The death then creates guilt feelings and remorse.

People with strong dependency needs, who crave attention and emotional support, are more vulnerable than others. Fenichel[22] said these people are "love addicts", and have difficulty loving others. Their attachment to others is narcissistic; they exploit others, taking what they can get, and fail to give mature love. The death of a person to whom they are attached often precipitates a pathological grief reaction in dependent people. For example, a 44-year-old widow came under my care when she was admitted to hospital by her sister. The patient was dirty, emaciated, and was described as a heavy drinker. Her husband had died four months earlier and she began drinking heavily almost immediately, remained indoors, and avoided contact with her family. She described an idyllic relationship with her deceased husband, and idealized him. She was frightened, lacked confidence, and felt that she could not carry on without him.

Her three daughters had left home at an early age and had rejected their mother. One daughter described her mother as selfish, said both parents were alcoholics, and that the marital relationship involved constant bickering.

Treatment was directed towards withdrawal from alcohol and I enlisted the aid of our social service department to help the patient explore how she might undertake job retraining.

Forms of Pathological Grief

Pathological grief can take various forms, from variants of normal grieving to such reactions as hypomania, dissociative reactions, drug abuse, etc.

Chronic grief

With resolution of grief, the person should be able to look ahead with optimism, although it is not unusual for grief to recur for a short time at anniversaries or if there are strong reminders of the deceased. In chronic grief, the reaction is prolonged and the

person suffers intense sadness. Guilt and self blame seem to be frequent symptoms in these people.

Inhibited grief

Parkes[4] described this as a situation in which the total picture of grief is permanently absent and the patient shows little reaction to the death. This type of reaction is seen most commonly in children or in the elderly, but may occur in others. The inhibition of grief can be seen as a defense against a catastrophic reaction. The patient whose son committed suicide expressed a feeling of fragility and wanted to "keep on top of things". She was afraid of condolences from others because she feared being flooded with sadness.

Delayed grief

With this reaction, a period of delay is followed by a typical grief reaction. The period of numbness which is the first stage of grief may be extended or the numbness may be absent. Lehrman[11] said questioning may reveal that patients suffering grief over a recent loss are still grieving for someone who died many years ago. He gave the example of a 38-year-old woman who suffered a severe reaction over her mother's death, but was deeply engrossed in fantasies about her brother's death from cancer 20 years earlier.

Atypical grief

Patients can develop a hypomanic reaction. These individuals show elation, over-activity, and rapid thought processes and deny the significance of the loss. When they are unable to ward off sad thoughts about their loss, their elation may change to sadness, but this is often short-lived.

'Splitting'

In 'splitting', one part of the person is aware of the loss and another part functions as if the loss never occurred. Volkan[3] gave the following example. A 38-year-old housewife lost her daughter suddenly. The daughter was a student nurse who had lived in another town and used to come home on Fridays. Although her mother consciously knew her daughter was dead, she continued to act and feel as if her daughter was still alive, and regularly cleaned the daughter's room for her weekly visit. In this way, people may fool themselves, believing that the loved object is gone, but behave as if this is not the case. Underlying this process is hope and an attempt to regain the lost love object.

When such a dissociative reaction occurs as part of a pathological grief reaction, the expected emotions of grief are separated from the situation of death. A selective amnesia may occur whereby unconsciously the person attempts to avoid the emotional impact of the loss.

For instance, a 34-year-old woman was admitted to hospital suffering from concussion and other injuries after a car and train accident. When I saw this patient nine days later, she had amnesia for the accident as well as for the subsequent days. Her husband and daughter had been killed and she had been unable to attend the funeral. Although her mother-in-law from England had come to attend the funeral and was grieving and the patient had been told about the deaths, she continued to express surprise that her husband failed to visit. Her unconscious acceptance of the death was signified by extreme concern about her other daughter who had also been in the accident. This patient gradually showed increasing awareness of her loss and left hospital prematurely to return to England with her mother-in-law to "have a holiday to recover".

Treating Grief Reactions

Mourners should be encouraged to participate in funeral rites and to allow themselves to experience the full impact of loss. Wishing to avoid the pain of grieving, certain family members may take on the task of making funeral arrangements. Volkan[3] described how often the only male or eldest male child in the family takes this role. As a result, the grief of these men may be delayed or inhibited. Parkes[8] described the person who makes the arrangements as "setting an example to the rest of the family" and acting as a "tower of strength".

The degree to which unresolved grief exists can be detected by questioning. DeVaul et al.[5] listed basic questions that might be asked to determine this. When one has elicited that there has been a death of a family member or a friend, one can ask the patient: "Did you attend the funeral?", "How did you feel about this person's death?", "Were you able to cry for this person?", "Do you still feel a need to cry for him (or her)?", or "Do you think that you have accepted the death?" In cases of unresolved grief such questions might cause the patient to cry and recognize that he still pines for the deceased.

Parkes[23] outlined certain principles for the management of unresolved grief. The helper must encourage the bereaved to express all feelings of sadness, anger, and guilt about the bereavement. The bereaved person should also be helped to "review the relationship with the dead person" in order to understand the "nature of their emotional reactions". Part of grieving involves forming an acceptable relationship with the deceased in one's mind, and gradually feeling free to move towards relationships with others.

The family physician or helper can reassure the mourner in various ways. Many bereaved people are surprised and frightened by the intensity of their emotions and need reassurance that they are not going mad.[24] The bereaved person can be reassured that feelings of anger and guilt are a normal reaction to loss. If the bereaved person has fleeting hallucinations of the deceased or has tended to misidentify people as the deceased, he can again be reassured that this is a normal reaction. In cases where the bereaved person has identified to such a degree with the deceased that he has developed similar symptoms of the illness suffered by the deceased, he can be reassured that he does not suffer from this disease. If the bereaved person is a mother, she can be reassured that she is not bad if she finds it difficult to cope with her children's demands, and told that her children might express negative feelings towards her while they idealize their father.

The helper can encourage the bereaved to call upon the support of others. Visits and expressions of concern are appreciated by the bereaved as they are seen as a tribute to the dead and help to confirm for the mourner that the dead person is worth all the pain.[24]

Parkes[23] wrote of the need for the helper to give permission to the bereaved to stop grieving. People with

a strong sense of loyalty may need indication after months of grieving that it is acceptable for them to reorient their lives in new directions.

Anything that tends to inhibit the grieving process—including the use of medication—should be avoided. However, when insomnia lasts for several weeks, it is advisable to give sedation at bedtime and tranquillizing medication for daytime anxiety.

The bereaved may also need help with legal, financial and household problems.

The treatment of pathological grief follows the same principles as those for the treatment of grief. The bereaved person must be helped to overcome the blocks that have interfered with the grieving process.

There are certain situations of grieving which require extra concern and tact. Families that have experienced a suicide seem to be very vulnerable and manifest guilt, hostility and extreme sensitivity. Herzog and Reznick[14] said that the fathers in their study needed much help in dealing with a child's suicide. They discovered that the parents wished a professionally trained person could have talked with them immediately after the suicide, and that the parents who refused an interview were probably the parents who needed help most.

Conclusion

Individuals suffering grief can be expected to visit their family physician much more frequently during the first year of bereavement.[1] Obscure complaints may disguise grief, which the bereaved fails to express. Awareness of factors leading to pathological grief can help the family physician to more effectively diagnose and treat this condition. Individuals suffering pathological grief have a high morbidity rate and increased rates of physical disease and death. The family physician can be very helpful to bereaved patients if he develops a technique for counselling them. ◉

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