

# Follow-up of patients who seek treatment for grief

M. Gamó Medina, C. del Álamo Jiménez, L. Hernangómez Criado and A. García Laborda

*Mental Health Care Service. Parla (Madrid). Spain*

## Seguimiento de pacientes que consultan por duelo

### Summary

**Introduction.** *Based on several contributions and studies on evolutive aspects of grief, this study aims to focus on the two-year follow-up of patients from the Community Mental Health Service of Parla who came to the clinic in relationship with grief.*

**Methods.** *Based upon a previous research, the authors have performed a follow-up study at two years in a sample of 51 patients, carried out by a telephone interview that examined subjective improvement, coping strategies and grieving process, biographical continuity and later life events.*

**Results.** *Two years after the first visit, most of the patients considered that they had coped well with the loss and were able to resume their normal activities. They ranked their clinical situation as «much better». One out of every four reported a partial or marked detention in their biographical course.*

**Conclusions.** *In the long term evolution of a visit due to grief, a positive outcome might be expected in the most of the cases. Factors associated with a worst outcome are a problematic bond with the deceased, and the son/daughter loss. Positive outcome was associated with social support and psychotherapy.*

**Key words:** Grief. Follow-up. Biographic course. Risk factors.

### Resumen

**Introducción.** *Partiendo de diversas aportaciones y estudios sobre aspectos evolutivos del duelo, el presente trabajo se centra en el seguimiento a los 2 años de pacientes del Servicio de Salud Mental de Parla que consultaban en relación a un duelo.*

**Métodos.** *A partir de una investigación anterior se realizó un estudio de seguimiento a los 2 años a una muestra de 51 personas mediante una encuesta de aplicación telefónica que exploraba mejoría subjetiva, afrontamiento de la pérdida, continuidad del curso biográfico y circunstancias posteriores.*

**Resultados.** *A los 2 años de la primera consulta la mayoría de los pacientes afirmaban una mejoría clínica, así como haber podido afrontar total o parcialmente la pérdida y continuar sus actividades con normalidad, si bien una cuarta parte refería una parcial o marcada detención del curso biográfico.*

**Conclusiones.** *En la evolución a largo plazo de una consulta por duelo es mayoritaria la remisión de sintomatología asociada. Asimismo influyen negativamente en este proceso variables como la calidad del vínculo con el fallecido y el hecho de que el fallecido sea un hijo, y positivamente factores como el apoyo social y la psicoterapia.*

**Palabras clave:** Duelo. Seguimiento. Curso biográfico. Factores de riesgo.

## INTRODUCTION

Grief as an emotional reactions to the loss of a loved one is one of the most universal phenomena seen in the psychiatric activities. Its elaboration is influenced by the most diverse intrapsychic and environment conditionings and gives rise to multiple effects and consequences for mental health. It always involves a development, a non-established series of stages, that do not have the same duration in each individual or cultural setting. Freud<sup>1</sup> spoke about the grief work involved in accepting the reality of the loss and of releasing the libido

from the lost object. The successive grief processes relocate the subject in relationship with the order of the generations<sup>2</sup>. Neimeyer, Keese and Fortner<sup>3</sup>, from a constructivist view, approach grief as the reconstruction of meaning after a loss that means fragmentation and disorganization. Rood<sup>4</sup> emphasizes the temporal discontinuity produced in the personal identity.

Worden<sup>5</sup> summarizes the order of the grief tasks: accept the reality of the loss, work with the emotions and consequent pain, adapt to the environment in absence of the deceased one, relocating this emotionally and continuing on with life. The factorial analysis of the TRIG inventory<sup>6</sup> to measure grief, made by Paulhan and Burgeois<sup>7</sup>, make it possible to establish two factors with a time order in relationship with the grief: immediate reaction and present feelings, and a third factor that includes characteristics associated to the attitude of confrontation. Among their results, the importance of the death circumstances, the traumatizing effort of deaths

### Correspondence:

Emilio Gamó Medina  
Servicio de Salud Mental de Parla  
Pablo Sorozábal, 4  
28980 Parla (Madrid) (Spain)  
E-mail: PILARITA.G@terra.es

by suicide, age of the deceased in inverse correlation with the age of the person suffering the loss, depressiveness factor, protective effect of a good social support and of a locus of internal control in regards to good confrontation stand out. The order of the evolution and meaning of the participating factors is very complex, although it has some regularities; it implies an unrepeatability combination of each subject so that any measurement of grief is very difficult.

Many investigations have studied the relationship between vulnerability or prognostic factors and the evolution of grief. Parkes<sup>8</sup>, in 1971, analyzed the factors of grief, regrouping them into three categories: *a)* biographic and personality elements, that condition tolerance to pain. Included among these are age, the young people being those who are less prepared to support death and bond with the deceased, so that the deeper the relationship, the more intense the feeling of loss; ambivalent and dependent bonds are problematic; *b)* circumstances that surround the death, such as the fact that it is sudden or unexpected, which leads to intense reactions of greater seriousness more frequently<sup>9</sup>, and *c)* subsequent events. The stress called secondary by Parkes groups social factors such as poverty, disease or adverse events and overadded losses. Another aspect within this third factor that stands out is the existence of social support or isolation; elderly persons who are less interested in social life, work or who are not in charge of any children suffer more. Horowitz<sup>10</sup> stresses how the incapacity to reestablish new and close relationships conditions the prolongation of the bereavement.

The weight of certain circumstances such as unexpected death, living with the deceased, previous accumulated losses, problematic bond with the deceased (ambivalence, hate, symbiotic-dependent, etc.) and the relationship (with a greater detention of the biographic course in the grief for children) was observed in the first part of this paper<sup>11</sup>. The predominating symptoms were depressive, followed by anxious symptoms, and in a lower proportion of cases, somatizations, substance abuse and suicide attempt.

This present study aimed to study the follow-up and evolution of the patients who visit the doctor in relationship with a grief in a mental health care service. Subjective improvement, confrontation with the loss and capacity of reestablishing the biographic continuity as well as the later life changes in relationship with socio-demographic, clinical, grief and treatment variables were assessed.

## METHODS

The baseline sample was made up of persons over 18 years who visited the Mental Health Care Service of the Parla district (Madrid) for the first time during 1999 ( $n = 972$ ). Those in whom grief was the object of the visit, precipitating symptoms or relevant intervening factors in the psychopathology (N072), were selected.

This accounted for 8% of the first visits of the year in question. These persons were assessed by data extraction from the clinical history in the first study phase<sup>11</sup>. These data referred to the sociodemographic (age, gender, civil status, type of cohabitation, work situation), clinical (reason for visit, symptoms, previous psychiatric background), grief (time since the death, relationship with the deceased, predictability of the death, cohabitation, accumulated losses, bond with the deceased, detention of the biographic course) variables and to the treatment followed in Mental Health. Assessment of the follow-up, whose results are shown in this paper, was performed two years after these first visits using the survey methodology. Data was obtained from a total of 51 participants (experimental mortality of 28 subjects by death, change of address or impossibility of contact).

The follow-up procedure consisted in an interview performed telephonically. Multiple choice answers were used to examine the aspects of: *a)* subjective improvement; *b)* confrontation of the loss; *c)* continuity of the biographic course and daily life activities, and *d)* added circumstances in the evolution of the grief in the economic, family, health and other spheres. In addition, together with this, data was recorded in regards to the treatment during the year following the first visit. The surveys were performed by investigators who, in turn, were therapists of the Mental Health Service.

The investigation design, therefore, corresponds to a panel survey methodology with descriptive and analytic objectives, so that a descriptive and inferential statistical analysis was performed with the SPSS version 9.0 statistical program.

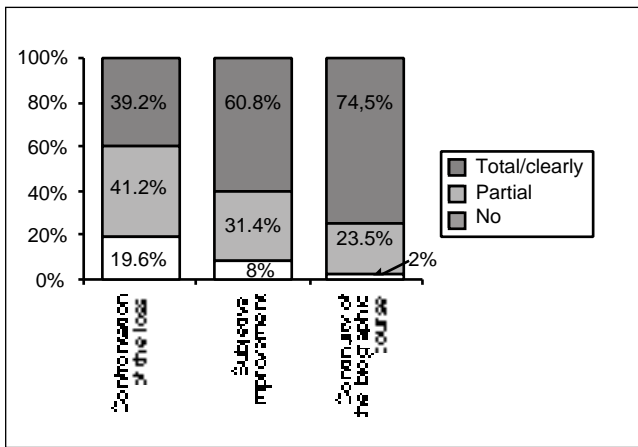
## RESULTS

Age range goes from 19 to 83 years, with a mean (and median) of 45 years (standard deviation = 16). A total of 78.5% of the sample were women, which significantly exceeds the global proportion of women who visited this service in 1999 ( $p = 0.001$ ). In regards to civil status, 18% of the patients were single, 57% were married or living with a partner, 1.3% separated and 24% were widow(ers). At the time of the visit, 56% lived with their partner, 14% lived alone, another 14% with their children and 13% with their parents.

The time that passed from the loss and the moment of the visit in mental health was, as a general tendency, one year in most of the patients (61%); only 14% came for a visit after more than six years. Death of the parents was that which affected the patient in most of the cases (38%), followed by the death of the partner (24%). A total of 10% came due to the death of a child.

Figure 1 shows the descriptive results in the variables of subjective improvement, confrontation of the loss and continuity of the biographic course.

The significant interactions found in the variables registered in the follow-up were:



**Figure 1.** Distribution of the proportions in confrontation of the loss, subjective improvement and continuity of biographic course.

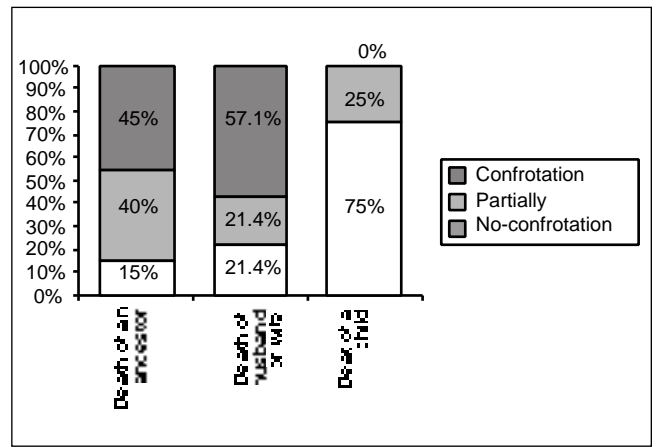
- *Subjective improvement.* A significant relationship ( $p=0.046$ ) was manifested with posterior familial circumstances modulated by the type of relationship with the deceased, so that the correlation was only significant in those who had lost a child: only those who were clearly improved did not report unfavorable changes in their families.
- *Confrontation with the loss.* This variable significantly correlated with the type of cohabitation ( $p=0.014$ ), so that those who lived with children manifested that they had totally confronted the loss in a proportion greater than the other types of cohabitation. In addition, the relationship was mediated by whether the person had lived with the deceased at the time of the loss, it being clearer in the cases in which the sufferer had lived with the deceased at the time of death.

Furthermore, the type of relationship with the deceased was significant in the relationship with confrontation of the loss ( $p=0.026$ ), so that when the deceased was a child, the confrontation difficulty was much greater (fig. 2).

Another factor that showed a significant relationship with the confrontation of loss capacity was the quality of the bond with the deceased ( $p=0.02$ ), so that 60% of the persons who stated they had an ambivalent bond with the deceased considered that they had not been able to confront it at two years of the follow-up compared to 80.8% of those who reported a good bond who believed they could totally or partially confront it.

Finally, the type of symptoms also significantly correlated with the capacity of confronting the loss ( $p=0.034$ ), so that 77.8% of the patients who considered that they could not confront the grief presented depressive symptoms.

- *Continuity of the biographic course.* The symptoms manifested by the patient had a significant relation-



**Figure 2.** Distribution of proportions in confrontation of the loss based on the family relationship with the deceased.

ship with the continuity of the biographic course at two years of the first visit ( $p=0.004$ ), the depressive symptoms also standing out in this interaction, since 44.4% of the persons with depressive symptoms considered that they had remade their life only partially compared to 95.8% of the rest of the diseases who considered they had completely remade it.

- *Posterior circumstances.* Most of the patients manifested that they had not undergone significant changes in their lives, although 29.5% declared they had lived unfavorable family events (factors related significantly with the subjective improvement in those who lost a child, as has already been mentioned.)
- *Continuity of the treatment.* Of the visits related with grief in the first phase of the study, 19% ( $n=15$ ) continued under treatment at one year. No sociodemographic, grief or clinical variable that seemed to influence this fact was observed.

In relationship with the rest of the follow-up variables, having maintained treatment for one year had a significant relationship with a better confrontation ( $p=0.044$ ) only in those in whom the treatment had consisted in psychotherapy and had not been limited to follow-up interviews.

Finally, the absence of a significant relationship between the follow-up variables and other variables considered to be relevant in the first study phase (predictability of death, accumulated losses) should be observed.

## CONCLUSIONS

Based on this study, we can conclude that remission of associated symptoms is predominant in long term (2 year) evolution of a visit for grief<sup>12-13</sup>. Furthermore, variables such as quality of bond with the deceased and the fact that the deceased was a child influence negatively in this process and factors such as social support and psychotherapy have a positive influence.

The importance of the previous bond with the deceased was already emphasized by previous investigators<sup>14,16</sup>, endorsing the concept of grief as a continuous process of relationship with the deceased that lasts all the life of the sufferer and that is supported by the relationship that existed before the death. This concept of grief as a continuous process also justifies the differentiation between confrontation, symptom improvement and psychosocial functioning. In the follow-up studies carried out by Tomita et al.<sup>17</sup> and Ott and Lueger<sup>18</sup>, it has been observed that there is improvement in symptoms and psychosocial well being, but not in the nostalgia for the deceased, which would coincide with present perspectives that consider the elaboration of grief as a never ending task<sup>19</sup> and with the observation of our study of some lower indices of confrontation of the loss compared to high scores of continuity of the biographic course and subjective improvement.

Another aspect that is confirmed in the present investigation is that the problems of confrontation are more obvious in those who have lost a child<sup>20</sup>. In these cases of paternal grief, the special difficulty to share the experience of the loss, that leads to instability of the marital relationship, has also been described<sup>21,22</sup>. Ochoa de Alda<sup>23</sup> attributes this difficulty to the different rules used by men and women to express and confront their emotions. In any event, Murphy<sup>24</sup> points out the enormous variability that can be manifested in samples of parents in grief, which indicates the need for posterior investigations to go more deeply into other variables such as the meaning that the sufferer attributes to the death. Investigation on the paternal grief indicates that the search for meaning is a fundamental process for adaptation after the death of a child, so that parents who are capable of giving a meaning to the death, finding an important existential benefit or a lesson in life on the loss are those who face it the best<sup>25,28</sup>.

On the other hand, cohabitation with children and psychotherapeutic treatment stand out as protection factors in the evolution of the patients. Importance of social support has been emphasized in many investigations for decades<sup>8</sup>. Investigation on psychotherapy is presently oriented to the knowledge of the specific variables that optimize its utility for persons with bereavement, such as a positive therapeutic relationship<sup>29</sup>, opening, differentiation and symbolization of painful feelings<sup>30,31</sup>, support for the reorganization of the family system<sup>23</sup> and giving a meaning to the death<sup>32,33</sup>, especially positive meanings, such as the appreciation of life and the human relationships and one's own personal growth<sup>34,35</sup>.

At present, some other variables that traditionally have been considered as predisposing or even determinants for a complicated grief are being re-analyzed in light of the empiric studies, and emphasis is beginning to be placed on the importance of idiosyncratic, intrapsychic and interpersonal processes, and not so much on general static characteristics. Thus, from longitudinal studies such as the present paper, the concept that grief is more serious if the death is sudden is controverted, since this relationship is not verified when follow-ups are performed at 6, 18 or even 48 months<sup>36</sup>.

On the other hand, in recent years, the investigation has focused on variables such as attachment style<sup>37</sup>, already treated by Bowlby<sup>38</sup>, defensive style<sup>39</sup>, and confrontation strategies<sup>17</sup>.

Other aspects that need to be gone into more deeply and that have not been treated in this study due to the sample characteristics (new cases in the Mental Health Service) are the differential aspects of grief in psychiatric patients under previous or chronic treatment<sup>40</sup>.

Finally, it is interesting to mention that the symptoms are not related with subjective improvement, but are related with the other follow-up variables measured. This seems to indicate that the confrontation difficulties and detention of the biographic course do not respond so much to the seriousness of the symptoms but rather to the meaning that the loss has within the psychological and social functioning in the successive stages of the bereavement and in the process of development of the personal identity.

## REFERENCES

1. Freud S. Duelo y melancolia. Obras completas. Vol XIV. Madrid: Biblioteca Nueva, 1981; p. 235-55.
2. Lemoine P, Lemoine G. El afecto y el duelo. En: Jugar, gozar. Barcelona: Gedisa, 1980.
3. Neimeyer RA, Keesee NJ, Fortner BV. Loss and meaning reconstruction: propositions and procedures. En: Rubin S, Malkinson R, Witztum E, editores. Traumatic and non-traumatic loss and bereavement: clinical theory and practice. Madison: Psychosocial Press, 1997
4. Rood L. Identity dissonance in trauma and loss. Paper presented at the XII International Congress on Personal Construct Psychology. Seattle, Washington, 1997.
5. Worden J.W. Las cuatro tareas del duelo. El tratamiento del duelo, asesoramiento psicológico y terapia. Barcelona: Paidós, 1997.
6. Faschingbauer TR, de Vul RA, S Zisook. Tescusc revised inventory of Grief Manuel. Houston: Honeycomb Publishing, 1981.
7. Paulham I, Bovegeois M. Le questionnaire de duil trig. Traduction francaise et validacion. L'Encéphale XXI, 1995; p. 257-62.
8. Parkes CM. Bereavement: studies of grief in adult life. New York: International Univ Press, 1972.
9. Weisman AD. Coping with untimely death. En: Moos RH, editor. Human adaptation: coping with life crises. Levington Mass: Heath & Co, 1976.
10. Horowitz M, Siergel B, Holen A. Diagnostic criteria for complicated grief disorder. Am J Psychiatr 1997;154:904-10.
11. Gamo E, del Álamo C, Hernangomez L, García Laborda, A. Problemática del duelo en la asistencia en salud mental. Psiquiatría Pública 2000;12(3):209-18.
12. Melges FT, de Maso DR. Grief-resolution therapy: reliving, revising and revisiting. Am J Psychoterapy, 1980;34:51-61.
13. Valdes M, Blanco A. Reacciones de la familia después de la muerte de un ser querido: duelo, aflicción, luto. Acta-Luso-Española Neurol Psychiatr 2001;27:101-7.
14. Levy SV. Tidal waves of grief: an experiential study of the grieving process. Diss Abs Intern Sec B Sci and Eng 2000; 61(1-B):538.
15. Field NP, Sturgeon SE, Puryear R, Hibbard S, Horowitz MP. Object relations as predictor of adjustment in conjugal

- bereavement. *Development-and-Psychopathology* 2001; 13(2):399-412.
16. Carr D, House JS, Kessler RC, Neese R, Sonnega J, Wortman C. Marital quality and psychological adjustment to widowhood among older adults: a longitudinal analysis. *J Geront Series B. Psych Sci Soc Sci* 2000;55B(6):S374.
  17. Tomita T, Seto M, Kagami N, Agari I. Grief and coping with the death of a loved-one: an exploratory analysis. *Jap J Couns Sci* 2000;33(1):48-56.
  18. Ott CH, Lueger RJ. Patterns of change in mental health status during the first two years of spousal bereavement. *Death-Studies* 2002;26(5):387-411.
  19. Neimeyer RA. *Meaning reconstruction and the experience of loss*. Washington: American Psychological Association, 2001.
  20. Neimeyer RA, Prigerson HG, Davies B. Duelo y significado. *Rev Psicoterapia* 2002;13(49):5-24.
  21. Hare-Musin R. Family therapy following the death of a child. *J Marital Fam Therapy* 1979;5:51-60.
  22. Schwab R. Effects of a child's death on the marital relationship. *Death Studies* 1992;16:141-54.
  23. Ochoa de Alda, I. La experiencia transformadora de la terapia narrativa de duelo. *Rev Psicoterapia* 2002;13(49):77-94.
  24. Murphy SA. The use of research findings in bereavement programs: a case study. *Death Studies* 2000;24(7):585-602.
  25. Braun ML, Berg DH. Meaning reconstruction in the experience of bereavement. *Death Studies* 1994;18:105-29.
  26. Davis CG, Nolen-Hoeksema S, Larson J. Making sense of loss and benefiting from the experience: two construals of meaning. *Jn Pers And Soc Psych* 1998;75:561-74.
  27. Kalischuk RG, Davies B. A theory of healing in the aftermath of youth suicide. *Jn Of Holistic Nurs Pract* 2001;19: 163-86.
  28. Wheeler I. Parental bereavement. The crisis of meaning. *Death Studies* 2001;25:51-66.
  29. Sewell KW. Psicoterapia con clientes traumatizados y en duelo: un marco constructivista para el amor y la curación. *Rev Psicoterapia* 2002;13(49):123-32.
  30. Segal DL, Chatman C, Boggards JA, Becker LA. One-year follow-up of an emotional expression intervention for bereaved older adults. *Jn of Mental Health Aging* 2001;7(4): 465-72.
  31. Angus L, Bouffard B. «No lo entiendo». La búsqueda de sentido emocional y coherencia personal ante una pérdida traumática durante la infancia. *Rev Psicoterapia* 2002; 13(49):25-46.
  32. Bauer JJ, Bonanno GA. I can, I do, I am. The narrative differentiation of self-efficacy and other self-evaluations while adapting to bereavement. *J Res Personality* 2001; 35(4):424-48.
  33. Sakaguchi Y. The role of meaning in the psychological process of bereavement: an examination of benefit finding effect. *Jap J Psychology* 2002;73(3):275-80.
  34. Nolen-Hoeksema S, Davis CG. Positive responses to loss. Perceiving benefits and growth. En: Snyder CR, Lopez SJ, editores. *Handbook of positive psychology*. London: Oxford University Press, 2002; p. 598-606.
  35. Pérez-Sales P, Hernangómez L, Santiago C. Terapia de grupo en duelo complicado: un enfoque desde los factores de cambio positivo. *Psiquiatría Pública* 2000;12(3):273-84.
  36. Carr D, House JS, Wortman C, Neese R, Kessler RC. Psychological adjustment to sudden and anticipated spousal loss among older widowed persons. *J Geront Series B. Psych Sci and Soc Sci* 2001;56B(4):S237-S48.
  37. Stroebe MS. Paving the way: from early attachment theory to contemporary bereavement research. *Mortality* 2002; 7(2):127-38.
  38. Bowlby J, Lyons I. Bereavement and unresolved grief in psychiatric outpatients. *Omega* 1990;20:307-22.
  39. Ashe KS. Defensive style and adjustment to conjugal bereavement. *Diss Abs Intern Sec B. Sci Eng* 2000;60(10-B): 5218.
  40. Gamo E, García A, Martínez MA, Sanz LJ, Valverde M. El impacto del duelo en pacientes psicóticos. *Rev Asoc Esp Neuropsiq* (aceptado para su publicación).