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The medicalised context of bereavement

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Head of Intellectual Property, The Open University
Designed and edited by The Open University

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Introduction

This course asks the reader to consider the experience of grief and bereavement and in particular the extent to which grieving people need professional help. The course considers the evidence for the effects of grief and the extent to which current ways of responding are helpful.

This OpenLearn course provides a sample of level 2 study in Health & Social Care

Learning Outcomes

After completing this course, you should be able to:

- demonstrate sound knowledge and critical understanding of multifaceted and diverse approaches to death, dying and bereavement
- explore multiple contexts of bereavement
- integrate different experiences of death, dying and bereavement with theoretical knowledge
- critically reflect on policy and practice in order to promote the interests of dying and bereaved people.

1 Is grief a medical problem?

Grief is a fertile area for debate and controversy within health care professions, and its significance as something in need of medical attention has been debated by both health analysts and social commentators alike. Is it a ‘natural’ phenomenon that should be respected and acknowledged, but one that requires that the bereaved individual is left alone to experience it in their own way? Or should the bereaved person be assisted with intervention which relies on the presumption that grief can be detected, quantified and treated?

Activity 1: A medical problem?

0 hour(s) 30 minutes(s)

Read the following case study and then make notes in response to the questions.

Bernadette

Bernadette's husband, Fred, died in hospital at the age of 70. He had suffered from motor neurone disease for several years before his death, and she had been his primary carer. They lived in a large house, and their only child, Paul, lived with his partner about 50 miles away. Paul did not get on very well with Fred, although towards the end of Fred's life they spent quite a lot of time together.

Bernadette was 64 when Fred died. She tried to develop new interests, getting involved in her local bridge club and meeting a few people who became friends. She struck up a particularly close friendship with a widower, Jeff, but after a couple of years she decided that she was still committed to Fred and did not want to get more involved with Jeff, so cooled their relationship.

Ten years after Fred's death, Bernadette still lives in the same house and keeps his ashes next to her bed. She has mobility issues and is increasingly confined to the ground floor of her house. She no longer attends the bridge club. Paul is concerned about his mother's mental health. One part of this, he believes, is his mother's inability to detach herself from Fred's ashes. He wants her to do something with the ashes, saying he does not think it is ‘healthy’ to have his father's ashes so close to her bed.

- Do you think that Bernadette needs medical help?
- What resources might be available to help her?
- What resources might have been available if a similar situation had developed 100 years ago?

In contemporary times the bereaved person and their family may well turn first to their local GP or primary care services. A century ago this option was not available to the vast majority of people (apart from the nobility and gentry who could afford to pay for help), and other forms of social support, such as the church, may have been the first port of call.

Paul may well, therefore, think of approaching the local GP for help. As well as the primary care team, there may be local bereavement support groups in the area where Bernadette lives. Bernadette may find it beneficial to get involved in all sorts of other

'normal' activities not directly associated with grief or having an explicitly helping or caring role.

Focusing on normal interests and activities may be more beneficial than specific bereavement-related groups or services.

However, many commentators and people in the caring professions consider that both grief and depression have become over-medicalised and over-diagnosed (Illich, 1976; Moynihan and Smith, 2002; Parker, 2007). Too much emphasis, they argue, has been put on 'treating' grief. Their argument suggests that grief should be placed alongside many other 'new' conditions that they claim have been artificially created in order to expand the reach of the medical profession and increase the market share of drug companies.

In contrast, other medical commentators, particularly American psychiatrists such as Selby Jacobs and Lorna Douglas (2004), and British psychiatrists such as Keith Hawton (2007), argue that grief, especially following a sudden death can be a serious clinical issue that should be recognised swiftly and treated intensively.

In attempts to answer this conundrum, at the time of writing (2008) there appears to be a growing consensus in the medical profession and among psychiatry researchers, such as BaoHui Zhang and colleagues in the USA, that there is a difference between *normal* forms of grief reaction that can be expected following a sad event, and *complicated* grief that may be associated with serious health outcomes (Jacobs and Douglas, 2004; Zhang et al., 2006).

Certainly, there have been efforts to test and measure the relationship between grief and health. It has been argued by Margaret Stroebe and colleagues (2007) that one of the best ways to do this involves longitudinal investigations. (A longitudinal study is one that follows a person or group over a period of time.) In such studies, some researchers will be looking for statistical differences that may be apparent between the two groups (quantitative data), while other investigators may want subjective responses from the two groups (qualitative data). There is a general consensus that research that includes both quantitative as well as qualitative data ('multi-method') will provide the most robust evidence. (Such research is sometimes referred to as 'triangulation', where several different methods are used to explore and examine social phenomena.)

Consequently, Stroebe et al. (2007) considered that 16 longitudinal studies were of sufficient quality to be included in their review of the health outcomes of bereavement, and concluded that:

> Bereavement is associated with an increased risk of mortality from many causes, including suicide … the mortality of bereavement is attributable in large part to a so-called broken heart (i.e. psychological distress due to the loss, such as loneliness (Stroebe et al., 2005) and secondary consequences of the loss, such as changes in social ties, living arrangements, eating habits and economic support (Parkes, 1996)). For widowers, the increased risk will probably be associated with alcohol consumption and the loss of their sole confidante, who would have overseen her husband's health status.
>
> (*p. 1962*)

It is important to note that there are considerable difficulties in conducting longitudinal research, however, and many problems can arise before 'real' differences in the health status of the two groups can be confirmed. For example, people going through an

upsetting event in their lives might not be willing (or able) to take part in the research, and therefore the most deeply affected people may be excluded from the study. Some people may remarry during the course of the investigation; how should they be treated for the purposes of the research? Furthermore, there may be factors that relate both to the death of the deceased person and to the health of the surviving bereaved person who is being studied. For example, they might have been injured in an accident that killed the deceased person.

What underpins all of these issues, however, is the assumption that grief can be 'measured' in some way. What do you think of this claim? How can grief be objectively measured? On what grounds? Some physiologists have suggested that they have the answer.

2 Efforts to measure the effects of grief

2.1 Introduction

A rapidly growing branch of medical science has begun to try to measure the physiological impact of grief. Incorporated into this study are the ways in which bodily functions change in response to emotional stimuli. This new area of scientific research has been called 'psychoneuroimmunology' and is the study of how different feelings and stresses lead to changes in hormone levels and other metabolic functions within the body. These can often be quantified through blood tests and other physiological measurements, an example of which has come from Dutch clinical psychologist Ellen Beem and colleagues (Beem et al., 1999), who attempted to catalogue measurable physiological changes when people were bereaved.

In another area of scientific study, an argument is growing that there is a complex interaction between the brain and the immune system in emotional states such as depression and grief. American psychoneuroimmunologists Michael Irwin and Andrew Miller (2007) have proposed a model to demonstrate the way in which immunological responses are brought about by the emotions associated with bereavement (or depression). In their model, not only do emotional responses have an impact on the immune system: immunological changes in themselves go on to affect the way the brain works and emotions are experienced. They argue that these adverse circular actions and re-actions cause potentially serious medical and psychological effects that may lead to an increased susceptibility to many short-term conditions, such as infections, and a wide range of longer-term health problems, such as arthritis, ischaemic heart disease and cancer.

The precise mechanisms through which these adverse health effects are brought about are still being determined, but it has been suggested that people experiencing grief have some of their immunological responses stimulated while other 'protective responses' seem to be suppressed. In lay terms, the protective responses that may be damaged or reduced when someone experiences grief include the way in which immune cells, such as T cells and lymphocytes, work to control infections in the body and possibly even ingest or 'mop up' early cancer cells. At the same time, other components of the immune response are activated, such as inflammatory enzymes. The release of these substances and their subsequent effects on other organs may have relevance for the development of ischaemic heart disease and auto-immune disorders. Irwin and Miller argue that some of these adverse physiological effects can be controlled and reversed by factors such as physical exercise and sleep.

2.2 Neuronal changes during grief

Recently medical researchers have been joined by neuroscientists determined to pin down precisely those parts of the brain that are activated by the experience of grief. Although this approach might be considered to be reductionist, it demonstrates the way in which some scientists are attempting to explain complex behaviour in neuroscientific terms.

Eight volunteers who had experienced the death of someone close in the previous year agreed to be studied as part of a research project conducted by American neuroanatomist Harald Gündel and colleagues (Gündel et al., 2003). As part of their study, functional magnetic resonance imaging (fMRI) scans were taken of their brains as they were shown photographs of the deceased person and given words associated with the person who had died. Their results suggested that it is possible to identify parts of the brain that are activated when a person is bereaved.

Reductionist, in this context, means that the body is reduced to its component parts, as if it were a machine.

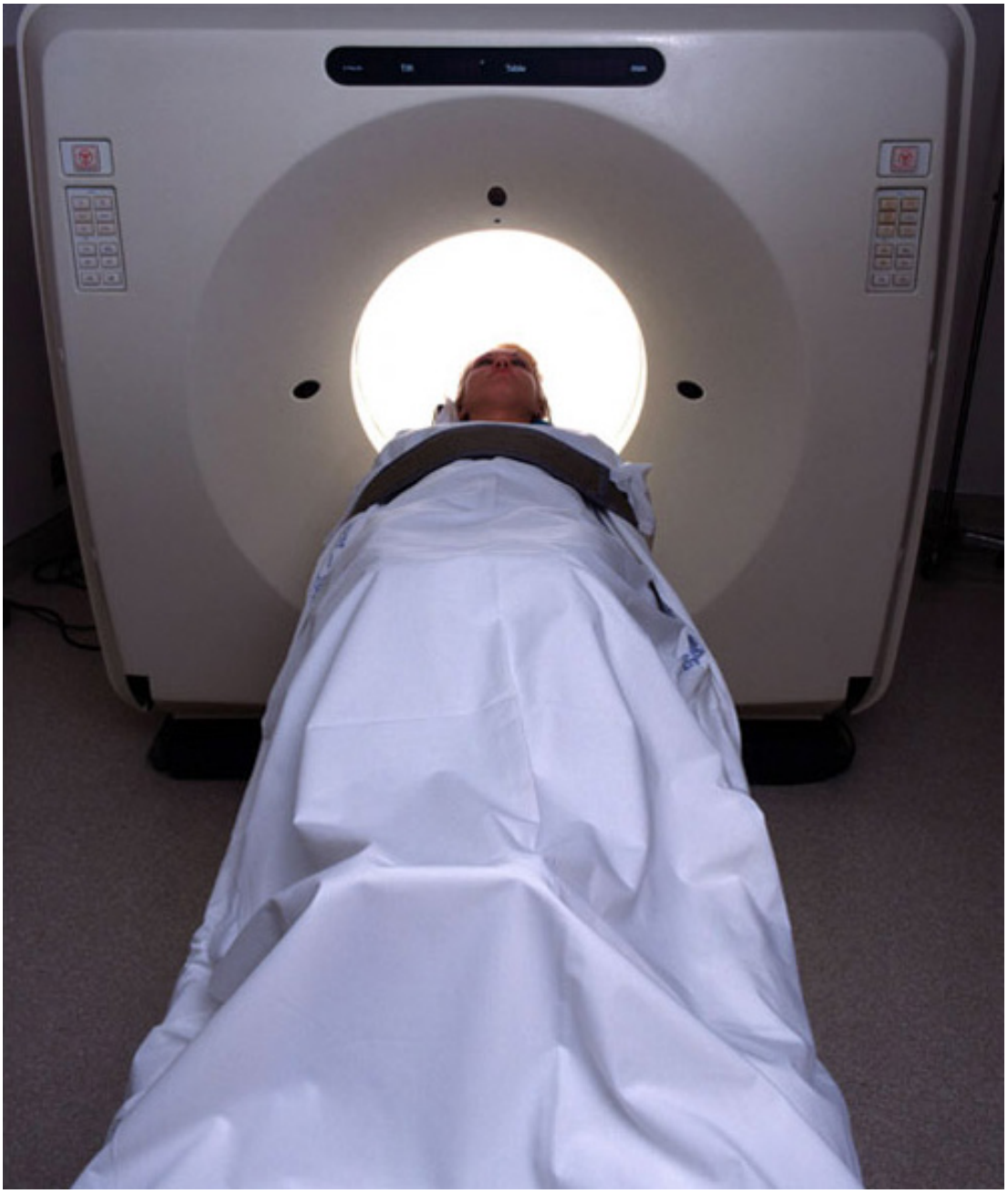

Figure 1 An MRI scanner

Although this particular study was of only eight people, it indicates the way in which new types of investigative science may be able to throw light on complex emotional problems.

This type of research is obviously of interest to drug companies and those who may want to prioritise and benefit from chemical solutions to emotional problems.

Activity 2: The benefits of scientific study?

0 hour(s) 15 minutes(s)

What benefits, if any, do you think can be derived from studying the physiological and neurological effects of bereavement?

You may have seen many benefits of testing for the physiological and neurological effects of bereavement, or you may have seen none. Certainly, some social scientists have been very critical of efforts to quantify and measure grief in such a way. However, in terms of medicalised support for bereaved people, studies such as these may derive great benefit for some. As you will see next, there is much debate on the medical handling of grief, yet if science and medicine can provide possible solutions that make life more tolerable for some bereaved people, then studies such as this may well be of great use. But a problem arises when studies such as these are accepted wholeheartedly as the 'factual truth'. 'Truths' about death, let alone grief, can be problematic, so assumptions about 'facts' within the discipline of physiology, and science more generally, need to be open to challenge.

This activity was not intended to make you feel that you have to 'take sides' in a pro-science versus anti-science debate. Indeed, there has been much criticism from both scientists and social scientists about the artificial disciplinary divisions that force people to choose to support one view over another. It is more productive, therefore, to consider how *both* scientific and non-scientific studies of grief can contribute to understandings of the experience of bereavement.

Indeed, this has been found elsewhere. American researcher Mary-Frances O'Connor (2005) brought together some of the information that is generated in neuroscience research, such as Gündel's imaging study, and matched it to the various ways in which bereavement and grief have been studied by social scientists and psychologists. In the end she was left with questions rather than answers, pondering 'What can bereavement teach us about the brain? And what can the brain tell us about bereavement?' (p. 905).

3 When grief goes wrong

Most people experiencing a grief reaction do not need specific professional help, although everyone could probably do with as much support as they can get from friends and family. Indeed, labelling someone as 'bereaved' and therefore by definition different, and possibly in need of some form of intervention, may in itself be harmful. But sometimes the usual sequence of events does not go to plan; people may develop an excessively severe or extremely long-term reaction to their bereavement. For those who support the continuing bonds thesis this may be a part of their ongoing relationship with the deceased person, but within orthodox medicine, very strong or overly long responses to bereavement are frequently referred to as 'complicated grief' (Hawton, 2007).

In attempting to categorise and 'pin down' complicated grief, psychiatrists and other professional grief specialists, for example a team of American psychiatrists headed by Mardi Horowitz (Horowitz et al., 1997), have developed criteria that spell out specific features of 'complicated grief' (CG) in order to distinguish it from other forms of depression or more usual forms of grief reaction. The features of complicated grief are listed in the box below.

Diagnostic criteria for complicated grief

Criterion A

The person has experienced the death of a significant other and their response involves three of the four following symptoms, experienced at least daily or to a marked degree:

1. intrusive thoughts about the deceased person
2. yearning for the deceased person
3. searching for the deceased person
4. excessive loneliness since the death.

Criterion B

In response to the death, four of the following eight symptoms are experienced at least daily or to a marked degree:

1. purposelessness or feelings of futility about the future
2. a subjective sense of numbness, detachment or absence of emotional responsiveness
3. difficulty in acknowledging the death (e.g. disbelief)
4. feeling that life is empty or meaningless
5. feeling that part of oneself has died
6. a shattered worldview (e.g. loss of sense of security, trust, control)
7. assuming symptoms or harmful behaviours of, or related to, the deceased person
8. excessive irritability, bitterness or anger related to the death.

Criterion C

Disturbance (symptoms listed) endures for at least six months.

Criterion D

The disturbance causes clinically significant impairment in social, occupational or other important areas of functioning.

(*Based on Latham and Prigerson, 2004, p. 351*)

From a medical perspective, people experiencing bereavement exhibit various features that might indicate that they are at particular 'risk' of developing a complicated grief reaction. It appears more common when the death is sudden, violent or unexpected. The death of children also appears to be a trigger and death by suicide often gives rise to complex feelings. In addition, the quality of the relationship between the deceased person and the bereaved survivor may affect the form that any grief reaction takes. But do these features mean that the grief experienced as a result is necessarily 'complicated'?

Activity 3: Complicated grief?

0 hour(s) 20 minutes(s)

Read the extract below describing the way in which Sylvia reacted to a string of bereavements, then write notes in answer to these questions:

- What features of Sylvia's story do you think made her vulnerable to complex feelings following the deaths she experienced?
- Do you think that Sylvia meets the criteria for CG (complicated grief) as set out in the box above?

Sylvia

Sylvia began to experience a string of bereavements. First, her father died after a long illness during which he had developed a debilitating lung disease and had increasing difficulty with breathing. Although Sylvia had never got on particularly well with her mother, Gloria, and their relationship was distant and strained, she brought her to live with her family. From Sylvia's point of view, Gloria remained miserable and self absorbed. Sylvia and her household became dominated by her mother's problems until she herself died of a chest infection about six months later.

While her mother's affairs were still being sorted out, Sylvia was called in an emergency to the local hospital. There she witnessed the death of her only child, Lucy, after a road accident.

Three years later, Sylvia was unable to comprehend that Lucy was dead. She was convinced that the hospital hadn't done enough to save her life and she wouldn't go anywhere near the crossing where the van driver had 'murdered' Lucy. She remembered each of Lucy's anniversaries and clutched her toys to her chest almost all the time. She refused to talk about the events that had happened to her and would often sit for whole days at a time in Lucy's room without heat or light. She began to eat only 'nursery food' and was often seen talking to herself. Through her frequent tears Sylvia would claim that she was waiting to die and that then at least she would be reunited with her daughter.

How can anyone ‘get over’ such a horrible sequence of events? Is Sylvia behaving just like anyone would react, or should her reaction be labelled as ‘complicated grief’? In some situations there might not be sufficient information to be certain that the diagnostic criteria for CG were met, but with Sylvia it seems, from a medical standpoint at least, that this is what was happening.

From this perspective, she was vulnerable to developing CG because of the multiple bereavements she suffered in short succession, and the sudden violent death of her child. Having a poor relationship with one of the deceased people, her mother, could also have been predicted to cause psychological problems in the future. Thus, although the case study does not go into sufficient details about Sylvia's feelings to tick off all the relevant symptoms, it must be almost certain that a psychiatrist would give Sylvia the label of ‘complicated grief’.

The question that arises, however, is where the boundaries of what is considered ‘complicated’ are drawn. Referring back to what you learned earlier in this course about measuring grief, is it possible to quantify people's feelings and behaviours in such an objective way? And who decides what the boundaries of CG are? You can see in this activity how there are issues of authority in who decides what complicated grief is: whoever identifies what is appropriate and acceptable grieving behaviour, and for how long it should continue after someone has died, is necessarily in a powerful position. An outcome of this is an expectation that those who decide what is ‘complicated grief’ (or even ‘grief’) are the experts about people's responses to bereavement overall. One result of this has been that medical opinion is often sought by bereaved people. Pressure on the medical profession to respond with medication to bereaved people who seek help has led to a steady increase in the prescribing of drugs, particularly antidepressants and tranquilisers. However, while these pressures exist, the effectiveness of these types of medication is currently difficult to demonstrate, and for the time being many doctors choose not to prescribe a drug treatment that they feel could end up interfering with the experience of grief.

4 To medicate or not to medicate?

4.1 Introduction

Although there has been a considerable reaction to the routine use of anti-anxiety medication for people presenting symptoms of complicated grief, the practice remains common in western societies. Joan Cook and her psychiatry colleagues (2007a, 2007b) interviewed doctors and older people in the USA to find out how people in both groups dealt with bereavement. She found that many of the doctors usually prescribed mood-altering drugs such as tranquilisers because of a compassionate sense of wanting to do something to help. On occasion, however, they also prescribed medication as a formulaic response for their own convenience:

> A benzodiazepine becomes a quick fix because you don't have time, this is what they want, they don't feel good, here it is. It numbs them up and you're not gonna get a phone call afterwards, you're not gonna get anything, you'll see them in a month, here's your renewal, see ya later.
>
> (*Cook, 2007b, p. 305*)

The following comment from Cook's research was quoted in the health pages of the *New York Times* website.

> People who call me up and say my son died, my husband died … I would give that [the anti-anxiety medication] to them in a flash. Fifteen pills, twenty pills, a month's worth, of course. If this isn't enough, you should make an appointment and come and see me. So they're wonderful drugs for that.
>
> (*Parker-Pope, 2007*)

The report of this research on the website sparked a lively web-based discussion in which people provided moving examples from their own experience of doctors who have used, and possibly misused, anti-anxiety medication for the treatment of grief reactions.

Figure 2 Are pills the answer?

Activity 4: Tranquilising grief

0 hour(s) 30 minutes(s)

Read the two excerpts below. They are taken from the above-mentioned web-based discussion.

After you have read the extracts, make some notes about your own feelings about the use of tranquilisers for grief. How would you like to be helped through a period of grief that you might experience in the future? Do these extracts relate in any way to your own experience?

> The only way to deal with grief is to deal with grief. Medication may ameliorate the symptoms without touching the underlying causes. People would wind up addicted and stuck in their grief. Those who grieve need to understand what they are dealing with and unfortunately there are no shortcuts.
>
> *Posted by Chaplain Barbara Sorin, 10 October 2007*

> When he passed away, I found myself in a situation that I was nearly friendless, except for Lilla, a wonderful friend of many years, with whom I could share my feelings. Lilla died in June. Another friend was murdered a week later. So, as a result of my husband's cancer, we saw our friends dwindle, and when he died, and Lilla died, I've been left without him, without my circle of friends for comfort and support, and very few people who want to sit with me while I go through all of the feelings, sadness and grief I feel. I try to stay even-minded, and if it weren't for Paxil [an antidepressant] and Xanax [a benzodiazepine tranquiliser], I don't know how I could function. I work full-time, and getting time off from work for therapy is impossible. So what are the grieving left with in the real world? If I felt every emotion I have, I wouldn't be able to function! Get real, get off of our backs, we feel like crap, we can't just 'get happy' or grieve according to your schedule. … Meds help, meds make it possible to function, and keep a cap on how much emotion is dealt with at a time. It might take longer to grieve, but the crippling feelings are kept at bay, and I can function, I can find joy in my grandchildren, and I can be strong enough to answer their questions about grandpa's death. Give people a break! No one solution will work for every person's situation.
>
> (*Online comments on Parker-Pope, 2007*)

The debate about the use or non-use of medication to help with grief raises a series of complex issues and, as demonstrated in the exchange above, can involve very raw emotions. For some people, grief is an ordinary part of the human condition, implying that it is something that people 'naturally' have to experience. However, people experiencing grief might find this a difficult, an impossible or even an unnecessary challenge. Why make things even more difficult if there are pills to ease the process?

Certainly, tranquilisers are very commonly used for a wide range of anxiety-related problems, including grief and other symptoms associated with bereavement. The most common type of tranquilisers are part of the pharmacological group known as benzodiazepines. You might be familiar with these from their popular, commercial names: Valium, Librium, Ativan, and so on, or know them by their pharmacological names: diazepam, chlordiazepoxide and lorazepam. They are used widely throughout the USA and Europe, where 2–3 per cent of the general population have been found to be taking this form of medication. This is despite the well-documented disadvantages of their long-term use (Voshaar et al., 2006), which include 'hangovers', memory impairment, emotional blunting, tolerance, dependence and an increased risk of falls and road traffic accidents (Chouinard, 2004).

So why do doctors prescribe benzodiazepines? A Belgian sociologist, Sibyl Anthierens, and colleagues (2007) asked 35 general practitioners in Belgium why they continued to prescribe benzodiazepine medication even though the adverse effects are so well known. The doctors seemed to be aware of the problems associated with the use of benzodiazepines but considered that prescribing the medication was the lesser of two evils. They also reported feeling overwhelmed by the psychosocial problems, such as grief, brought by the people who came to consult them, and they tried to demonstrate their empathy by writing out a prescription. Many of the doctors also felt that there were no practical alternative solutions available to them, or their patients, and that time constraints often led to them issuing prescriptions. Similarly, one of the American doctors responding to the *New York Times* article discussed above thought that pressure from people

experiencing emotional difficulty and their families was a significant factor when deciding whether to prescribe medication or not:

> As a physician, my dilemma is how to respond and help the patient (and bereaved family) asking, or even insisting on these medicines for the elderly after a significant loss. What response do we give without sounding cold hearted and accusatory – e.g. 'you see your mother might fall or get addicted… she cannot handle this medicine'. It is a tough line to walk. No doubt physicians operate from compassion but also are responding to specific requests from the bereaved and their loved ones in many instances.
>
> (*Online comment on Parker-Pope, 2007*)

4.2 Using antidepressants for grief

In addition to tranquilisers, antidepressant medication may be considered when a person approaches a doctor for help following bereavement. Prescribing doctors may feel under pressure to 'do something' to help the person who presents to them. Neither party may be aware of other options that may be effective in helping in these potentially difficult situations. Indeed, local support groups, psychotherapy, counselling and other possible alternatives may not be readily available.

Undoubtedly, there are pressures from some of the people, both bereaved and non-bereaved, who consult their doctors for the swift prescription of antidepressants. Mildred Reynolds, from the US organisation National Depressive and Manic-Depressive Association, relates her experience in getting effective medication for her problems:

> out of desperation I consulted a psychiatrist who had done research at the National Institute of Mental Health.
>
> At the first session, he told me that I had depression and that he thought medication would help. Furthermore, if the first one didn't work, there were others we could try. What a relief to hear that I was not just a 'weak person' as I feared, but that my problem was a medical illness, had a diagnosis, and could be treated. It gave me hope.
>
> (*Reynolds, 2002, p. 150*)

In the doctor's mind there may be other pressures to prescribe antidepressants. Certainly, the general consensus is that many doctors quite frequently miss the signs and symptoms of treatable depression, especially in older people who present to them (Iliffe, 2005), and can sometimes overcompensate by prescribing medication to others, including bereaved people. Furthermore, many doctors are taught to treat the people who come to them for help by using guidelines that are based on apparently reductionist models of the human condition. The typical chain of events is: a person presents with certain symptoms; the symptoms are matched against formal diagnostic criteria; a 'rational' and unquestioning drug-based treatment regime is prescribed as the logical outcome. A typical example from a medical text states:

> Management of late-life depression involves similar approaches to younger adults, although older people may take longer to respond. SSRIs [a common type of antidepressant medication] should be used as first-line treatment and

> lithium augmentation and electroconvulsive therapy are efficacious in those who do not respond after switching to an alternative antidepressant.
>
> (*Thomas and O'Brien, 2006, p. 127*)

Activity 5: Are antidepressants helpful for grief?

0 hour(s) 20 minutes(s)

Read the following case study and make notes in answer to the questions below it.

Indrajit and Heera

Indrajit's wife, Heera, died suddenly after a long-term chronic degenerative illness. They had married more than 25 years previously when Indrajit was 21. He was extremely shy and had depended on Heera's outgoing nature. They had two grown-up children who lived away from home.

After Heera's death, Indrajit was left alone for the first time in his life and found it extremely difficult to cope, despite the support from his and Heera's families. After five months he was still inconsolable. He was unable to work, could not sleep and spent most of the day just sitting in his kitchen, often in tears. His family thought that he needed help and persuaded him to see his GP, who prescribed an antidepressant, paroxetine.

- Why do you think that Indrajit's GP prescribed an antidepressant?
- How effective do you think this treatment would be?

Although this case study is very brief, it does appear that the GP was keen to provide a quick ‘remedy’ to the problems that Indrajit presented. In fact, most doctors would consider a diagnosis of depression if the person presents with a cluster of symptoms similar to those presented by Indrajit.

However, it may also be true that Indrajit was simply reacting normally to a stressful event, the death of his wife. Unfortunately, the doctor may be confusing the expression of grief in response to bereavement with symptoms that are a diagnostic pointer to an episode of serious depression. The symptoms may be the same, but the personal story that is the background to the symptoms will give all the necessary clues to differentiate between the two situations.

Although bereavement and other serious social events can trigger depression (Brown and Harris, 1978), there is no evidence that antidepressant medication has any positive effect on the experience of grief immediately following a bereavement (Wakefield et al., 2007). Evidently, one of the problems that arises is grief being mistaken for something else.

4.3 How effective are antidepressants in general?

Despite the rapidly expanding use of antidepressants, to date there is very little evidence that they are effective for the treatment of bereavement or in mild to moderate types of depression. Recent meta-analyses (a technique for combining the results of a number of studies) reported by Joanna Moncrieff and Irving Kirsh, a British psychiatrist and psychologist respectively, show that selective serotonin re-uptake inhibitors (SSRIs), such

as paroxetine (Seroxat) and fluoxetine (Prozac), have no clinically meaningful advantage over placebo tablets (Moncrieff and Kirsch, 2005). They similarly found little evidence in support of the claim that these drugs are effective in more severe types of depression. Findings that appear to show a positive effect for antidepressant medication when compared with a placebo are probably therefore the result of methodological defects in the research.

Supporting these arguments, Canadian psychiatrist Corrado Barbui made an analysis of unpublished as well as published research, and concluded that SSRI antidepressant medication is not superior to placebos (Barbui et al., 2008). Indeed, for paroxetine, complete analysis of unpublished and published research demonstrated that the use of this medication is associated with a significant increase in the risk of suicide. Recent analysis by Irish psychiatrist and researcher David Healy and colleagues has also linked modern antidepressant use to increases in violent behaviours (Healy et al., 2006).

So how do antidepressant drugs compare in effectiveness with other possible types of treatment for bereaved people? The evidence, at the time of writing in 2008, does not look wholly convincing. Charles Reynolds, an American psychiatrist (Reynolds et al., 1999), conducted a placebo-controlled trial that compared antidepressant drug treatment with interpersonal psychotherapy for bereaved people. Although the drugs were shown to reduce some of the symptoms of depression, they had no effect on the intensity of the grief experienced by the bereaved people in the trial.

4.4 Are there alternatives to medication?

Another response to bereavement has been to suggest that the bereaved person should go through some form of bereavement counselling. Cruse Bereavement Care is the largest bereavement counselling organisation in the UK.

There are contrasting opinions about the effectiveness of bereavement counselling (also called grief counselling). For many years it had been thought that there was no evidence for the effectiveness of grief counselling, and there was even an opinion that substantial numbers of people might be *harmed* by the experience. In 2003 a review in the US by John Jordan, a psychologist, and Robert Neimeyer, a professor of clinical psychotherapy, analysed the effectiveness of counselling intervention following bereavement and concluded:

> grief counselling does not appear to be very effective, most probably because many of the people who receive it would do just as well (and perhaps in some cases better) without it. The assumption that grief counselling is 'naturally' beneficial for everyone fails to recognize the possibility of harmful effects of bereavement interventions for some individuals.
>
> (*Jordan and Neimeyer, 2003, p. 781*)

Their research claimed that almost 50 per cent of 'normal grievers' might deteriorate as a result of the experience of bereavement counselling. At the time, this was a sensational conclusion.

Perhaps unsurprisingly, the foundations on which Jordan and Neimeyer built their claims were subsequently attacked and argued to be fundamentally flawed. Two American psychology professors in particular, Dale Larson and William Hoyt, went to great lengths to systematically dismantle the research methodology used by Jordan and Neimeyer (Larson and Hoyt, 2007). They found that the data on which the original research was

based had never been published and that it had come from a single dissertation that, in turn, had not been peer reviewed. (Peer review means that a publication has been critically reviewed by an expert colleague in the field. It is largely used as a measure of quality.)

They further argued that Jordan and Neimeyer's research used an inappropriate statistical methodology. Larson and Holt concluded with a message that was much more hopeful for advocates of bereavement counselling:

> There is no evidence that bereaved clients are harmed by counselling or that clients who are 'normally' bereaved are at special risk. There is not any strong evidence that grief counselling, as typically practiced, is less efficacious than other forms of counselling and psychotherapy.
>
> (*Larson and Hoyt, 2007, p. 354*)

This debate is ongoing. Wolfgang Stroebe and colleagues (Stroebe et al., 2005) have reviewed the available evidence relating to the effectiveness, or lack of effectiveness, of bereavement work in general and counselling more specifically. Their review concludes with a number of significant findings:

- Some of the previously held assumptions about the effectiveness of bereavement work and bereavement counselling should be challenged.
- There is little evidence to support the notion that the disclosure of emotions positively assists in the recovery from bereavement.
- Bereavement counselling is not effective for people who have been referred simply because they have been bereaved, but should instead be focused on people with significant problems or who have expressed a need.
- Loneliness is a common feeling after bereavement, but one that only abates with time, not as a result of bereavement work.
- Certain types of bereavement, such as sudden death, increase the likelihood of grief complications.

Conclusion

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