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Webinar

Working Together to Recognise and Treat Complicated Grief

Tuesday, 23rd February 2016

"Working together. Working better."

Supported by The Royal Australian College of General Practitioners, the Australian Psychological Society, the Australian College of Mental Health Nurses and The Royal Australian and New Zealand College of Psychiatrists

Tonight's panel

Dr Konrad Kangru
GP (Qld)

Prof Kay Wilhelm
Psychiatrist (NSW)

Mr Greg Roberts
Social Worker / Bereavement Counsellor (Vic)

A/Prof Moira O'Connor
Psychology Academic (WA)

Facilitator

Ms Vicki Cowling
Social Worker and Psychologist (Vic)

Ground Rules

To help ensure everyone has the opportunity to gain the most from the live webinar, we ask that all participants consider the following ground rules:

- Be respectful of other participants and panellists. Behave as if this were a face-to-face activity.
- Post your comments and questions for panellists in the 'general chat' box. For help with technical issues, post in the 'technical help' chat box. Be mindful that comments posted in the chat boxes can be seen by all participants and panellists. Please keep all comments on topic.
- If you would like to hide the chat, click the small down-arrow at the top of the chat box.
- Your feedback is important. Please complete the short exit survey which will appear as a pop up when you exit the webinar.

Learning Outcomes

Through an exploration of grief and depression, the webinar will provide participants with the opportunity to:

- Describe the difference between complicated grief and depression
- Implement key principles of providing an integrated approach in the early identification of complicated grief
- Identify challenges, tips and strategies in providing a collaborative response to assisting people experiencing complicated grief after a significant loss.

General Practitioner Perspective

GP Context

- Usual carer for Dorothy over several years
  - Probably was also Arthur's GP
  - Watch out for guilt, transference and counter-transference
- Has watched her progress over that time
  - Initial grief response but Rheumatoid Arthritis since
- Knows Dorothy very well
  - Often difficult to notice subtle changes over time
- May not be suspecting Major Depressive Disorder
  - Revelation that Dorothy "just doesn't want to be here anymore" a major alarm
- Will remain central to ongoing care co-ordination

Dr Konrad Kangru

General Practitioner Perspective

Practicalities of Care for GP

- Dorothy is eligible for GP Mental Health Care Plan (1)
  - (MBS Items 2700,2701,2715,2717)
- Simple grief should not be a disorder
- Adjustment Disorder (F43.2) and Recurrent Depressive Disorder (F33) both valid ICD-10 diagnoses (2)
  - K10, DASS both entirely appropriate initial assessment tools
- Suicidality **must** be assessed
  - Intent, access to means, previous attempts, supports
  - May need Involuntary Mental Health Assessment

1. http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A45&qt=noteID&criteria=2715
2. http://apps.who.int/classifications/icd10/browse/2016/en#/F30-F39

Dr Konrad Kangru

General Practitioner Perspective

What to do?

- Pharmacotherapy?
  - Very cautious about sedatives or anxiolytics
  - SSRI might have a role but needs time
- Psychologist referral?
  - Completely appropriate but not for acute care
  - May be able to access online resources in interim
- Psychiatrist input?
  - Definitely indicated when concerned about suicide
  - Inpatient or Outpatient, Voluntary or Involuntary

Dr Konrad Kangru

Psychiatrist Perspective

What would be issues for me?

- What was her personality style, general and under stress?
- What was her marriage like over time? Before Hb's death? Any marital problems (i.e. other reasons for prolonged grief)?
- What about previous health? Has she definitely got RA? Is it well controlled? On prednisone? Other autoimmune conditions?
- Any Hx depression or bipolar disorder in her/family?
- What has she been doing (social interaction/exercise) in past 7 years? When did things change?

GP and daughter both know her well and are concerned

Prof Kay Wilhelm

Psychiatrist Perspective

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What is the trajectory?

- Initially doing well but now depressed (illness factors, growing isolation, realisation)
- Depressed all along (personality style, difficulty coping, being in new role)
- Depressed all along now much worse

Prof Kay Wilhelm

Psychiatrist Perspective

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Context for trajectory

Age	Life events	Comments	Medical Hx
0-5	Raised on farm, youngest of 4	Sibs at school, lonely	
	Local primary	Shy, average student	
5-12			
	Started local HS		Appendix out
12-16			
16	Finished school after SC		
	Met Arthur in year 10		
18	Married Arthur	'Love of my life'	
20	First child	'Busy years'	
22	2nd child		
24	3rd child (followed miscarriage)	Took 6 months to recover	Post natal depression
26	4th child		Given ADM by GP
30	Bought house on coast near parents	Happy years, camping holidays, kids doing well, I was content	
	Father died suddenly	Cried for weeks, Mo also very sad. "We comforted each other"	
	Arthur: 'health scare'		
	Mother died		
48	Arthur died	Life lost its meaning	Menopause
50	Best friend Dx breast Ca	Crying++++	Onset of Rh arthritis Rx prednisone initially Worsening depression
55			

Example of time line

Prof Kay Wilhelm

Psychiatrist Perspective

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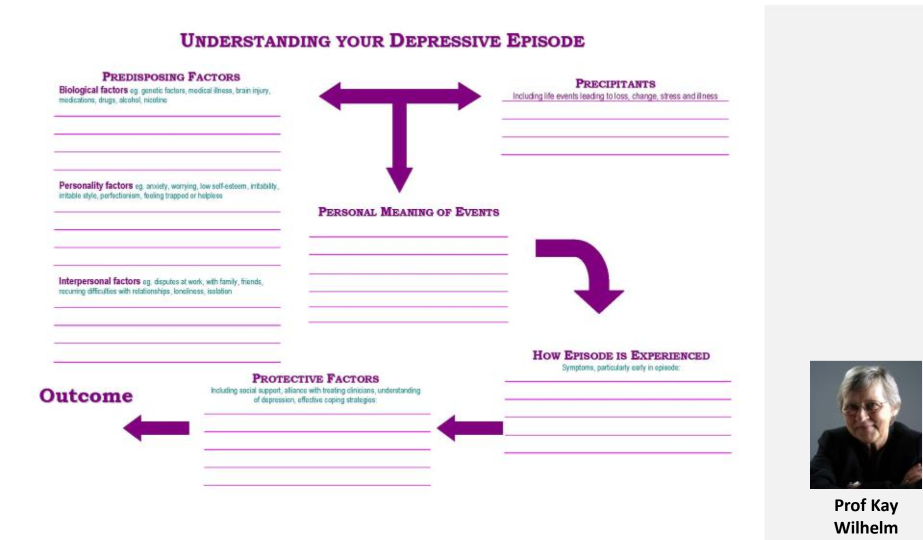

Psychiatrist Perspective

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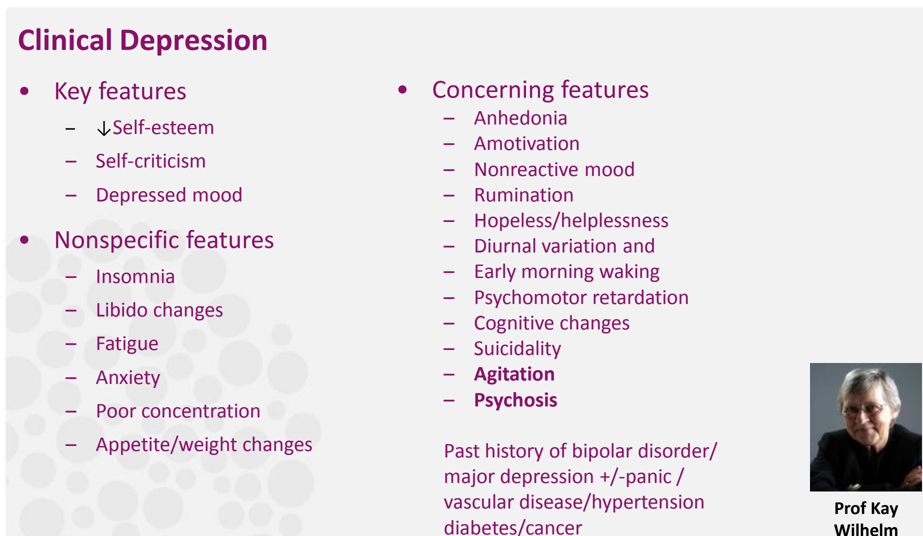

Psychiatrist Perspective

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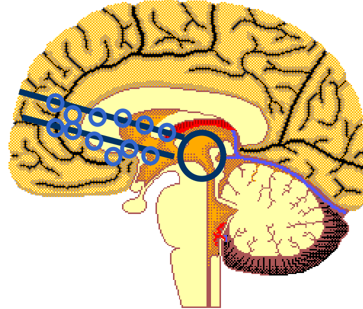
Structural Melancholia



- Older onset (eg. 60+ years)
- Family Hx of depression less significant
- Cerebrovascular disease more common
- Poorer response to antidepressants/ECT
- Risk of delirium
- Mechanism: **Structural** disruption of circuits linking basal ganglia and pre-frontal circuits, presaging full dementia in months or years

  Cognitive processing problems: ↓ concentration, inattention, 'pseudo-dementia' picture

  Retardation and/or **agitation**

  Based on observation: Family members report CHANGE in behaviour

Prof Kay Wilhelm

Psychiatrist Perspective

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Suicide risk assessment

- Is she using alcohol/tobacco? analgesics? sedatives? stimulants?
- Does she have a depressive episode? panic? agitation?
- Any previous Hx of suicidality?
- When did ideas start in relationship to grief, depression?
- What does she have to live for?
- Has she plans? Has she acted on them?
- What access does she have?
- Who can she talk to?
- Is she concerned herself?

Prof Kay Wilhelm

Psychiatrist Perspective

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Addressing different trajectories

Trajectories	Questions	Discuss with GP
Says she initially did well, now depressed	What led to change? What type of depression? Any reversible factors? Will ADM help? Which one?	If she has a clinical depression, aim to improve symptoms to enable her to start to deal with grief counselling
Says she has been depressed since Hb's death, not resolving, may be gradually worsening	Has pattern changed over time? How's she been functioning? What does she make of this? Does she have an episode?	Ensure that what started as unresolved grief has not become depression, keep a watching brief during grief counselling
Says she has been depressed 'as long as I can remember' and Hb's death has compounded this	How has she dealt with depressive feelings in past? Has she any superimposed mental/physical conditions? Does she have an episode?	Likely to have personality style vulnerable to complicated grief; unresolved issues from past may complicate the grieving process/counselling

Prof Kay Wilhelm

Social Worker Perspective

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Greg's Face Value Assessment of Case

- Dorothy has a Chronic Adjustment Disorder?
- Loss of a primary reciprocal attachment figure (Arthur)
- Has lived life for 7 years without tangible connections to primary reciprocal attachment figure and has not adjusted to this (some resilience evident to survive that long?)
- Adjustment may occur through development of symbolic attachments to reciprocal attachment figure (Mikulincer & Shaver 2008) PLUS - strategies for self-soothing?
- Need to manage the changed relationship to the deceased (Klass, Silverman & Nickman 1996)

Mr Greg Roberts

Social Worker Perspective

Depression or Complicated Grief?

- Depression – generalised lowered mood that impairs daily functioning in life
- Complicated Grief (Prolonged Grief Disorder) – intrusive/unabated thoughts of deceased that impairs daily functioning of life and affects mood
- Adjustment Disorder – heightened stress reaction to change/loss that brings changes in mood (depressed/anxious/combined) and affects daily functioning in life (can be acute or chronic)

Mr Greg Roberts

Social Worker Perspective

Principles for Integrated Approach

- Thorough assessment of Dorothy – K10, PHQ-9, WEMWBS, ICG (inventory of complicated grief), DIAD (diagnostic inventory adjustment disorder)
- MHCP/referral to establish relationship between GP and Allied Health Professionals
- Combined focus of 'understanding' (meaning/adjustment/reframing) and 'treatment' (symptomatology/physiological change)
- Clarification and monitoring of statement "don't want to be here" – ??an expression of inability to adjust to Arthur's death (passive - giving up?) OR ??actively being suicidal (active – plan to die?)

Mr Greg Roberts

Social Worker Perspective

Challenges, Tips, Strategies for Dorothy

- Consistent communication pathways amongst interdisciplinary team can be challenging
- Dorothy needs to be aware of different focus of each professional and purpose of their interventions (invite Dorothy's sense of self-agency)
- Combine a willingness to understand and work with the 'functionality' of grief (as part of adjustment to change/loss), along with treatment of symptoms that impair daily living
- Assist Dorothy in establishing meaningful connections/activities in life, as it is now, rather than simply trying to return to past connections/activities, as they were then – life has changed and can never be the same as it was!

Mr Greg Roberts

Social Worker Perspective

Relevant Contemporary Theories for Dorothy's Case

- Dual Process Model (DPM) (Stroebe & Schut)
- Two Track Model (Rubin)
- Continuing Bonds (Klass, Sliverman & Nickman)
- Expert Companioning (Wolfelt)
- Exquisite Witnessing (Jeffreys)

Mr Greg Roberts

Psychology Academic Perspective

The role of the General Practitioner

- Primary care and General Practitioners (GPs) have a clear role in mental health generally and in bereavement support specifically
- The role of the GP in appropriate support and referral
- Relies heavily on:
  - GPs' knowledge
  - GPs' communication and empathic listening
  - GPs' willingness to refer
- A UK study found that had little awareness of contemporary understandings of grief (Wiles et al., 2002)
- Education on dying, death and bereavement is often limited in medical schools (Breen et al., 2012; Dickenson, 2007)

A/Prof Moira O'Connor

Psychology Academic Perspective

General Practitioners' experiences

- In a study of GPs, we found (O'Connor & Breen, 2014):
  - a lack of clarity
  - a lack of consistency
  - piece-meal knowledge
- Some GPs referred but others were very unwilling
- There were/are several barriers
- Focus on own ideas and experiences – could lead to problems for the GP or other health professional
- Health professionals generally may emphasise their 'worst' type of loss
- Complicated or prolonged grief reactions may be more related to background factors such as relationship with the person who has died or attachment style (Lobb et al., 2010)

A/Prof Moira O'Connor

Psychology Academic Perspective

Public health model of bereavement

- The public health model of grief:
  - emphasises that most people do not need any extra support other than family or friends
  - some people need community supports
  - and a significant minority need access to a mental health professional (Aoun et al., 2012)

A/Prof Moira O'Connor

Psychology Academic Perspective

Complications of grief

- Prolonged grief disorder (PGD) is a more complicated form of grief
- It causes significant social and occupational impairment
- It is associated with:
  - suicidality
  - poorer health-related quality of life
  - substance abuse
  - and a reduced likelihood to seek assistance from mental health services
- It involves:
  - separation distress
  - an unrelenting yearning for the deceased
  - a sense of meaninglessness, and difficulty accepting the loss
- All of which remain elevated for 6 months or more following the loss

A/Prof Moira O'Connor

Psychology Academic Perspective

What is needed?

- Grief education needs to alert health professionals (and the community) to the range of responses
- We need to target care appropriately to those most in need, based on the complexity and persistence of grief symptoms
- We also need interventions including one-on-one but also other forms of interventions and supports

A/Prof Moira O'Connor

Psychology Academic Perspective

References

Aoun SM, Breen LJ, O'Connor M, Nordstrom C, Rumbold B: A public health approach to bereavement support services in palliative care. Aust N Z J Public Health 2012, 36:14–16.

Breen L, Fernandez M, O'Connor M, Pember AJ: The preparation of graduate health professionals for working with bereaved clients: an Australian perspective. Omega 2012, 66:313–332.

Dickinson GE: End-of-life and palliative care issues in medical and nursing schools in the United States. Death Stud 2007, 31:713–726.

Lobb EA, Kristjanson LJ, Aoun SM, Monterosso L, Halkett GKB, Davies A: Predictors of complicated grief: a systematic review of empirical studies. Death Stud 2010, 34:673–698.

O'Connor M, Breen LJ: General Practitioners' experiences of bereavement care and their educational support needs: a qualitative study. BMC Medical Educ 2014, 14:59.

Wiles R, Jarrett N, Payne S, Field D: Referrals for bereavement counselling in primary care: a qualitative study. Patient Educ Couns 2002, 48:79–85.

A/Prof Moira O'Connor

Q&A session

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- Each participant will be sent a link to online resources associated with this webinar within one week.
- Upcoming webinars:

Working collaboratively to address the social and emotional well-being of older LGBTI people
Wednesday, 27th April 2016

Working collaboratively to support students experiencing anxiety whilst completing end of high school studies
Wednesday, 25th May 2016

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