Annals of Internal Medicine

Bereavement Care in the Wake of COVID-19: Offering Condolences and Referrals

Wendy G. Lichtenthal, PhD, FT; Kailey E. Roberts, PhD; and Holly G. Prigerson, PhD

The coronavirus disease 2019 pandemic has left, and will continue to leave, hundreds of thousands of bereft family members in its wake (1). These deaths are unlike others in recent history. Unprecedented conditions—massive numbers of casualties; forced separations during a patient's final days; and denial of physical touch, final goodbyes, and traditional mourning rituals—pose threats to bereaved family members' mental health, leaving them vulnerable to intense and enduring psychological distress.

Front-line physicians are uniquely positioned to provide critically needed psychosocial support to bereaved family members. Regardless of medical specialty, physicians are now caring for more dying patients than ever before and, concomitantly, are tasked with talking to a deceased patient's family members. Many well-intentioned but weary and emotionally depleted physicians search for the words to say and wonder how to know when a bereaved family member is at risk and when they should refer them to a mental health professional.

To address this need, we offer words to say and guidance on when to make referrals to offset the risks that the pandemic has posed to family members' mental health. We recognize that communicating condolences in the context of a pandemic is challenging for many reasons, including the sheer volume of deaths, barriers to communication imposed by social distancing, time pressures, compassion fatigue, and mental and physical exhaustion. Our tips aim to make this difficult but potentially impactful interaction both easier for physicians responsible for talking with surviving family members and more comforting and beneficial for the bereaved family members. Specifically, we suggest ways to communicate compassionately, assess risk for acute bereavement challenges, and refer to a mental health professional when indicated (**Table** and **Figure**). This guidance is based on decades of research and clinical experience; we acknowledge that studies have not yet confirmed a link between these recommendations and better outcomes, nor their cultural universality.

Communicate Compassionately

Physicians speaking with family immediately after the death of a patient should begin by expressing how sorry they are for their loss, using the deceased patient's first name to personalize the death. They may have an impulse to say things to "fix" the situation, but in working with bereaved persons, we have learned that there are no easy fixes. Grieving family members have taught us that what they most appreciate is a physician's empathic presence—that is, a willingness to stay with their grief, feel their pain, and take a moment to acknowledge their loss and sorrow. Family members want to know that their loved one mattered. Physicians may ask if the family members have questions about the patient's final days or moments or the medical care that the patient received near death and may provide answers or reassurances. Finally, care should be demonstrated by asking how they are coping and waiting for a response (for example, not speaking while counting to 10). Some family members may seem numb, angry, or in shock, but this should not be interpreted as a lack of appreciation for the physician's effort. Communicating compassion is a way to show respect for the deceased patient and the bereaved family member; reduce feelings of abandonment by the medical team; and promote a sense of support, concern, and care (2).

Assess Risk

Providing adequate bereavement care requires the ability to identify and triage those in greatest need of targeted mental health services (3, 4). Bereavement poses risk for serious physical illness, including takotsubo cardiomyopathy, or "broken heart syndrome" (5); increases in substance use; and mental health disturbances (6), including major depressive disorder, posttraumatic stress disorder, and now prolonged grief disorder, a newly recognized psychiatric illness in the International Classification of Diseases, 11th Revision, and the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) text revision (7). (As of this writing, the DSM-5 Text Revision Steering Committee formally approved prolonged grief disorder for inclusion as a new mental disorder. See www.psychiatry.org/psychiatrists/practice/dsm/proposed-changes.) Although there are multiple factors that increase bereavement risk (for example, sudden death, not having an opportunity to say goodbye, social isolation, dependence on the deceased, and history of mental health problems [3, 7]), physicians can ask 2 telling questions as an initial risk assessment: "Would you say that you've felt so overwhelmed by your loss and grief that you're having trouble coping; that is, that you're finding it hard just to get through the day?" and "Do you have support; that is, do you have someone to help you out or to talk to?"

See also:

Web-Only
Supplement

This article was published at Annals.org on 23 June 2020.

Table. CARE: A Framework for Physicians' Condolence Communication With Surviving Family Members

CARE Recommendations	Description	Examples of What to Say
Communicate compassionately	• Offer condolences using the deceased's first name • Acknowledge how difficult this might be • Ask if you can answer questions about the death • Ask how they are coping • Listen, wait for them to respond—offer empathic presence—taking a moment to acknowledge how profound their loss may be	• "I'm so sorry to hear about _____ [deceased patient's name]." • "I can't imagine how hard this must be for you and your family." • "Do you have questions about _____'s [deceased patient's name] medical care that I may be able to answer?" • "How are you coping?"
Assess risk for acute bereavement challenges	• Screen for the extent to which their grief and loss is affecting their ability to cope and function • Determine whether they are isolated and have social support, including practical and emotional support	• "Would you say that you've felt so overwhelmed by your grief and loss that you're having trouble coping; that is, that you're finding it hard just to get through the day?" • "Do you have support; that is, do you have someone to help you out or to talk to?" *If the family member is having difficulty coping or getting through the day OR is lacking support, have a mental health provider reach out to them directly.*
Refer when appropriate	• Normalize the need for support • Be mindful that intense distress is typical and not pathologic in the initial weeks and months after a significant loss; further assessment of risk for future challenges should be done by a mental health provider • Have a mental health provider directly reach out to the family member if they indicate they are having difficulty functioning or lack support • Provide contact information for the team mental health provider or hospital mental health services if they do not appear at risk	• *If the family member appears to be having difficulty coping or functioning OR lacks support:* "I can see how difficult this is. I'd like us to get a better sense of what you might need right now. I am going to have our [social worker] follow up with you to see what might be most helpful for you." • *If the family member does not appear to be having difficulty coping or functioning AND appears to have support:* "So many people are struggling now. Would you be interested in additional support through a counselor or support group? I'm going to provide you with the contact information for our [social worker] should you feel you need more support now or in the future."
Educate about resources	• Provide contact information for hospital bereavement services and mental health providers • Share information about online and community bereavement resources	• "I want to make sure you have resources should you or anyone in your family [if relevant] become interested in one-on-one or group support." • "There are many online resources available with more information and options for support. We will send you a list."

Refer When Appropriate and Educate About Resources

On the basis of responses to these simple questions, physicians can distinguish those who may be in greatest immediate need and should be directly contacted by a mental health provider from those who can be provided with referrals and resources to use in the future should they need them. Physicians should let family members who are having difficulty coping or who lack even minimal support know that someone from their team will follow up with them. If possible, they should then alert a mental health provider from their team or hospital mental health services to contact these survivors for an evaluation; support; and, if indicated, a referral for specialized mental health care. If these resources are not available or if bereaved family members appear able to cope and do have support, they should be offered contact information for hospital bereavement services and community bereavement resources (see https://findingourway.prolongedgrief.com/ and the **Supplement**, available at Annals.org).

Indeed, not everyone needs or benefits from professional grief support (8). Caution should be taken not to pathologize intense mental and physical distress in the weeks and months immediately after loss because these are normal, expected reactions to a loved one's death. Clinicians should be more concerned about bereaved persons presenting with multiple bereavement risk factors or debilitating psychological symptoms, including suicidality (see **Supplement Tables 1** and **2**, available at Annals.org, for information on risk factors and distinctions between normative grief and bereavement-related mental disorders [3, 4, 7, 9, 10] and https://endoflife.weill.cornell.edu/grief-resources for additional grief resources).

Conclusion

Coronavirus disease 2019 has resulted in disturbing circumstances of death known to heighten risk for pathologic grief reactions (3). Physicians are well positioned to comfort and create a critical link to bereavement services for those who may need it. We offer brief

Figure. Sample script using CARE.

"Hello, Mrs. X? This is Dr. Y. I'm calling to let you know that I'm so sorry about ____. (*Use the patient's first name.*) I can't imagine how hard this must be for you and your family. I was wondering if you have questions about ____'s care at the end that I might answer?" (*Respond to the questions*.)

"And how have you been coping with all of this?" (*Let the family member respond, pausing to allow for expression of emotion.*)

"That sounds so difficult. I'm sorry it's been so hard. I do want to know if you might find it helpful to talk with someone, so I wanted to ask, would you say that you've felt so overwhelmed by your grief and loss that you're having trouble coping; that is, that you're finding it hard just to get through the day?" (*Allow the family member to respond.*)

"I also wanted to check, do you feel like you have support? Someone who could help you out or who you could talk to about your loss?" (*Allow the family member to respond.*)

If difficulty coping or functioning OR no support:

"Well, I'm going to have someone from our team reach out and see what might be most helpful for you. I want you to know that it was a privilege to take care of _____, and I appreciate having the chance to speak with you and share how very sorry I am."

If no difficulty coping or functioning AND has support:

"Well, I want you to know that if you need support, we have some resources and referrals we can provide. I'm going to give you our _____'s (*e.g., social worker's*) contact information and a list of resources that we'll be sending in an e-mail. I want you to know that it was a privilege to take care of _____. I appreciate having the chance to speak with you and share how very sorry I am."

CARE = Communicate compassionately, Assess risk for acute bereavement challenges, Refer when appropriate, and Educate about resources.

guidance on how to assess risk and when to make a referral to a mental health provider, providing a road map for physicians who are navigating these challenging conversations and giving crucially needed support to bereaved family members in the wake of this pandemic.

From Memorial Sloan Kettering Cancer Center, New York, New York (W.G.L., K.E.R.); and Cornell Center for Research on End-of-Life Care, Weill Cornell Medicine, New York, New York (H.G.P.).

Acknowledgment: The authors thank Lindsay Lief, MD, and Sophia Kakarala, BA, for their thoughtful comments on drafts of this manuscript.

Financial Support: By the National Cancer Institute grants CA197730, CA218313, CA139944, CA172216, CA192447, CA009461, and CA008748; National Institute on Minority Health and Health Disparities grant MD007652; National Institute of Nursing Research grant NR018693; National Institute on Aging grant AG049666; National Institute of Mental Health grants MH121886 and MH095378; and National Center for Advancing Translational Sciences grant TR002384.

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M20-2526.

Corresponding Author: Wendy G. Lichtenthal, PhD, FT, Memorial Sloan Kettering Cancer Center, 321 East 61st Street, New York, NY 10065; e-mail, lichtenw@mskcc.org.

Current author addresses and author contributions are available at Annals.org.

Ann Intern Med. doi:10.7326/M20-2526

References

1. **Verdery AM, Smith-Greenaway E.** COVID-19 and family bereavement in the United States. Appl Demor. 2020;32:1-2.
2. **Lichtenthal WG, Sweeney CR, Roberts KE, et al.** Bereavement follow-up after the death of a child as a standard of care in pediatric oncology. Pediatr Blood Cancer. 2015;62 Suppl 5:S834-69. [PMID: 26700929] doi:10.1002/pbc.25700
3. **Roberts K, Holland J, Prigerson HG, et al.** Development of the Bereavement Risk Inventory and Screening Questionnaire (BRISQ): item generation and expert panel feedback. Palliat Support Care. 2017;15:57-66. [PMID: 27516152] doi:10.1017/S1478951516000626
4. **Lichtenthal WG.** Supporting the bereaved in greatest need: we can do better. Palliat Support Care. 2018;16:371-374. [PMID: 30226127] doi:10.1017/S1478951518000585
5. **Tofler GH, Morel-Kopp MC, Spinaze M, et al.** The effect of metoprolol and aspirin on cardiovascular risk in bereavement: a randomized controlled trial. Am Heart J. 2020;220:264-272. [PMID: 31923768] doi:10.1016/j.ahj.2019.11.003
6. **Siegel MD, Hayes E, Vanderwerker LC, et al.** Psychiatric illness in the next of kin of patients who die in the intensive care unit. Crit Care Med. 2008;36:1722-8. [PMID: 18520637] doi:10.1097/CCM.0b013e318174da72
7. **Prigerson HG, Horowitz MJ, Jacobs SC, et al.** Prolonged grief disorder: psychometric validation of criteria proposed for DSM-V and ICD-11. PLoS Med. 2009;6:e1000121. [PMID: 19652695] doi:10.1371/journal.pmed.1000121
8. **Currier JM, Neimeyer RA, Berman JS.** The effectiveness of psychotherapeutic interventions for bereaved persons: a comprehensive quantitative review. Psychol Bull. 2008;134:648-661. [PMID: 18729566] doi:10.1037/0033-2909.134.5.648
9. **Lichtenthal WG, Maciejewski PK, Craig Demirjian C, et al.** Evidence of the clinical utility of a prolonged grief disorder diagnosis [Letter]. World Psychiatry. 2018;17:364-365. [PMID: 30229568] doi:10.1002/wps.20544
10. **Wright AA, Keating NL, Balboni TA, et al.** Place of death: correlations with quality of life of patients with cancer and predictors of bereaved caregivers' mental health. J Clin Oncol. 2010;28:4457-64. [PMID: 20837950] doi:10.1200/JCO.2009.26.3863

Current Author Addresses: Dr. Lichtenthal: Memorial Sloan Kettering Cancer Center, 321 East 61st Street, New York, NY 10065.
Dr. Roberts: Memorial Sloan Kettering Cancer Center, 641 Lexington Avenue, 7th Floor, New York, NY 10022.
Dr. Prigerson: Weill Cornell Medicine, 420 East 70th Street, Suite 3B, Room 321, New York, NY 10021.

Author Contributions: Conception and design: W.G. Lichtenthal.
Drafting of the article: W.G. Lichtenthal, K.E. Roberts, H.G. Prigerson.
Critical revision of the article for important intellectual content: W.G. Lichtenthal, K.E. Roberts, H.G. Prigerson.
Final approval of the article: W.G. Lichtenthal, K.E. Roberts, H.G. Prigerson.
Provision of study materials or patients: W.G. Lichtenthal, K.E. Roberts, H.G. Prigerson.
Obtaining of funding: W.G. Lichtenthal, K.E. Roberts, H.G. Prigerson.
Administrative, technical, or logistic support: W.G. Lichtenthal.
Collection and assembly of data: W.G. Lichtenthal, K.E. Roberts.