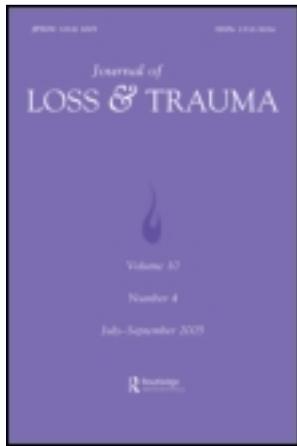


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# Pharmacological Treatment Following Traumatic Bereavement: A Case Series

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*There is little evidence to guide the use of psychotropic medications immediately following bereavement. This article presents a review of the relevant literature, followed by a case series on the use of psychotropic medication in traumatically bereaved individuals. Of 20 active subjects, nine had been prescribed psychotropic medication in the days and weeks following a traumatic loss. The amount, type, and timing of medication in this sample is explored and compared to the extant literature. Results suggest that clinical practice may not be guided by empirical research in this area.*

It has long been recognized that experiencing the death of a loved one is an inevitable part of the human experience. Grief is the normal, though painful, response to such a loss, but there is a great deal of variation in the duration, expression, and intensity of grief. Although the majority of bereaved individuals do not require formal intervention to help them cope with grief (Neimeyer & Currier, 2009), a small number of mourners continue to experience difficulties that may merit clinical attention. There are various opinions on how to characterize such difficulties. Some argue for using the existing DSM-IV diagnoses of posttraumatic stress disorder (PTSD) and major depressive disorder (MDD) (Bonanno et al., 2007). Others argue that grief is distinct from these disorders and that symptoms associated with intense and prolonged grieving are better characterized as prolonged grief disorder (Prigerson et al., 2009). Among those at risk of experiencing symptoms of prolonged grief are those who have experienced traumatic bereavement. Traumatic bereavement encompasses deaths that are sudden, violent, or due to human actions (Green, 2000), as well as the death of a child (Rando, 1985).

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There appears to be a high rate of PTSD and MDD following traumatic bereavement. A 1998 study of PTSD and bereavement (Zisook, Chentsova-Dutton, & Shuchter, 1998) found that 45% of individuals met criteria for PTSD 2 months after the death of a spouse, using measures that approximated PTSD. At 25 months, 7% met criteria for this disorder. Among the group bereaved by sudden unexpected death (accident or suicide), 36% met the criteria. This study reported that 99% of individuals who met the criteria for PTSD also met the criteria for depression, underscoring the high rates of comorbidity among these two disorders. Studies of bereaved spouses have reported that a major depressive episode occurs in about a third of cases 1 month after the loss, and in about 15% of cases at 13 months after the loss (Reynolds et al., 1999). Research into prolonged grief, a category that encompasses many traumatically bereaved individuals, has also addressed this issue. Studies have estimated that prolonged grief co-occurs with PTSD in 30% to 50% of individuals, and co-occurs with depression in 21% to 54% of individuals (Shear, Frank, Houck, & Reynolds, 2005).

While psychotropic medications are widely used to treat depression and posttraumatic stress, there is little research on their use with the recently bereaved. The purpose of this article is to investigate the use of psychotropic medications in a traumatically bereaved sample through the use of a case series. Specific areas to be addressed include the number, type, and timing of medications. The findings are then compared to the extant literature. There is some concern that, in the absence of formal guidelines, psychotropic medications are being used improperly with the traumatically bereaved. Because bereavement-related difficulties are often classified under depression and posttraumatic stress disorder, the next two sections provide an overview of relevant research into the use of psychotropic medications for these disorders.

### PHARMACOLOGICAL TREATMENT OF BEREAVEMENT-RELATED DEPRESSION

While there is some evidence that pharmacological treatments may decrease symptoms of depression that may be present following bereavement, there is no clear evidence that they actually decrease symptoms of grief (Forte, Hill, Pazder, & Feudtner, 2004; Zhang, El-Jawahri, & Prigerson, 2006). Antidepressants are among the most-studied drugs for treating bereavement-related depression. Only two randomized controlled trials evaluating the effectiveness of an antidepressant, nortriptyline, for grief-related symptoms could be found.

In the first, nortriptyline, a tricyclic antidepressant, was used to treat bereaved individuals after the loss of a family member, most often a spouse or significant other, though five subjects had lost an adult child (Reynolds et al., 1999). This study included 80 individuals, age 50 or older, who had also been diagnosed with a major depressive episode that had begun within 6 to

12 months of the loss. While nortriptyline, either alone or with interpersonal therapy, improved depression scores more than interpersonal therapy alone or a placebo, it had no effect on grief scores, which improved equally across groups (Reynolds et al., 1999). Subsequently, 27 of these subjects who responded either to the drug or placebo were enrolled in a randomized controlled trial of nortriptyline on EEG sleep measures (Taylor et al., 1999). Nortriptyline was found to decrease REM sleep time and increase REM density, while no such changes were observed in placebo responders. However, upon discontinuation of the drug, EEG sleep measures reverted to pre-treatment baseline, though both groups reported continued sleep quality improvement and remission of depression was maintained. Throughout the study, both groups scored similarly on measures of sleep quality and depressive symptoms. These two studies suggest that nortriptyline had little effect on grief.

In addition, four open trials of antidepressants have been conducted, all of which found that symptoms of depression were reduced to a greater extent than symptoms of grief. The first study was of desipramine, a tricyclic, with participants who met criteria for depression according to the DSM-III, though the average time since the loss was not reported (Jacobs, Nelson, & Zisook, 1987). The second was of paroxetine, a selective serotonin reuptake inhibitor (SSRI), conducted with participants displaying traumatic grief an average of 17 months after the loss (Zygmunt et al., 1998). This study also measured depressive symptoms. The third was of bupropion, an atypical antidepressant, conducted with participants meeting DSM-IV criteria for depression as early as 2 months following the death (Zisook, Shuchter, Pedrelli, Sable, & Deaciuc, 2001). The fourth was of escitalopram, an SSRI, conducted with participants meeting DSM-IV criteria for depression within 12 months of the loss (Hensley, Slonimski, Uhlenhuth, & Clayton, 2009). Sixty percent of this sample also met the criteria for PTSD, and 48% met criteria for complicated grief. Among these four studies, the majority of participants were female, and the mean age was 52. Most had lost a spouse or significant other, though smaller numbers had lost a parent, a child, a sibling, or a grandchild.

All four of these studies reported that depression symptoms decreased to a greater extent than grief symptoms and concluded that the medications show promise for treating symptoms of grief. However, none of them took into account the finding that grief symptoms tend to naturally resolve in time, even without intervention (Neimeyer & Currier, 2009). In addition, one study combined drug treatment with psychotherapy for traumatic grief (Zygmunt et al., 1998), making it difficult to determine the impetus for any improvement. Given the limitations noted above, the authors of all four studies called for randomized controlled trials. However, to date, no such trials for these drugs in treating grief have been published.

Even though antidepressants are often the first line of treatment for depression, the evidence on their efficacy is mixed, with some studies suggesting that SSRIs are no more effective than placebo. In a meta-analysis

that has provoked much debate, Kirsch and Sapirstein (1998) found that 75% of drug response is attributable to placebo response. The authors speculate that the remaining 25% may be due to an active placebo effect rather than a true drug effect. Such findings call into question the actual effectiveness of these medications in treating depression. In addition, a 2003 meta-analysis found that SSRIs “yield an excess of suicides and suicide attempts on active treatments compared with placebos” (Healy, 2003, p. 71). Studies using healthy volunteers have also shown increased suicidality, suggesting that there may be considerable dangers in using SSRIs (Healy, 2003).

In addition to antidepressants, benzodiazepines have been trialed for treating bereavement, with somewhat discouraging results. The only randomized controlled study to date, on diazepam, found no effect for the drug (Warner, Metcalfe, & King, 2001). In fact, the placebo group actually reported fewer problems with sleep disruptions and nightmares, classic symptoms in a PTSD subscale. The authors concluded that, at best, benzodiazepines have a neutral effect (Warner et al., 2001).

However, other studies suggest that the practice of prescribing benzodiazepines shortly after bereavement appears to be common, despite the lack of demonstrated efficacy and concern about long-term use and dependence. For instance, 49% of obstetricians surveyed endorsed using sedatives, such as benzodiazepines, to treat bereavement following a stillbirth (Gold, Schwenk, & Johnson, 2008). In a separate survey of bereaved parents, 41% reported being prescribed sedatives after the loss of their young child (Harper & Wisian, 1994). While this study did not evaluate the effectiveness of the medications, bereaved parents generally found the prescription of medication less helpful than other actions taken by their doctors, such as providing medical information or psychoeducation, compassionate care, social support, or grief counseling. In a survey of physicians on their use of benzodiazepines in elderly adults, Cook, Biyanova, and Marshall (2007) found that 18 out of 33 physicians spontaneously reported using them to treat bereavement shortly after a death. This study also found that 20% of elderly adults surveyed had continued to take the drugs long term, some up to 10 years later. The authors report that the interviews indicated that physicians prescribed benzodiazepines in an effort to reduce the suffering of their patients following a loss. The authors caution that this apparently widespread practice may be unnecessarily exposing griever to inappropriate, and potentially harmful, treatment (Cook et al., 2007).

## PHARMACOLOGICAL TREATMENT OF POSTTRAUMATIC STRESS DISORDER

Some bereaved individuals may meet the criteria for PTSD, especially if the death was traumatic. Medication is frequently used to target a variety of

symptoms, including insomnia, psychosis, and excessive anger and arousal (Cooper, Carty, & Creamer, 2005). Though many types of medication are used, currently only two drugs have been approved by the Food and Drug Administration (FDA) for the treatment of PTSD: sertraline and paroxetine, both SSRIs (Davis, Frazier, Williford, & Newell, 2006). There is mixed evidence from randomized controlled trials for the efficacy of fluoxetine, another SSRI (Hertzberg, Feldman, Beckham, Kudler, & Davidson, 2000; Martenyi, Brown, & Caldwell, 2007; Martenyi & Soldatenkova, 2006). There is also some support from randomized controlled trials for venlafaxine, a serotonin-norepinephrine reuptake inhibitor (Davidson et al., 2006); imipramine, a tricyclic antidepressant (Kosten, Frank, Dan, McDougale, & Giller, 1991); phenelzine, a monoamine oxidase inhibitor (Kosten et al., 1991); and lamotrigine, an anticonvulsant (Hertzberg et al., 1999), in treating different aspects of the disorder. There is also some evidence of efficacy for mirtazapine, a tetracyclic antidepressant, from a pilot randomized controlled trial (Davidson et al., 2003) and for the antipsychotics risperidone (Padala et al., 2006) and olanzapine (Stein, Kline, & Matloff, 2002) in various populations from controlled trials. However, none of these studies focused primarily on bereaved individuals.

Studies of benzodiazepines have generally shown no effect on PTSD symptoms and suggest that they do not have a preventative effect when used shortly after a trauma, though they may help reduce generalized anxiety (Cooper et al., 2005). In one study of clonazepam and alprazolam, administered to trauma victims between 2 and 18 days after the trauma, the medication group was found to have higher rates of PTSD than the placebo group at a 6-month follow-up, though the authors refrained from concluding that the drug was responsible for this difference (Gelpin, Bonne, Peri, Brandes, & Shalev, 1996). Overall, the evidence for medications is, at best, mixed, and exposure therapy remains the only treatment identified by the Institute of Medicine (2007) as having sufficient evidence to support its efficacy.

One limitation of pharmacological treatment for PTSD is that when the treatment is discontinued the symptoms often recur (Cooper et al., 2005). A combination of pharmacological and psychotherapeutic interventions may be the best approach in some cases, though evidence is limited (Cooper et al., 2005). In general, the research on pharmacological treatment for PTSD is limited by small sample sizes, use of predominantly female sexual assault survivors or male veteran populations, and differences due to type of trauma (Cooper et al., 2005). For instance, SSRIs appear to be less effective in veteran, as compared to civilian, populations (Davidson & van der Kolk, 2007). In addition, most studies exclude individuals with comorbid substance abuse, which is common in PTSD (Cooper et al., 2005). As in drug trials for depression, drug trials for PTSD show a high placebo response rate, and there is the risk of serious side effects with pharmacotherapy (Cooper et al., 2005). While pharmacotherapy may be effective once psychopathology has been

established, there is little evidence to support its use immediately after a trauma in an attempt to prevent the development of further problems. Instead, it is recommended that medication be used prudently with individuals not demonstrating a normal pattern of recovery (Cooper et al., 2005). However, because few studies have been conducted primarily with bereavement-related PTSD, the generalizability of this body of knowledge is limited.

Although only two medications have obtained FDA approval, a variety of drugs are used to treat PTSD in practice. In a study of over 10,000 privately insured Americans diagnosed with this disorder, the authors concluded that the choice of pharmacological treatment does not appear to be determined entirely by diagnosis (Harpaz-Rotem, Rosenheck, Mohamed, & Desai, 2008). This study found that 60% of those diagnosed with PTSD were prescribed medications. Among those treated with medications in their sample, 74.3% were prescribed antidepressants, 73.7% were prescribed anxiolytics or sedatives, and 21.3% were prescribed antipsychotics, with many individuals being prescribed more than one class of medication. There were also high rates of comorbidity with depression and other disorders, and in cases where more than one diagnosis was listed, the authors were unable to determine which was the primary diagnosis. However, 16.2% of individuals prescribed antipsychotics did not have a comorbid diagnosis of bipolar disorder or schizophrenia, the only approved indications for these medications. The authors expressed concern at the off-label (not approved by the FDA) usage of this class of medication and speculated that clinicians may be targeting specific symptoms with various medications (Harpaz-Rotem et al., 2008).

## METHODS

### Design

This is a case series on the current use of psychotropic medication in the traumatically bereaved. This study utilizes a cross-sectional record review of subjects receiving counseling services within a 90-day period.

### Instruments

The 25-item Hopkins Symptom Checklist (HSCL) is a modification of the 58-item HSCL originally developed by Parloff, Kelman, and Frank (1954) and adapted by many subsequent researchers (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). This instrument is a self-report questionnaire that measures anxious and depressive symptoms. The overall score is divided by 25 (number of items) to provide a mean score. It has demonstrated an 86.7% concordance rate with physician assessments of global psychopathology in primary health care settings (Hesbacher, Rickels, Morris, Newman,

& Rosenfeld, 1980) and is considered to be adequate for screening for psychiatric disorders (Veijola et al., 2003). Studies have identified different cutoff points for mean scores to denote significant symptoms, ranging from 1.55 to 1.75 (Veijola et al., 2003) in various populations. Given the intensity of symptoms often observed in traumatic bereavement, the current study uses the higher cutoff point of 1.75.

The second intake instrument is the Impact of Event Scale-Revised (IES-R), developed by Weiss and Marmar (1997), which measures traumatic stress responses along three subscales: hyperarousal, intrusion, and avoidance. This self-report questionnaire has demonstrated high internal consistency ( $\alpha = 0.96$ ) (Creamer, Bell, & Failla, 2003), high test-retest reliability ( $\alpha = .89$  to  $.94$ ), and good predictive validity (Weiss & Marmar, 1997). The total score is divided by 22 (number of items) to obtain a mean score. Though the developers did not specify a standard cutoff point (Weiss, 2004), a mean score of 1.5 or higher is generally accepted as indicating significant trauma symptoms (Creamer et al., 2003). Separate subscale scores were not used for the current study. Though not direct measures of grief, these two instruments measure symptoms commonly seen in traumatic bereavement, namely depressive, anxious, and traumatic stress symptoms.

## Procedure

The location of the study is a mental health agency that serves individuals and families who have experienced a traumatic death. Counseling is offered on a sliding scale or ability-to-pay basis. Counseling is delivered vis-à-vis mindfulness-based counseling techniques, as well as narrative and logo therapy. The subjects in the case series differed as to the length of time they remained in treatment. Since this study does not consider outcomes or the effect of therapy, only the use of psychotropic medication, all subjects who completed the intake instruments and were seen by a therapist at least once were included. This includes subjects with a previous psychiatric history so long as medication was newly prescribed following the death. The aim is simply to provide a comprehensive overview of the types of prescribing patterns observed in this sample, including factors that may have influenced these patterns. No attempt is made to gauge the impact of counseling on subjects. The dosage of medications is included when it was reported by the subject or contained in documents obtained from other sources.

Permission to review files was obtained from the participants following institutional review board approval. Consent was obtained from subjects whose information is presented in the case series. All information presented in the series was obtained from the subjects' files at the mental health agency. In some cases, information from outside sources (i.e., hospital, counselor) was included in the chart. Unless otherwise noted, all information included was reported by the subject to his or her therapist and documented in the chart.

## Subjects

The charts of all active subjects who completed intake measures ( $n = 20$ ) were reviewed. "Active subjects" are defined as subjects over the age of 18 years who had been seen within 90 days of data collection. All subjects had experienced a traumatic death and were self-referred for grief-specific counseling. Of these 20, nine charts mentioned the use of psychotropic medication following the loss. None of the prescribing was done at the counseling agency.

Of the nine subjects who had taken medications, six were female and three were male, with a mean age of 39.1 years and a range of 23 to 58 years. Seven subjects experienced the deaths of children, ranging in age from stillbirth to 26 years. One subject experienced unexpected conjugal death, and another experienced the unexpected death of a sibling. Two of nine case study subjects had a previous psychiatric history noted in the chart. One subject was diagnosed in early grade school with attention deficit hyperactivity disorder (ADHD) and had received prior psychiatric treatment for this disorder. The other subject's chart contained hospital records showing a history of postpartum depression.

## RESULTS

The charts of the nine subjects who used psychotropic medications and the 11 subjects who were not taking psychiatric medications were reviewed to determine if there were any noticeable differences in measures or symptoms. The two groups were similar on a number of variables, contained in Table 1. The cases of each of the nine subjects who had taken the medication are summarized in Table 2. The majority of subjects in both groups were female, White, and had lost a child. Both groups had a similar mean age at intake and mean time from the loss to intake at the agency. No one in the unmedicated group had a previous psychiatric history noted in the chart. In both groups, all subjects met both instrument cutoff points for significant depressive, anxious, and trauma symptoms. On average, subjects who took medications had slightly higher scores on both instruments at intake than those who did not take medications, indicating more self-reported distress in this group. The mean score for the medicated group on the IES-R ( $n = 9$ ) was 2.6, while the mean score for the unmedicated group ( $n = 11$ ) was 2.41. The mean score on the HSCL for the medicated group was 2.98, while the mean score for the unmedicated group was 2.33. It is possible that the subjects who received medication had more severe symptoms, that medication somehow led to greater symptom levels, or that there is another explanation. Though this finding is interesting, no inferences can be drawn from it due to the small, nonrandom sample used in this case series. Overall, based on clinical impressions, the two groups of subjects were similar to each other in terms of biopsychosocial symptomatology, such as sleep disruption, hyperarousal, and the expression of painful emotional states.

**TABLE 1** Comparison of Unmedicated and Medicated Subjects.

	Unmedicated ( <i>n</i> = 11)	Medicated ( <i>n</i> = 9)
Mean intake IES-R score	2.41	2.6
Mean intake HSCL score	2.33	2.98
Mean age at intake	40.6	39.1
Gender (%)		
Male	18	33
Female	82	67
Ethnicity (%)		
White	91	78
Hispanic	9	11
Asian	0	11
Average time from death to intake (months)	14.5	14.7
Relationship to deceased (%)		
Parent	82	78
Sibling	0	11
Spouse	18	11
Prior psychiatric history noted in chart (%)	0	22
Met threshold for probable PTSD (IES-R score >1.5) (%)	100	100
Met HSCL threshold for anxiety and depression (HSCL score >1.75)	100	100

This review focuses on the features of subjects who had taken medications. Below is a description of each of the nine subjects who had used psychotropic medications since experiencing a traumatic death (details have been slightly augmented to protect subject anonymity).

### Case 1

This subject, a woman in her mid-50s, is a mother of two who experienced the death of her son in his mid-20s to suicide. Six months prior to his death, her son was diagnosed with depression and prescribed psychotropic medications by his general physician, which she identified as escitalopram and lithium. The subject noticed a slight improvement in his affect for about 1 month, then a gradual decline, including what she described as “blatantly bizarre and erratic” behaviors, which culminated with his suicide. Within 2 weeks of his death, her family physician referred her to a psychiatrist due to her apparent emotional distress. The subject reported that the psychiatrist diagnosed depression and first prescribed escitalopram, which she refused to take, as this was one of the drugs prescribed to her son prior to his suicide. She was then prescribed paroxetine, 25 mg per day. After a brief period of time on this medication, she experienced “a bad reaction,” including thoughts of self-harm, at which time her prescription was changed to trazodone, 150 mg twice a day, and dextroamphetamine/amphetamine, 25 mg once a day. She remained on the medications for several weeks and

**TABLE 2** Description of Subjects on Psychotropic Medications.

Case	Age range	Sex	Relationship to decedent	Time from loss to intake (months)	IES-R score	HSCL score	Time from loss to medication	Brief case description
1	50 s	F	Mother	21	2.77	3.36	2 weeks	Diagnosed with depression and placed on paroxetine 2 weeks after 26-year-old son's suicide. Had adverse reaction, was switched to dextroamphetamine/amphetamine and trazodone. Discontinued medications after several weeks. Is not currently taking any medications.
2	30 s	F	Mother	1	3.68	3.76	7 days	Prescribed sertraline 7 days after 1-year-old died at caregiver's home. Alprazolam was added 3 weeks later. Venlafaxine was given at a later point. Has a past history of postpartum depression and treatment with antidepressants. Hospitalized due to suicidal ideation and diagnosed with mood disorder NOS, PTSD, and bereavement. During hospitalization, was prescribed lithium, valproic acid, haloperidol, quetiapine, mirtazapine, venlafaxine, zolpidem, lorazepam, and clonazepam, as well as benzotropine to control for side effects, in various combinations. Is not currently taking any medications.
3	20 s	F	Mother	3	2.18	3.28	Same day	Experienced stillbirth of first baby at full term. Prescribed lorazepam and sertraline prior to hospital discharge. Would like to discontinue due to being "unable to feel." Status of medications unknown.
4	50 s	F	Mother	18	2.36	2.56	2 months	Was prescribed citalopram 7-8 weeks after her only child was killed in a car accident. Was

5	30 s	M	Father	14	3.09	3.48	Same day	diagnosed with adjustment disorder 5 months after death. Status of medications unknown. Prescribed alprazolam and venlafaxine same day that adolescent child died. Zolpidem added within 6 months. Was diagnosed with polysubstance dependence, MDD, PTSD, and bereavement subsequent to the death. Is not currently taking any medications.
6	20 s	M	Brother	55	2.23	3.4	Within 1 week	Diagnosed with ADHD in grade school and took methylphenidate throughout high school and then discontinued. After sibling's death, he was prescribed paroxetine and clonazepam, and later methylphenidate, triazolam, and bupropion. Is not currently taking any medications.
7	40 s	F	Spouse	16	2.5	2.44	3 weeks	Prescribed quetiapine 3 weeks after spouse died of a sudden illness. Had adverse reaction and was switched to fluoxetine, but reaction recurred and was switched to sertraline for 2 weeks before switching back to quetiapine. Subsequently prescribed mirtazapine, then changed to bupropion and temazepam. Attempted suicide, requiring hospitalization. Is not currently taking any medications.
8	30 s	F	Mother	2	2.05	2.4	Same day	Prescribed clonazepam, fluoxetine, and single dose of lorazepam by obstetrician the day her second child died at full term of traumatic birth injury. Is still taking medications.
9	30 s	M	Father	2	2.5	2.16	3 weeks	Prescribed escitalopram 3 weeks after second child died at full term of traumatic birth injury. Is still taking medications.

“didn’t like the way they were feeling,” so she took herself off both medications. She began counseling at the agency 21 months after her son’s death. Upon intake, her IES-R score was 2.77 and her HSCL score was 3.36.

## Case 2

This subject, a mother of two in her early 30s, experienced the death of her baby at a caregiver’s home. Seven days later, her physician prescribed sertraline, 50 mg. One week later it was increased to 100 mg, and then to 150 mg. Three weeks after that, she was also prescribed alprazolam, .25 mg twice per day, with venlafaxine, 112.5 mg daily, prescribed at a subsequent time. This subject has a history of postpartum depression and past treatment with escitalopram, sertraline, bupropion, and venlafaxine noted in hospital records included in her chart. She had one family and individual crisis intake meeting with the clinician nearly 1 month following her baby’s death, wherein she reported “pacing the house at night” and recurrent nightmares. She failed to make her next appointment the following week and did not return repeated phone calls to the clinician. Two months later, the subject’s psychiatrist called the clinic from an inpatient facility where she had been hospitalized for 3 weeks due to suicidal ideation. During her stay in the inpatient facility, the subject reported repeated visual hallucinations and increasing nightmares.

Hospital records showed the following diagnoses: mood disorder NOS, PTSD, and a V-code for bereavement. There was also a note to “rule out” non-psychotic bipolar disorder in her hospital chart, though the final diagnosis was not specified. She was offered electroconvulsive therapy, which she refused, as she did not want to lose any memories of her child. She was released to the care of the clinic 4 weeks following admission. The subject reported being prescribed the following medications, in various combinations, since her admission to the hospital: lithium, 450 mg in the morning and 900 mg at night; valproic acid, 1,000 mg in the morning and 1,500 mg at night; haloperidol, 1 mg four times per day; quetiapine, 600 mg at night; mirtazapine, 30 mg at night; venlafaxine, 150 mg per day; zolpidem, 10 mg at night; lorazepam, 1 mg every 6 hours; and clonazepam, 1 mg four times per day. In addition, she was taking benztropine, 1 mg twice per day, in order to manage the side effects of the psychotropic medications, as well as medication for health conditions. She began biweekly counseling sessions at the agency and, under medical supervision, weaned herself off medications during the 2 months following the hospital discharge. Upon her initial intake at the clinic, her IES-R score was 3.68, and her HSCL score was 3.76.

## Case 3

This subject is a woman in her early 20s who experienced the death of her first child during birth. She was given lorazepam during labor and birth, which she

says “helped to calm” her because she was “hysterical and screaming and crying a lot.” Prior to her hospital discharge, the obstetrician prescribed 50 mg of sertraline. The subject claimed she wanted to wean herself off the medication because she “can’t feel” when taking it. She began counseling 3 months following the death of her baby. On intake, her IES-R score was 2.18 and her HSCL score was 3.28. This subject only attended two sessions when she relocated out of the area.

#### Case 4

This subject is a woman in her late 50s. Her only child, a teenager, was killed in a car accident. Approximately 7 to 8 weeks later, she was prescribed citalopram, 20 mg, by her physician. Approximately 3 to 4 months after this, the subject was diagnosed with adjustment disorder with mixed anxiety and depressed mood by a counselor. She began counseling at the current agency 13 months later. At intake, her IES-R score was 2.36 and her HSCL score was 2.56. This subject relocated out of the area after attending two counseling sessions and was still taking the medication at termination.

#### Case 5

This subject is a father of four in his late 30s whose adolescent child died suddenly from a brain hemorrhage of unknown etiology. Later that same day, his physician prescribed alprazolam, .5 mg twice per day, and venlafaxine, 75 mg once per day. Within 6 months, the physician added zolpidem, 10 mg once per day. The medications have been adjusted since the death. At the time of data collection, the subject was under the care of a psychiatrist for medication management. Documents obtained from outside sources, and contained in the chart, show diagnoses of polysubstance dependence, recurrent, moderate major depressive disorder, and PTSD, as well as a V-code for bereavement, all given subsequent to his child’s death. At the time of intake, this subject reported he was self-medicating with alcohol. He began intensive counseling 14 months following the death. At intake, his IES-R score was 3.09 and his HSCL score was 3.48. He stopped taking all of his psychotropic medications after 16 sessions while under medical supervision.

#### Case 6

This subject is a man in his early 20s whose sibling died following an accident. The subject was in his late teens at the time of the death. He was diagnosed with ADHD during grade school and prescribed methylphenidate, which he continued to take through high school. He was not taking any psychotropic medications when the death occurred. Within 1 week of the death, the subject was prescribed paroxetine and clonazepam by his general physician. He was

subsequently prescribed methylphenidate, triazolam, and bupropion. At intake, the subject was taking paroxetine and clonazepam as prescribed by a psychiatrist. He began counseling 4.5 years after his sibling's death. At intake, he had been unable to leave his home for nearly a year. His intake IES-R score was 2.23 and his HSCL score was 3.4. Under medical supervision, he began weaning himself off medications after 16 counseling sessions and remains off all medications.

#### Case 7

This subject is a woman in her early 40s whose spouse died traumatically of a sudden-onset illness. The subject was prescribed 12.5 mg of quetiapine by her physician 3 weeks after her husband's death. She experienced an "extreme reaction" to the medication, at which point her prescription was changed to fluoxetine, 5 mg once per day. Again, she experienced a reaction to the drug, and 1 month later her prescription was changed to sertraline, 12.5 mg per day. Two weeks later, she was switched back to quetiapine at 10 mg per day. The next month, she was prescribed mirtazapine, 3.75 mg per day. Five months after her spouse's death, the prescription was changed to bupropion and temazepam. This subject noted she was very sensitive to medications and had only wanted them in small doses. She claimed she "felt significantly more depressed," and later that month she had a serious suicide attempt requiring hospitalization. She discontinued the medications within 2 months of hospital discharge and was not taking any medications at intake 16 months after the death. Her intake IES-R score was 2.5 and her HSCL score was 2.44.

#### Case 8

Cases 8 and 9 represent a married couple who were seen for both individual and couple's grief counseling. Their second child was stillborn at 40-plus weeks gestation and died as a result of a traumatic birth injury. Case 8, the child's mother, is in her late 30s and has one other child, age 2. She was given a single dose of lorazepam and was prescribed clonazepam, 1 mg, and fluoxetine, 20 mg, while in the hospital by her obstetrician, on the same day of the baby's death. Her intake IES-R score, 2 months after the infant's death, was 2.05 and her HSCL score was 2.4. This subject was continuing to take the medication at last contact.

#### Case 9

This subject, in his late 30s, is the husband of the subject presented in Case 8. He was prescribed escitalopram by his general physician, 20 mg once per day, 3 weeks following his baby's death after he reported having difficulty focusing on running his family business. Upon intake at 2 months after the

death, his IES-R score was 2.5 and his HSCL score was 2.16. He was continuing to take the medication at last contact.

## DISCUSSION

This case series sought to investigate the amount, type, and timing of psychotropic medications in a small sample of traumatically bereaved individuals. A review of subject records at the study agency found that nine of 20 individuals (45%) had been prescribed medications in the 2 months following a traumatic death. Three subjects (33%) were given medications the same day as the loss, while two more (22%) were given medications within a week. In these five cases, an antidepressant (most often an SSRI) was given, sometimes in conjunction with a benzodiazepine. In an additional three cases (33.3%), medications were prescribed within 2 to 3 weeks of the loss. In two cases it was an SSRI, and in one case it was an antipsychotic. In a final case (11.1%), medication (an SSRI) was prescribed 8 weeks after the loss. In six cases, the initial prescriber was the subject's physician, in two cases it was the obstetrician, and in one case the prescriber could not be determined.

The most commonly prescribed types of medication initially used were antidepressants and benzodiazepines. Among the five subjects given benzodiazepines, three prescriptions were given the same day as the death, one was given a week after the death, and another was given 3 weeks after the death. Two of the subjects given prescriptions the same day were women who had experienced stillbirth, and the prescribing was done by an obstetrician, which reflects the findings of Gold et al. (2008) that this is a common practice. The third subject who received a prescription for benzodiazepines the day of the loss was male, and the prescriber was his physician. Though it is unlikely that prescribers were attempting to treat specific disorders, it is possible that they used these medications in an attempt to provide some relief from the intense suffering experienced by their patients following a traumatic death. However, research suggests that benzodiazepines are not effective at preventing the development of problems following a trauma (Cooper et al., 2005) and should be used with caution.

The increasing use of multiple psychotropic medications has been of concern to some clinicians and researchers, as many combinations have not been adequately studied to determine safety and efficacy. This case series found that a single medication was initially used with five of nine subjects (in all cases, an antidepressant was prescribed). Two of these subjects had another medication added within a few weeks. Four subjects were initially prescribed two medications, which consisted of a benzodiazepine and an antidepressant. This includes one case in which a single dose of a benzodiazepine was used, along with a prescription for an SSRI (Case 3). Overall, five individuals had medications added after the initial prescription or had their

initial prescription changed. Additional medications prescribed include antidepressants of various classes, benzodiazepines, sedatives, stimulants, lithium, and valproic acid. While the majority of subjects took no more than two medications at one time, three subjects took at least three medications concurrently (Cases 2, 5, and 6).

In addition, Case 2 may raise additional concerns regarding the use of multiple medications. This subject was initially prescribed an SSRI and had a benzodiazepine added 3 weeks later. She was later switched to a different class of antidepressant. Upon discharge from an inpatient unit 3 months after the loss, she indicated that she had taken at least nine psychotropic medications during her 4-week stay at the facility, including two antipsychotics, two antidepressants, two benzodiazepines, and a sedative, as well as lithium and valproic acid. Though it is not clear what specific medication combinations were used, the high number of medications prescribed is noteworthy, and hospital records confirm at least five medications being used concurrently.

This case series noted some apparently off-label prescribing of antipsychotic medication. In one case, an antipsychotic was the first medication prescribed to a subject 3 weeks after the loss (Case 7). This subject indicated that she had not, to her knowledge, ever been diagnosed with a psychotic or bipolar disorder, the only diagnoses for which this class of medication is currently approved. The prescriber's reason for choosing this class of medication is unknown. In another instance (Case 2), antipsychotics were used in conjunction with other medications, including lithium and valproic acid, after an SSRI and benzodiazepine were not effective. This subject reported hallucinations of hearing her deceased child's voice, which may have been the symptom being targeted by the prescriber. However, the subject indicated that her hallucinations worsened upon treatment with antipsychotics in an inpatient facility. Records from the facility, included in the subject's chart, show a diagnosis of mood disorder NOS, PTSD, and a V-code for bereavement. This subject's chart indicated a directive to rule out nonpsychotic bipolar disorder, which may explain the use of some of the medications, though the final diagnosis was not specified. In both cases, additional information may have provided a rationale for the use of psychotropic medications; however, it was not available for this study.

This study did not evaluate outcomes, and thus whether or not subjects benefited from the use of psychotropic medications remains unknown. Some subjects continued to take the medications, which may indicate that they found them to be helpful. However, it is notable that two subjects (Cases 1 and 7) described adverse reactions to medication, and that one of them (Case 7) appeared to link a change in medication to worsening depression, culminating in a suicide attempt. A third subject (Case 3) described a calming effect of a benzodiazepine the day of the loss but reported an inability "to feel" while taking an SSRI and wanted to discontinue the medication. The dosages reported by subjects generally fall within

the typical dose ranges for the medications being used. However, Case 2 reported a higher than usual dose of valproic acid (2,500 mg daily), and Case 7 reported lower than usual doses of quetiapine (10–12.5 mg), fluoxetine (5), and mirtazapine (3.75). While Case 7 reported wanting only very low dosages, the prescriber's reasons for utilizing a high dose of valproic acid in Case 2 are unclear. It is also possible that subjects misreported the dosage of their medications.

Even though significant differences between grief and depression and posttraumatic stress have been documented (Lichtenthal, Cruess, & Prigerson, 2004), the overlap in symptoms makes it difficult to determine the best course of treatment. According to the intake IES-R and HSCL scores, all subjects (in both the medicated and unmedicated cohorts) were potentially eligible for a diagnosis of PTSD and a depressive or anxiety disorder, though the etiology and course of symptoms due to bereavement may be different than for non-bereavement-related symptoms. For example, a recent longitudinal epidemiological study (Mojtabai, 2011) found that individuals who experienced single, brief episodes of bereavement-related depression showed a different symptom profile, fewer comorbid anxiety disorders, and less impairment in role functioning than individuals who had experienced non-bereavement-related single, brief episodes. Additionally, those with bereavement-related depressive episodes had a lower rate of past treatment than those with other types of depression and showed no increased risk of future episodes beyond what is found in the general population.

Another epidemiological survey (Gilman et al., 2012) found that bereavement-related depression, even when severe enough to be diagnosed as MDD in spite of the bereavement exclusion, was associated with less severe psychopathology than MDD unrelated to bereavement. Those with bereavement-excluded MDD, as well as those who qualified for MDD in spite of bereavement, reported fewer previous psychiatric problems, less psychosocial impairment and service utilization, fewer depressive episodes, and a lower rate of subsequent psychiatric disorders over a 3-year period. Though the validity of the bereavement exclusion has been called into question, its planned removal in the DSM-5 (American Psychiatric Association, 2010) may further obscure the differences between bereavement-related and non-bereavement-related symptoms, potentially leading to hasty or inappropriate treatment. Psychotropic medications should be used with care when symptoms occur in the weeks and months following bereavement, as there is not yet any compelling evidence to support their use in this population and little is known about how they may affect the trajectory of grief (Cook et al., 2007; Spiegel, 2010). Even when a diagnosis of a disorder has been made following bereavement, research suggests that medication should be only one component of treatment. For instance, based on a review of more than 500 articles on depression, Malhi et al. (2009) recommended a careful process of evidence-based intervention. First, ensure subject safety and education and

establish a therapeutic relationship. Then conduct a thorough assessment, considering factors that may influence treatment strategy. Finally, in the following order, utilize psychological and psychosocial therapies, pharmacological therapy, a combination of both, and electroconvulsive therapy as a last result.

It is important for clinicians to remember that grief, in and of itself, is not pathological. In addition, research suggests that traumatic death presents a unique set of emotional responses not found in non-traumatic death, including separation distress and prolonged pining (Raphael & Martinek, 1997). The deaths of children, and other untimely and sudden deaths, have been recognized as an especially traumatic form of loss, to be particularly intense, and to evoke a wider range of reactions than other types of loss (Rando, 1985). In such cases, expressions of grief, even if they appear somewhat extreme, may represent a normal reaction to an especially devastating event. For individuals who have experienced traumatic bereavement, it may be unrealistic to expect a resolution of symptoms of grief or of active mourning processes within the 2-month time period allowed by the DSM-IV before MDD can be diagnosed or within the 1-month period before PTSD can be diagnosed.

### Limitations

This is a small case series at one clinic that treats the traumatically bereaved. All information in this study was obtained from subject files at one point in time, so additional information regarding medication use and outcomes is not available. Two subjects discontinued counseling at the agency, due to relocation, shortly after intake, so information on their medication usage is limited. Additionally, two subjects had a prior psychiatric history, which may have affected a provider's decision to prescribe medication following traumatic loss. The subjects in this case series differed from one another in many ways, including the length of time since the loss to intake at the agency, relationship to the deceased, circumstances of the loss, and previous psychiatric history. No attempt was made to gauge the impact of therapy or to distinguish the effects of therapy from the effects of medications. The aim was simply to provide a description of the prescribing patterns seen in this sample and compare them to the relevant literature. Case series are descriptive only, are vulnerable to many limitations such as bias and the absence of a control group, and are not representative of the general population. No causal inferences can be drawn from the case series. Nevertheless, the observations noted in this study may be useful in the design and implementation of future studies with this population and others.

### Clinical Implications

It is often difficult for clinicians to distinguish between normal and pathological bereavement trajectories and reactive and endogenous sadness,

particularly in the aftermath of traumatic death, as there is often an overlap in symptoms. More research is needed in this area to ensure that clinicians do not inadvertently utilize unnecessary or even harmful treatments. Due to the lack of evidence to support their use, medications should be dispensed judiciously following traumatic death. Medications may be indicated, possibly in conjunction with an empirically supported psychosocial intervention, if psychopathology can be clearly established or if a client specifically requests medications. In that case, there should be informed consent regarding the potential risks and benefits. Determining a “normal” period of grief in the aftermath of a traumatic loss, such as the death of a child, is not an easy task. When medications are indicated, prescribers should follow current evidence-based practices (Raphael, Minkov, & Dobson, 2001) and choose interventions that pose minimal risk and the greatest potential benefit to the subject. However, given the lack of efficacy and the concerns raised by pharmacological treatments, psychosocial interventions may currently be the safest treatment options following traumatic bereavement, especially when there is no evidence of prior or concurrent psychopathology.

## Conclusion

Overall, the number of empirically based randomized controlled trials conducted with traumatically bereaved individuals is severely limited, and no medication has yet demonstrated efficacy for treating grief. In this case series, medications were found to be frequently used as a first course of treatment following traumatic bereavement. They were often prescribed very early in bereavement, sometimes on the same day as the death. There appears to be little evidence to support this practice, as it is difficult to assess a trajectory of pathology so quickly after a traumatic loss. The elimination of the bereavement exclusion in the DSM-5 may lead to an increase in the trend of prescribing medication for symptoms of grief. This case series noted the apparent off-label use of antipsychotic medications to treat grief-related symptoms. Though this was only documented in two subjects, it is worthy of further investigation to determine how common a practice this is in the general population as well as to determine the risks and benefits. Also of note is the finding that three of the nine subjects taking medication described an adverse reaction, raising additional concerns about the safety and efficacy of medication early in bereavement.

This case series utilized a small sample, and more research should be conducted on this population to determine if the trends in the use of psychotropic medication noted here are representative of the traumatically bereaved. It is concerning that 45% of active agency clients were prescribed psychotropic medications, often very soon after the death, despite the lack of evidence to support medicating normal or complicated grief (Cook et al.,

2007). Only two subjects had a psychiatric diagnosis noted in their charts that predated the deaths. Because psychopharmacological means, to this point, have not demonstrated efficacy in treating bereavement, some of the prescribing patterns noted in this case series may not reflect evidence-based practice. A lack of practice guidelines for working with this population may contribute to these patterns. The findings of this case series highlight the need to develop effective bereavement interventions that are evidence based in both medicine and mental health practice.

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