The grieving adult and the general practitioner: a literature review in two parts (part 2)

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use time since loss as a marker. However, views vary regarding the most appropriate duration, from two months, two to six months, to over 12 months. Equally, others have begun to use specific symptoms as discriminators; for example, negative perceptions of self, functional impairment, profound depression, suicidal ideation, and pervasive feelings of worthlessness. Once again, a general agreement remains elusive.

Different authors have described specific bereavement reactions that fall outside psychiatric classification, and suggest they constitute new syndromes. This has resulted in a confusing mix of definitions. To simplify this topic, this review will take advantage of Middleton’s paper where experts in the field were surveyed for their understanding of various bereavement disorders. Those syndromes that reached some international consensus will be described here (Table 1). Three texts are used to illustrate descriptive terms for these syndromes.

The debate as to what constitutes pathological bereavement has exercised theorists for some time, and the evolving paradigm of abnormal bereavement will continue to include definitions with overlapping characteristics. However, today’s practitioner can use these descriptions clinically to broaden understanding of bereavement, thus allowing them to identify and assist those with disabling reactions.

### Risk factors

Given the adverse consequences of bereavement summarized in this review, it becomes clinically attractive to consider those risk factors that may predict poor bereavement outcome, giving the prospect of preventive care. Studies exploring the epidemiology of bereavement are limited by considerable methodological difficulties as described in part 1 of this review (July 1997, pp 443-448). It is particularly relevant to consider how different studies define each risk factor and which outcomes are applied. Any attempt to amalgamate findings to produce an accurate summary of important risk factors is fraught with such difficulties and consequently is open to potential bias. In spite of this criticism, there is some evidence that interventions that use this research by performing routine risk assessment to target care have some advantages.

To the practising GP, such assessments may seem intuitive and possibly unnecessary. Yet, in less familiar cases, an awareness of this literature may prompt the practising GP to initiate appropriate care. Considering the above reservations and the extent of the literature, this review will only give a summary of the common

<table>
<thead>
<tr>
<th>Table 1. Examples of bereavement disorders.</th>
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<tbody>
<tr>
<td><strong>Reaction</strong></td>
</tr>
<tr>
<td>Absent</td>
</tr>
<tr>
<td>Delayed</td>
</tr>
<tr>
<td>Chronic</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Table 2. Factors associated with bereavement outcomes.</th>
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</thead>
<tbody>
<tr>
<td><strong>Factor considered</strong></td>
</tr>
<tr>
<td>Individual factors</td>
</tr>
<tr>
<td>Poor general health</td>
</tr>
<tr>
<td>Past history of mental illness</td>
</tr>
<tr>
<td>‘Adverse’ personality types</td>
</tr>
<tr>
<td>‘Protective’ personality types</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Relationship with deceased</td>
</tr>
<tr>
<td>Shorter marriage</td>
</tr>
<tr>
<td>Circumstances at death</td>
</tr>
<tr>
<td>Sudden death</td>
</tr>
<tr>
<td>Death at home</td>
</tr>
<tr>
<td>Multiple loss</td>
</tr>
<tr>
<td>Stigmatized deaths</td>
</tr>
<tr>
<td>Circumstances after death</td>
</tr>
<tr>
<td>Poor social support</td>
</tr>
<tr>
<td>Few relationships</td>
</tr>
<tr>
<td>‘Adverse’ coping strategies</td>
</tr>
<tr>
<td>Economic difficulties</td>
</tr>
<tr>
<td>Low socio-economic status</td>
</tr>
</tbody>
</table>

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themes explored by the research, while also illustrating the controversy that exists (Table 2).

**Interventions in bereavement**

Give sorrow words: the grief that does not speak
Whispers the o’er fraught heart, and bids it break.29

The professional and human response to research confirming the suffering of grief is to provide assistance by developing patterns of care. GPs are no different in this respect and the content of this support will be described later. This section of the review will highlight the literature on bereavement interventions that may be applicable to general practice. Central to this discussion will be a systematic review of trials of bereavement services, thus emphasizing the need for evidence when planning care.

**Bereavement counselling and therapy**

This review is unable to equip the reader with the skills necessary for bereavement support, given the practical nature of this work. Consequently, it will only give a flavour of the extensive literature on this subject.

Some of the basic communication skills will be familiar to GPs and have been adopted in medical training (e.g. active listening, reflecting, empathy, setting limits, clarification30). Specialist authors have gone further and formulated approaches that provide greater guidance on helping the bereaved, either as general principles31-35 or for use in particular situations.36,37 Generally, these have been based on the concept of grief work,17 of which Worden’s book has been the most influential.31 Given the dominance of Worden’s text and the confines of this review, the remaining literature will not be discussed here. He suggests that it is useful to separate counselling (helping people facilitate normal grief) from therapy (specialist techniques that help people with abnormal grief). Worden also proposes that if resolution is to be achieved, then the bereaved has to pass through the four ‘tasks of mourning’:

- To accept the reality of loss
- To work through the pain of grief
- To adjust to the environment in which the deceased is missing
- To emotionally relocate the deceased and move on with life.

**Table 3.** Controlled trials of bereavement interventions.

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Country</th>
<th>Intervention</th>
<th>Benefit</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raphael26</td>
<td>1977</td>
<td>Australia</td>
<td>One-to-one therapy by psychiatrist</td>
<td>Yes</td>
<td>P&lt;0.02</td>
</tr>
<tr>
<td>Polak93</td>
<td>1975</td>
<td>US</td>
<td>Intensive crisis intervention</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Williams94</td>
<td>1979</td>
<td>Holland</td>
<td>Trauma desensitization, hypnosis, psychodynamic therapy</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Kleber95</td>
<td>1987</td>
<td>US</td>
<td>Therapist led groups</td>
<td>Yes</td>
<td>Only for certain outcomes</td>
</tr>
<tr>
<td>Barret96</td>
<td>1978</td>
<td>US</td>
<td>Therapist led groups</td>
<td>Yes</td>
<td>Only for certain outcomes</td>
</tr>
<tr>
<td>Vachon27</td>
<td>1980</td>
<td>US</td>
<td>Volunteer led groups</td>
<td>Yes</td>
<td>Only for certain outcomes</td>
</tr>
<tr>
<td>Constantino98</td>
<td>1981</td>
<td>US</td>
<td>Therapist led groups</td>
<td>Yes</td>
<td>Small numbers and only for certain outcomes</td>
</tr>
<tr>
<td>Wallis99</td>
<td>1985</td>
<td>US</td>
<td>Therapist led groups of different types</td>
<td>Yes</td>
<td>Only for certain outcomes</td>
</tr>
<tr>
<td>Liberman100</td>
<td>1986</td>
<td>US</td>
<td>Volunteer led groups</td>
<td>No</td>
<td>Design bias</td>
</tr>
<tr>
<td>Sabatini101</td>
<td>1988/9</td>
<td>US</td>
<td>Therapist led groups</td>
<td>No</td>
<td>Small numbers</td>
</tr>
<tr>
<td>Liberman102</td>
<td>1992</td>
<td>US</td>
<td>Therapist led groups</td>
<td>Yes</td>
<td>Only for certain outcomes</td>
</tr>
<tr>
<td>Levy103</td>
<td>1993</td>
<td>US</td>
<td>Volunteer led groups</td>
<td>Yes</td>
<td>Small numbers and for only certain outcomes</td>
</tr>
<tr>
<td>McCallum104</td>
<td>1993</td>
<td>US</td>
<td>Therapist led group</td>
<td>No</td>
<td>Uncertain outcome measures and small numbers</td>
</tr>
<tr>
<td>Caserta105</td>
<td>1993</td>
<td>US</td>
<td>Volunteer led groups</td>
<td>No</td>
<td>Confounding variables poorly accounted for</td>
</tr>
<tr>
<td>Tudvier106</td>
<td>1995</td>
<td>Canada</td>
<td>Volunteer led group</td>
<td>Yes</td>
<td>Doctor contacts are sole outcome</td>
</tr>
</tbody>
</table>

**Trained volunteer counselling**

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Country</th>
<th>Intervention</th>
<th>Benefit</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkes27</td>
<td>1981</td>
<td>UK</td>
<td>Hospice style service</td>
<td>Yes</td>
<td>For ‘at risk’ groups</td>
</tr>
<tr>
<td>Cameron107</td>
<td>1983</td>
<td>Canada</td>
<td>Hospice style services</td>
<td>Yes</td>
<td>Small numbers</td>
</tr>
<tr>
<td>Reich108</td>
<td>1989</td>
<td>US</td>
<td>1. Education program. 2. Social interview</td>
<td>No</td>
<td>Small numbers</td>
</tr>
<tr>
<td>Relf*</td>
<td>1993</td>
<td>UK</td>
<td>Hospice style service</td>
<td>Yes</td>
<td>For ‘at risk’ groups</td>
</tr>
<tr>
<td>Carr*</td>
<td>1996</td>
<td>UK</td>
<td>Counselling service from oncology unit</td>
<td>Yes</td>
<td>But recognized significant confounding</td>
</tr>
</tbody>
</table>


**Table 4.** Contacts between GP and bereaved within five to seven months.

<table>
<thead>
<tr>
<th>Number of contacts</th>
<th>All consultations</th>
<th>Home visits</th>
<th>Contact with own GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>24%</td>
<td>67%</td>
<td>34%</td>
</tr>
<tr>
<td>1</td>
<td>25%</td>
<td>17%</td>
<td>24%</td>
</tr>
<tr>
<td>2–4</td>
<td>37%</td>
<td>13%</td>
<td>31%</td>
</tr>
<tr>
<td>5–9</td>
<td>9%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>10+</td>
<td>5%</td>
<td>1%</td>
<td>4%</td>
</tr>
</tbody>
</table>
This model has recently been criticized for not allowing denial, for lacking evidence of effectiveness, and for its inconsistencies with cross-cultural or historical perspectives. While this theoretical controversy continues, GPs may find some of Worden’s suggestions helpful.

Suggested interventions for general practice

There have been several calls for GPs to become more involved in bereavement care. General recommendations include raising general awareness, training the primary health care team, and the use of audit and protocol development to improve care. In addition there have been specific suggestions as to what form this care might take, and these are listed below. The reader must view them in the knowledge that they are not supported by published controlled evaluations, although some have empirical appeal.

- Efficient means of notifying practice team of death
- Routinely record death in the bereaved’s notes
- Letter of condolence
- Written information about grief and the services available
- Practical advice
- A bereavement visit soon after death
- The use of risk assessment in planning care
- A follow up visit at 6–10 weeks
- Links with other bereavement services
- Professional bereavement counselling within practices
- Psychologist-led group bereavement therapy within practices

Systematic review of controlled trials of bereavement interventions

Introduction. Given the growing interest in bereavement care by health professionals, it is important to be aware of the research evidence that supports interventions.

Method. English language articles were retrieved from the following computer databases: Medline (1991–1996), Cinnhal (1986–1996), Psychlit (1974–1996), and the Palliative Care Index (1992–1995). In addition, relevant cited articles were collected from the above literature and previous reviews. In order to further widen the search, the 14 members of the Bereavement Research Forum (an interest group with membership in the UK and Ireland) with an expressed interest in evaluation were approached to provide additional material. Only adequately controlled trials were included. Both authors read the material independently, recording their qualitative interpretation according to pre-determined criteria. These findings were amalgamated and mutually agreed.

Results. Twenty-one studies were retrieved that satisfied the inclusion criteria; they are presented in Table 3. A copy of a study by Gerber et al could not be reviewed, despite help from the British Library.

Conclusions. Difficulties in generalizability make a general practice interpretation of these studies problematic. This is compounded by the methodological concerns of selection bias of subjects and relevant outcome measures. However, it is important to realize the inherent hurdles in this type of research and the need to consider the evidence available, however limited. In summary, this review provides tentative support for some bereavement interventions.

The bereaved in general practice

General practitioners have traditionally involved themselves in caring for their bereaved patients. This section will review the studies that have attempted to measure this activity and those that have sought the patient’s opinion of this care. Central to this discussion is the work of Cartwright, completed in 1979. In this study, structured interviews were conducted using a representative sample of 361 widows and widowers (74% response rate). In 97% of cases, subjects consented to allow their GP to be sent a questionnaire covering aspects of bereavement care (this questionnaire had a 61% response rate). The number of contacts with the GP is shown in Table 4.

Of the single-practice studies, Gunnell’s review of the medical notes of 31 recently bereaved patients revealed that in only nine cases was there any record of the bereavement. Daniel’s study showed that, although most patients (14/18) were offered some contact with the GP, only seven accepted it. Brown showed that, of the 95 deaths within his practice in one year, 45 had an identifiable survivor and that the practice was aware of their progress in 37 cases. Blyth’s audit of terminal care over one year concluded that all bereaved patients were visited at least once. These studies are limited by their small size, lack of generalizability, and inability to account for those bereaved who were registered outside the same practice. In Relf’s evaluation of a bereavement service, almost half of the control group had seen their GP more than eight times in the 13 months following their loss.

But what of the content of this contact? Cartwright revealed that psychotropic medicine was prescribed in 77% of cases where the GP made contact prior to the funeral. A small audit of referrals to a psychiatric bereavement clinic (12 cases) concluded that only one had received practice-based counselling and that only two were felt to need specialist services. The conclusion that some GPs need to increase their awareness should be tempered by the fact that this study cannot comment on the many cases that are not referred. A qualitative exploration of patient’s views of GP support revealed that 11 out of 15 were satisfied with this care (Pearce V. Personal communication, 1996).

There has been additional work exploring patients’ bereavement needs, but the literature on this subject is conflicting. Cartwright revealed that only 13.5% of patients who had not received a visit would have preferred one. Conversely, 23 out of the 34 in Blyth’s sample felt that bereavement counselling from the GP was not necessary. These results are contradicted by Daniel’s, who showed that 16 out of 18 would have liked an acknowledgement from the GP, and that 10 out of 18 would have liked a visit. Gunnell’s small study concurs with this view, with 8 out of 10 believing that the GP should visit. The reader must remain aware of the small size of these studies and the recognized difficulties in retrieving critical assessments of GP practice from patients.

Conclusions

The second part of this literature review has illustrated the controversial subject of abnormal bereavement and highlighted factors that put patients at particular risk of an adverse response. In addition, a critical analysis of possible bereavement interventions has been presented from a GP perspective. Finally, an assessment of existing GP bereavement practice has revealed inconsistencies.

The future direction of GP bereavement care will be influenced by public and professional opinion. This consideration needs to balance the empirical desire to develop care and ethical concerns that surround the medicalization of what could be seen as a social condition. Research evaluating developments and
identifying needs will inform this debate.

Summary

- Research needs to continue to clarify the difference between normal and abnormal bereavement in a way that helps clinicians.
- Extensive research has been performed into risk factors which, although difficult to amalgamate, may be of value when used to plan care.
- Bereavement care will seem intuitive to some GPs, but more advanced methods have been suggested.
- Controlled trials of bereavement care are difficult to perform well but should be attempted before a service is adopted in general practice.
- GPs have been traditionally involved in caring for the bereaved although the exact nature of this care seems to vary.
- The important question of whether GPs should become more formally involved in bereavement care needs research that canvases opinion from patients and professionals, and also evidence confirming patient benefit for any GP-based service.

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