A study of bereavement in general practice

B. LEVY, M.R.C.G.P.
General practitioner, Glasgow

A. BALFOUR SCLARE, F.R.C.P. (Glas. & Edin.) F.R.C.Psych., D.P.M.
Consultant Psychiatrist, Royal Infirmary and Duke Street Hospital, Glasgow
Honorary Clinical Lecturer in Psychological Medicine, University of Glasgow

SUMMARY. Forty six bereaved relatives were assessed by a general practitioner four to eight weeks after the bereavement. In 36 (78·3 per cent) the immediate reaction to bereavement was one of numbness or stupefaction; in seven (15·2 per cent) emotional relief occurred; and in three cases (6·5 per cent) there was no obvious immediate reaction. The numbness reaction was limited in duration to a week or less in 31 of the 36 instances.

At four to eight weeks after bereavement 29 (63·0 per cent) of the subjects continued to experience difficulty in coming to terms with their loss. Twenty subjects reported guilt feelings and a similar number expressed aggressive reactions. The bereaved subjects tended to increase their consumption of cigarettes and alcohol, while their appetite and weight tended to be reduced. Thirty six (78·3 per cent) of the subjects reported physical symptoms, notably headache, dizziness, generalised aches, and abdominal complaints.

The most prominent psychological features of bereavement were found to be: preoccupation with thoughts of the deceased, idealisation of the lost person, depressive mood, and loneliness.

The findings are discussed and reference made to the role of the family doctor in the management of bereavement reactions.

Introduction

This paper is a sequel to our previous investigation of patterns of fatal illness in general practice (Levy and Sclare, 1976) and this account centres upon the reactions to bereavement among the survivors of the deceased patients previously described.

There exists an extensive medical literature on the subject of bereavement. Pioneer contributions from the psychoanalytic standpoint were made by Abraham (1912) and Freud (1917). Thereafter there was little medical interest in the topic until the contribution of Lindemann (1944) who, on investigating the survivors of the Coconut Grove fire, was able to delineate the bereavement process as a clear-cut " syndrome ". Marris (1958) described the specific problems of widowhood; the majority of the widows studied were still distressed a year after their loss. Parkes (1964, 1965, 1973) has further charted the nature and course of bereavement, including its occasional relationship to mental illness. Lifton (1963) has described the special problems experienced by the survivors of the atomic bomb at Hiroshima in 1945, e.g. the interminable encounter with death arising from delayed radiation effects upon the population.

Our study used an epidemiological approach within the setting of a general practice. The bereaved persons were visited on the initiative of the family doctor rather than as a result of their complaint behaviour.

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Aim

The objective was to gain information about patterns of bereavement in an unselected population.

Method

The nature of the practice has been previously described (Levy and Sclare, 1976). It is in an underprivileged, working-class district of Glasgow. During the year of investigation the practice comprised 5,897 patients; 58 deaths occurred during the 12-month period.

Of the 58 dead, 26 did not have available or accessible relatives as 13 had lived alone and in another 13 cases the relatives were not on the practice list. The remainder of 32 deceased patients had a total of 46 relatives who had lived with them and who were on the practice list. In 21 families one bereaved individual was interviewed (21 people); in ten families two bereaved people were interviewed (20 people); and in one family five bereaved people were seen (five people).

Among the 46 people seen the relationship with the deceased was as follows: daughter, 14; wife, ten; husband, seven; mother, five; son, five; father, one; brother, one; son-in-law, one; female cousin, one; grandson, one. There were 16 male and 30 female subjects. Relatives under 16 years of age were excluded from the study.

The age range of the subjects was 16–84 years, the age distribution being as follows:

TABLE 1
AGE DISTRIBUTION OF BEREAVED SUBJECTS

Age	16–19	20–29	30–39	40–49	50–59	60–69	70–79	80–89
Number	5	9	5	13	5	4	4	1

Their religious affiliation was as follows: Protestant, 28; Roman Catholic, 17; Jewish, 1.

Their social class distribution is shown in table 2:

TABLE 2
SOCIAL CLASS DISTRIBUTION

Social class	*Number*
1	— (*0·0%*)
2	1 (*2·2%*)
3	13 (*28·3%*)
4	18 (*39·1%*)
5	14 (*30·4%*)
	Totals 46 (*100·0%*)

Each relative took part in a semi-structured interview at home or in the consulting room, whichever was more convenient, by the family doctor four to eight weeks after the bereavement. The data were recorded on a proforma and included: demographic information about the relative; awareness of and reaction to the terminal illness of the deceased; physical or psychological complaints; reaction to viewing the body of the deceased; personal and social adjustment after the bereavement. In order to obtain the required information, it was necessary in most instances to conduct multiple interviews rather than a single interview with the relative.

The data were tested statistically by means of the chi squared test and the difference between percentages.

Results

The relatives' awareness or otherwise of the terminal nature of the deceased's illness was considered first. In 23 instances the survivors claimed to have been unaware of the impending death, the loss having occurred unexpectedly. Of the remaining 23 bereaved subjects, 18 had been given information about the terminal nature of the deceased's illness, while five stated that they had not been so informed. In the five cases there had been either a failure of communication or a substantial denial factor.

Data about actual deaths were considered next. Of the 32 deceased individuals, 18 were buried and 14 were cremated. Of the 46 survivors, 21 (45·6 per cent) were present at, and 25 (54·4 per cent) absent from, the death itself. 36 (78·3 per cent) survivors saw the body of the deceased and three of them regretted having done so. Of the ten (21·7 per cent) survivors who did not view the body, three regretted not having done so.

Enquiry about the survivors' immediate reaction to the bereavement provided the following information:

TABLE 3
IMMEDIATE REACTION TO BEREAVEMENT

Reaction	*Number*	*Male*	*Female*
" Numbness "	36 (*78·3%*)	12	24
Relief	7 (*15·2%*)	3	4
Nil	3 (*6·5%*)	1	2

The reaction of " numbness " was of variable duration as shown in table 4:

TABLE 4
REACTION OF NUMBNESS (N = 36)

Duration	*Male*	*Female*	*Number*
Less than 24 hours	4	1	5 (*13·9%*)
1–3 days	3	14	17 (*47·2%*)
4–7 days	5	4	9 (*25·0%*)
More than 7 days	0	5	5 (*13·9%*)

Reactions of numbness or stupefaction in most cases continued until after the funeral. All five cases in whom numbness lasted longer than a week were female relatives of people who died suddenly.

In all seven instances a reaction of relief on bereavement was associated with a lingering and distressing illness of the deceased—four cases of malignant neoplasm, two of respiratory disease, and one of cardiac disease. When the death occurred suddenly, the immediate reaction on the survivor's part was most likely to be one of numbness than relief (T = 2·15).

Lack of immediate reaction to the bereavement occurred in three relatives, one of whom was a mental defective and another an 84 year-old woman; in a further case there was no obvious explanation.

Subsequent attitudes towards the bereavement, as disclosed at interview four to eight weeks following the death, are now considered. Table 5 summarises information as to whether emotional acceptance of the death was partial or complete at this stage.

TABLE 5
EMOTIONAL ACCEPTANCE OF DEATH AT 4–8 WEEKS

	Male	*Female*	*Total*
Incomplete acceptance	10	19	29 (*63·0%*)
Complete acceptance	6	11	17 (*37·0%*)

As to the degree of acceptance of the loss in their lives, there was no significant difference in attitude between the male and female relatives. Where the deceased was under one year of age (three cases), the mother had completely accepted the death within four to eight weeks. Incomplete acceptance of the death occurred oftener (T = 2·3) when the deceased had been buried rather than cremated.

Feelings of guilt

Of the 46 subjects, 20 (six male, 14 female) expressed a sense of guilt in association with their loss. In 11 instances the guilt reaction arose from a sense of having caused inconvenience or distress to the deceased in a variety of ways; in four cases, from a sense of having failed to take more active steps to save the life of the deceased; in another four cases, through allowing the deceased to die in hospital and in one case, from her insistence that the deceased should travel on a train which was implicated in the fatal collision.

Feelings of hostility

Twenty (six male, 14 female) of the subjects expressed hostility towards a variety of individuals. Some directed their anger towards multiple targets; 16 subjects expressed resentment towards their relatives; six towards the deceased; and two towards ministers of religion owing to their allegedly indifferent attitude.

Complaints about medical attention to the deceased

Fourteen (five male, nine female) of the 46 relatives made complaints about various aspects of the professional attention to their deceased relative. Six were critical of the hospital, e.g. for alleged delay in diagnosis, and four found fault with their general practitioners, again mainly on the grounds of tardy diagnosis. Two were critical of the ambulance service, one complained of a generally-poor standard of medical attention and one criticised a nursing orderly.

Smoking

Table 6 summarises the smoking behaviour of the respondents at the time of the interview.

TABLE 6
SMOKING BEHAVIOUR OF BEREAVED

	Male	*Female*	*Total*
Non-smokers	8	14	22
Smoked more	5	13	18
Smoked same	3	3	6
Smoked less	0	0	0

Thus of the 24 smokers, 18 (75 per cent) stated that they smoked more after the bereavement.

Alcohol

The respondents were asked about their consumption of alcohol (table 7).

TABLE 7
ALCOHOL INTAKE OF BEREAVED

	Male	*Female*	*Total*
Abstainers	0	11	11
Drank more	6	4	10
Drank same	9	13	22
Drank less	1	2	3

Thus of the 35 alcohol drinkers, 10 (28·6 per cent) admitted that their drinking was still increased four to eight weeks after the bereavement.

Appetite and weight loss

At the four to eight week assessment, two of the relatives reported increased appetite, 14 diminished appetite and 30 no change in appetite. Two reported a weight gain, 17 weight loss and 27 no change. Thus reduced appetite and weight constituted the principal pattern of change.

Physical health

General and specific questions about their physical health after bereavement were put to the relatives. Four of the subjects reported an improvement in their general health, 15 a deterioration, and 27 no change.

On specific questioning, it emerged that 36 of the 46 relatives reported physical complaints in association with their bereavement. Some voiced more than one complaint. 20 subjects complained of headache which in five cases was migrainous in type. Other complaints included: dizziness, 15 subjects; generalised aches, 12; diffuse abdominal discomfort, six; palpitations, six; undue frequency of micturition, five; diarrhoea, two; and constipation, two. Females were more likely than males to make such complaints ($p<0 \cdot 01$).

Social features

Of the 46, 12 (26 per cent) were living alone after the bereavement; 29 stated that their social contacts were unchanged, 16 increased, and one diminished. Nineteen (41·3 per cent) had not talked of the deceased with anyone since the funeral, while 27 (58·7 per cent) had done so.

Only 12 (26·1 per cent) of the respondents (seven of them having been churchgoers) had been visited by a minister, while 34 (73·9 per cent) (eight having been churchgoers) had not been so visited at home since the funeral.

Psychological features

The psychological profile of the 46 subjects at the time of interview is summarised in table 8.

Pre-occupation with thoughts of the deceased person was the outstanding feature, occurring in 93·5 per cent of the bereaved and entailing a more or less obsessive absorption with their lost relative. Closely associated with this feature was the idealisation of the deceased which occurred in 82·6 per cent of the survivors; despite having had an unhappy married life, several surviving spouses portrayed the deceased as faultless; memories of the negative aspects of the deceased appeared to be repressed.

TABLE 8
PSYCHOLOGICAL FEATURES 4–8 WEEKS AFTER BEREAVEMENT

	Male	*Female*	*Total*
Pre-occupation with thoughts of deceased	14	29	43
Idealisation of deceased	14	24	38
Depressed mood	12	25	37
Loneliness	11	19	30
Sleep disturbance	9	20	29
Tearfulness	7	20	27
Irritability	8	19	27
Restlessness	8	16	24
Illusions of deceased	6	16	22
Loss of interest	6	16	22
Impaired concentration	3	16	19
Dreams about the deceased	4	9	13
Anxiety attacks	1	9	10
Fear of illness	3	4	7
Fear of insanity	2	2	4
Suicidal ruminations	0	2	2

A depressive mood was noted in 37 (80·4 per cent) of the respondents; in 13 of the 37 cases, the depression could be described as severe.

A sense of loneliness was significantly more frequent in patients over the age of 65, being reported by all of the eight respondents over 65, while 22 of the 38 patients under 65 complained of loneliness ($p<0{\cdot}01$). Similarly, seven of the eight patients over 65 reported illusions of the deceased, while 15 of those under 65 mentioned this experience ($p<0{\cdot}01$).

Sleeplessness was varied in its pattern. Ten complained of initial insomnia; 13 of middle insomnia; five of both initial and middle insomnia; and one of late insomnia.

It proved possible to interview 39 of the patients 12 months after their bereavement. Eight of them remained in a state of severe grief.

Discussion

In this study the reactions of 46 bereaved individuals were assessed by the general practitioner employing a semi-structured interview four to eight weeks after occurrence of the death. Over three quarters of the relatives reported that their immediate response to bereavement had been one of stupefaction or numbness. This reaction lasted less than seven days in most of the subjects. Visitors to the bereaved at an early stage may misinterpret the reaction of numbness as a state of wellbeing. Persistence of numbness for more than a week after the death was associated with sudden deaths, a finding similar to that of Parkes (1970).

When emotional relief was the predominant response to bereavement (15 per cent of cases), this was not surprisingly associated with chronic stress resulting from a lengthy or painful illness endured by the deceased. Probably these individuals had undergone a process of anticipatory grief long before the actual loss occurred. Obvious relief must not be assumed to be evidence of callousness in a bereaved person.

At four to eight weeks after the death, almost two thirds of the subjects were still experiencing difficulty in accepting and coping with the reality of the loss. Such incomplete acceptance of the loss was presumably related to the painful process of acquiring a new identity after bereavement (Parkes, 1972). Delayed acceptance is not, however, necessarily a sign of severe grief. A sense of guilt, present in almost half the subjects, was associated with the problem of accepting the loss.

Relatives, in cases of sudden death, were understandably anxious to find out the exact mode of death. Did the patient suffer or was death instantaneous? Or, where the relatives had been assured that the patient in hospital was making good progress and then had died suddenly, what actually had happened? In this series there were two cases of sudden death where the relatives had to wait several months before they could obtain information. In one, death had occurred in a train accident and the relatives had to wait until the pubic inquiry before they found out that the death was instantaneous. In the other case the patient died of drowning (was it suicide? was it an accident?). It was only after months of inquiry and the employment of a lawyer that the required information was obtained. Bereaved individuals can come to terms with their loss only when they have a factual basis concerning medical details of the death.

As for seeing the body of the deceased, it was found that in most of the bereaved relatives this proved an acceptable procedure. Nevertheless, medical advice in individual cases on this point must take into account, on the one hand, the subject's possible reaction of horror and, on the other hand, his need for a final farewell. Reactions of horror are more likely to occur when the body is substantially altered or mutilated.

Complaints about alleged shortcomings of the medical profession and reactions of hostility were common among the beareaved. Parkes (1972) observed that the hostility component was characteristic of the early weeks of bereavement. This feature has implications in management. Anger should be regarded by the medical practitioner or minister of religion as being within normal limits.

The bereaved persons tended to smoke and drink alcohol and to experience impaired appetite and weight loss. Similar findings for the use of cigarettes and alcohol were reported by Parkes and Brown (1972) in their study of young Boston widows, and doubtless nicotine and alcohol are best understood as self-prescribed tranquillisers to alleviate the distress of grief. Anorexia is probably symptomatic of the general withdrawal of interest during bereavement.

Over three quarters of the patients complained of physical symptoms—chiefly headache, dizziness, and generalised aches. Such physical complaints may provide the only means by which the medical practitioner makes contact with a bereaved individual. Symptomatic therapy is of limited value and the doctor does well to explore the emotional state behind the symptom. The predominance of females reporting " physical " symptoms in bereavement recalls the female preponderance in respect of psychiatric morbidity in general practice (Shepherd *et al.*, 1966) and in student populations (Manderson and Sclare, 1973). It would appear that complaint behaviour in the female has a lower threshold than in the male.

Just over a quarter of the subjects were visited by a minister after the bereavement. Such visits were understandably more likely to occur when the bereaved had been regular churchgoers. On the other hand, eight regular churchgoers did not receive a pastoral visit by the minister. In general, there seems to be room for increased pastoral support for the bereaved even in the present freethinking era. It is worth bearing in mind that for many individuals today their only contact with the church is at the funeral.

Of the psychological features of bereavement the most prominent were: pre-occupation with thoughts of the deceased, idealisation of the lost person, and a mood of depression. These phenomena are, of course, within the normal range of experience and arise as a result of the psychological " wound " caused by death. Such features remind us that the animal mode of human grief comprises pining for a lost mate, a process in which the surviving animal searches fruitlessly for the deceased mate (Lorenz, 1963).

Almost half of the subjects had not talked of the deceased since the funeral. These *individuals* stated that if they " opened up " on this topic they would become embarrassed by expressions of sympathy; or they would distress other members of the family; or they

would find other people disinterested; or their own sense of independence would be undermined. Possibly the cathartic value of expressing one's emotions is less pronounced in the lower socioeconomic groups.

This study was largely confined to the assessment of bereaved subjects a month or two after their loss. A " snapshot " of this nature largely fails to portray the " moving picture " or process of the mourning reaction. Nevertheless enough data were gleaned to indicate that, although the symptom-pattern of grief is varied, it tends to be a self-resolving process.

There is clearly a professional role for the doctor in helping the bereaved by means of support, counselling, and occasionally medication. His effectiveness is likely to be enhanced when he has had an opportunity of establishing a professional relationship with the individual before the bereavement. The clergy, the social worker and community nurse may also be of great assistance to the bereaved. All such professional workers require to be trained in the psychology of bereavement, the value of counselling, and the identification of abnormal patterns of grief which lead to a disturbance of mental health.

In helping patients to cope with grief, the family doctor will often require to confront their frank display of emotion. It is of little value to attempt to produce a " brave ", unemotional patient. Massive denial of any reaction whatever by the patient to his loss, or the persistence of physical complaints without organic basis, should suggest a need for more detailed assessment of the situation.

Acknowledgement

Our thanks are due to the staff of the Research Unit, Department of General Practice, University of Dundee, for advice and statistical assistance.

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