

The grieving adult and the general practitioner: a literature review in two parts (part 1)

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SUMMARY

This article is the first of a two-part literature review on bereavement. In part 1, those psychological theories that have improved the understanding of the bereavement process are summarized. In addition, the research examining the mortality and morbidity following a bereavement is critically analysed.

Keywords: bereavement; psychological models.

Introduction

Bereavement is an almost universal experience and is viewed by the public as the most stressful life event.¹ This fundamental observation has encouraged various health professionals to perform bereavement research and develop patterns of care. There have been calls for general practitioners (GPs) to extend their traditional role in bereavement support and become more involved in providing a service for this vulnerable group.^{2,3} The aim of this review is to provide a detailed overview of literature relevant to the role of the GP in bereavement care.

This review is presented in two parts. Part 1 will include literature on the psychological theories that help explain the grieving process and also the health consequences experienced by the bereaved. Part 2 (to be published in August's *Journal*) will cover abnormal bereavement reactions, factors that put the bereaved at greater risk, a detailed systematic review of treatment intervention trials, and the GP's role in bereavement.

Method

This paper attempts to provide a broad overview of the extensive literature on bereavement, that balances both the practical interests of GPs and the academic requirement for systematic review methodology. Consequently, the methods used remained inclusive and thorough, but not fully systematic. In spite of this criticism, it is possible to outline the general strategies employed. Literature was retrieved from various sources representing the multidisciplinary interest in the subject. Searches were performed on the following computer databases: MedLine, Psychlit, Cinnhal, and the Palliative Care Index. In addition, earlier seminal work and commonly cited articles were collected from the above literature and previous reviews.⁴⁻⁶ The literature was reviewed by both authors independently. When controversy arose over a particular subject, the prevailing arguments were explored. Given that general practice in the United Kingdom (UK) is exposed mainly to adult bereavement, other more specialized areas were left for separate enquiries. Where a specific

topic would justify attention beyond the scope of this article, this is stated.

Psychological bereavement theories

Conceptualizing bereavement may seem esoteric to the practising GP. A busy clinician may be tempted to understand grief in terms of depression or anxiety; this would ignore the wealth of helpful literature that has contributed to our understanding of the psychological processes involved. Seeking such an understanding is not just an intellectual exercise, but a means to improve patient care and comprehension.

It is not enough for us to stay close and open our hearts to another person's suffering; valuable as this sympathy may be, we must have some way of stepping aside from the maze of emotion and sensation if we are to make sense of it.⁷

For generations, scientists and artists alike have attempted to describe the emotions of grief. Over the last century, observational studies have led to the formulation of various models of grief. Given the extent of the literature, the dominant observational studies will be quoted here to give a context for a fuller description of bereavement theories.

The work of Freud in 1917 was instrumental.⁸ He described the emotions experienced in 'mourning' and compared them with those of 'melancholia', explaining them in terms of adjustment to loss. Grief is described as a period of work where reality is repeatedly tested until attachment is withdrawn. In 1944, Lindermann published his work on bereaved subjects from various sources.⁹ He categorized the symptomatology of bereavement into five sub-groups: somatic distress, preoccupation with the image of the deceased, guilt, hostility, and loss of patterns of conduct (e.g. restless, meaningless activity). He proposed the concept that this distress has to be confronted for an individual to work through his or her grief. The psychological responses to grief were further explored by Parkes in 1972.¹⁰ He categorized the emotions into alarm, searching, mitigation, anger, guilt, and gaining a new identity.

This work has formed the conceptual basis for the phase models of grief, which postulate that the bereaved work through a series of emotional responses. Although there have been various phase models proposed,¹¹⁻¹⁴ they tend to share common themes with the influential work of Bowlby.¹⁵ He built upon a psycho-analytical model for loss and attachment to interpret the published literature on how adults respond to bereavement. Although he had the advantage of drawing from a wide variety of sources, there were potential sources for bias. In particular, the samples tended to be young, widows, and reliant on volunteers. He concluded that there were four phases to bereavement and that, although subjects can move from phase to phase, there tends to be a progression through the phases over weeks or months (see Table 1).

Recently, these phase models have been criticized on the grounds that they assume that distress is inevitable, that failure to become distressed is pathological, that loss has to be worked through, that time to recovery is unknown, and that resolution is to be expected.¹⁶ Stroebe and Walter describe different conceptual models that answer some of these criticisms.^{17,19}

Stroebe has returned and expanded on an idea first proposed by Parkes¹⁰ to describe the 'dual process' model of coping with

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Submitted: 16 May 1996; accepted: 18 November 1996.

©British Journal of General Practice 1997, 47, 443-448.

Table 1. Bowlby's phase model for bereavement.

| | |
|--------------------------------------|---|
| Phase of numbing | The immediate reaction to the loss of a loved one tends to be a stunned disbelief. Feelings of anxiety and anger can also predominate. |
| Phase of yearning and searching | Over a matter of days or weeks the bereaved has pangs of intense pining and distress. There is also restlessness and a preoccupation with thoughts of the deceased. It is at this time that cues can be misperceived and interpreted as the actual presence of the deceased. Anger is often more intense in this phase. |
| Phase of disorganization and despair | The feelings of pining, searching and anger are complicated by the failure of old patterns of behaviour to serve the new existence. The enormity of the necessary transformation can lead to despair and depression. |
| Phase of reorganization | In time the bereaved begins to re-examine the new situation and to consider ways of accommodating to it. This involves a redefinition of self as well as accepting a new existence. |

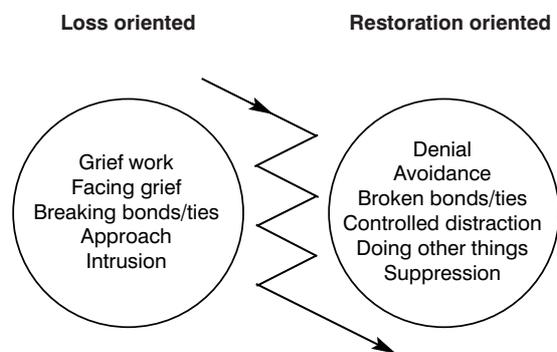


Figure 1. A dual process model of coping with grief.

loss.¹⁷ This theory describes a process where the bereaved oscillate from time to time between two psychological orientations (Figure 1). Individuals choose to change to one orientation to achieve relief from the emotional pain of the other. Experience tells us that, soon after a loss, patients tend to be loss-oriented, becoming more restoration-oriented in time. Such a model easily accommodates the concept that emotional avoidance can be a reasonable adaptive process.¹⁸

Walter has drawn from empirical and anthropological observations to propose that the bereaved's need to talk about the deceased is an attempt to construct a biography that they can integrate into their ongoing lives.¹⁹ This allows for the creation of a new identity that includes the persistent and usually unobtrusive memory of the deceased.

No one psychological model adequately explains the all-encompassing truth of the bereavement process; the practising GP may find more clinical benefit by appreciating the spectrum of theories.

Bereavement and health

The hypothesis that bereavement has a detrimental effect on health has a practical relevance to all health care professionals and GPs in particular. Given an annual mortality rate of 21.78 per 1000 for all ages of the general population in England and Wales, it is possible to estimate the number of individuals who endure a bereavement each year.²⁰ Researchers have for some time attempted to quantify this suffering in health terms. This section will review the literature on the mortality and morbidity that follows a bereavement.

Mortality

He first deceas'd; she for a little tri'd
To live without him: liked it not, and di'd.²¹

The evidence for a mortality excess following bereavement has come from cross-sectional and longitudinal studies. The former usually take advantage of large national databases, but are unable to take account of the duration of bereavement or control for many confounding variables. Given this criticism, this analysis has concentrated on longitudinal studies, which are presented

Table 2. Summary of longitudinal studies of mortality following bereavement.

| Name | Year | Country | Number of Subjects | Excess mortality in bereaved | Follow-up | Comments |
|---------------------------------|------|---------|--------------------|------------------------------|-------------|--|
| Comments Young ^{36,37} | 1963 | UK | 4486 | yes | 9 years | 40% increase in widowers for 6 months, no further statistical analysis |
| Ekbolm ³⁸ | 1963 | Sweden | 643 | no | 3 years | Small sample size |
| Cox ³⁹ | 1964 | UK | 60 000 | no | 5 years | Unusual control group |
| Rees ⁴⁰ | 1967 | UK | 903 | yes | 6 years | Exceptionally low mortality rate in controls |
| Clayton ⁴¹ | 1974 | US | 109 | no | 4 years | Small sample size |
| Ward ⁴² | 1976 | UK | 366 | no | 2 years | Small sample size |
| Helsing ⁴³⁻⁴⁵ | 1982 | US | 4032 | yes | 1-13 years | In widowers 55-74 years only |
| Mallstrom ⁴⁶ | 1982 | Sweden | 360 000 | yes | 1-11 years | In widows for 3 months and widowers for 12 months |
| Kaprio ⁴⁷ | 1987 | Finland | 95 647 | yes | 4 years | For 6 months only, in widowers more than widows |
| Jones ⁴⁸ | 1987 | UK | 156 060 | yes | 10 years | In both sexes under 65 years during first 6 months only |
| Bowling ⁴⁹ | 1987 | UK | 503 | yes | 13 years | In widowers over 75, during first 6 months only. Small sample size |
| Levav ⁵⁰ | 1988 | Israel | 3646 | no | 10-12 years | Poorly matched controls |
| Mendes de Leon ⁵¹ | 1993 | US | 1046 | no | 6 years | Excess did not reach statistical significance |
| Schaefer ⁵² | 1995 | US | 12 522 | yes | 14-23 years | In both sexes at 7-12 months |

Table 3. Summary of studies into depression following bereavement.

| Name Country Year | Sample characteristics Sample number | Depression outcome | | | | Reviewers comments |
|--|--|--------------------|--|-------------|---|---|
| | | 0-1 month | 2-6 months | 7-12 months | > 12 months | |
| Maddison US & Australia 1966 ⁵³ | Women only. Mean age 49.8 n = 375 | [| 12.8% of bereaved requiring medical treatment for depression (P<0.001) |] | | Unvalidated outcome, relying on retrospective self-reported data. Good use of controls. Part of larger study of morbidity. |
| Paykel US 1969 ⁵² | Age and gender not stated n = 16 | [| More depression than controls (P<0.05) |] | | Part of study into depression and different life events, therefore low numbers of bereaved. Used depression requiring hospital admission as outcome. Subject characteristics not described. |
| Clayton US 1972 ⁵⁴ | More women than men. Mean age 61.5 n = 109 | | 35% of bereaved depressed | | | Unvalidated outcome. Low acceptance rate. Sampling bias. No controls. |
| Parkes US 1972 ⁵⁵ | More women than men. Mean age 36 n = 78 | | | | More depression than controls (P <0.01) | Low acceptance rate. Good use of controls. Unvalidated outcome. |
| Crisp UK 1972 ⁵⁶ | Equal men and women. Mean age 51 n = 129 | [| No more depression in the bereaved than in the controls |] | | Outcome measure for psychiatric morbidity, including depression (uncertain validity). Unable to account for time since bereavement. |
| Heyman US 1973 ⁵⁷ | More women than men. Average age 72 n = 256 | | | | Slightly more depression in bereaved | Prospective study. Unvalidated outcome. Statistical comparison not stated. 21 months until observation. |
| Bornstein US 1973 ⁵⁸ | More women than men. Mean age 62 n = 92 | | | | 17% of bereaved depressed | No control group. Unvalidated outcome. Authors comment that none of the depressed were psychotically depressed. Sampling bias. Prospective study. |
| Weissman US 1978 ⁵⁹ | More women than men. Older than 26 n = 511 | [| 10.4% depressed within 3 months of bereavement |] | | Retrospective study that may result in inaccurate prevalence rates. Validated outcome. Women affected more than men (P<0.01) |
| Gallagher US 1983 ⁶⁰ | Slightly more women than men. Mean age 66.8 n = 199 | | More depression than controls (P<0.001) | | | Low acceptance rate. Some non-matching of controls. Adjustments made to account for matching. Women affected more than men. |

Table 3 (continued). Summary of studies into depression following bereavement.

| Name Country Year | Sample characteristics Sample number | Depression outcome | | | | Reviewers comments |
|--|---|--------------------|---|--|--|---|
| | | 0-1 month | 2-6 months | 7-12 months | > 12 months | |
| Jacobs US 1989 ⁶¹ | More women than men. Mean age 54 n = 111 | | 32% of bereaved depressed | 27% of bereaved depressed | | No control group. Validated outcome. Depression effects women more than men and those with a personal or family history of depression. |
| Bruce US 1990 ⁶² | More women than men. Mean age 73.4 n = 39 | [| 30.8% of bereaved depressed |] | | Prospective study. Adjustments made for unmatched controls. |
| Tudivier Canada 1991 ⁶³ | Men only. Mean age 62.9 n = 111 | [| More depression than controls (P<0.001) | | | Validated outcome. Unable to evaluate the effect of time since bereavement. Men only. |
| Avis US 1991 ⁶⁴ | Women only. Mean age 51 n = 76 | [| More depression than controls (P<0.01) | | | Unvalidated questionnaire that revealed high scores in the control group. Unable to evaluate the effect of time since bereavement. |
| Harlow US 1991 ⁶⁵ | Women only. 65-75 years old n = 136 | | 23.4% of bereaved depressed (P<0.001) | 17.5% of bereaved depressed (P<0.04) | 17.5% of bereaved depressed (P<0.01) | Validated outcome. Good follow- up. Prospective study. Widows only. Higher levels at baseline may bias results. |
| Zisook US 1991 ⁶⁶ | More women than men. Mean age 61 n = 350 | | 24% of bereaved depressed | 23% of bereaved depressed | 16% of bereaved depressed | Poor response rate. Validated outcome. No statistical comparison with controls. Women affected more than men. |
| Green UK 1992 ⁶⁷ | From a sample of men and women over 65. n = 7 | | More depression than controls | | Controls had a prevalence for depression of 4%. | Exceptionally small numbers. Prospective study. Used univariate analysis to demonstrate an association. Statistical significance not quoted. |
| Mendes de Leon US 1994 ⁶⁸ | More women than men. Mean age 76 n = 139 | [| 37.5% of bereaved depressed |] | 16.7% of bereaved depressed | No statistical comparison with controls. Prospective study. Validated outcome. Depressive symptoms more prevalent in first 6 months. |
| Surtees UK 1995 ⁶⁹ | Women only Mean age 51 n = 64 | [| 27.1% of bereaved depressed |] | | No control group. Validated outcome. |

in Table 2.

The evidence for increased mortality following bereavement has been conflicting, as it has required large sample sizes and well-matched controls to observe any association. In addition, only Mendes de Leon and Schaefer have addressed the criticisms that the bereaved will tend to share characteristics and environments with the deceased, and so suffer similar mortality rates. Their work has used statistical regression analysis to account for a wide variety of possible confounding variables.

In summary, research methodological problems have made it difficult to confirm statistically the increased risk of death that follows a bereavement. However, it is becoming increasingly possible to conclude that the bereaved are at greater risk of death in the first year of their loss, and that men are at greater risk than women, although this risk remains small in absolute terms.

Morbidity

Research examining the morbidity following a bereavement suffers from the same methodological difficulties as the mortality studies described above: namely, retrospective designs that rely on limited data that cannot control for all confounding variables, or prospective studies that need a large enough sample to observe an effect in the small number who become bereaved during the study. In addition, there are problems of recruitment bias and follow up. Also, unlike the mortality data, work on morbidity has to overcome difficulties of clearly defining morbidity outcomes that have clinical relevance. The questions of homogamy and shared environment are less rigorously answered in this literature.

There is a wealth of literature that has contributed to our understanding of the mental and physical morbidity following bereavement. Although many morbidity outcomes have been measured, most researchers have concerned themselves with the depression that occurs following bereavement. Given its clinical relevance, the practising GP will share this interest and consequently this review will concentrate on the depressive outcome of bereavement. The debate surrounding the differentiation between clinical depression and normal grief will be covered later in part 2 of this review. Literature on other psychiatric, general health and physical morbidity will be summarized in less detail. Research concentrating on the effects of bereavement on physiology and immunology have been excluded, being less immediately relevant to a GP. Also, the temptation to draw from the extensive psychosomatic literature into other stresses and ill health has been resisted on the grounds that it explores a similar but essentially different subject.

Methodological concerns limit any conclusions that can be drawn from the quoted studies (Table 3). In particular, the reader should remain aware that women and the elderly are over-represented in this research, and that some studies fail to employ a control group. However, this body of work does provide an insight into the association between clinical depression and bereavement. In practical terms, this research reminds GPs to actively consider depression in their bereaved patients.

A less substantial body of literature has shown an increase in anxiety,^{53,60,63,69} alcohol usage,^{22,55} use of prescribed medication,^{22,23,55,64} and suicide^{24,25,47} in adults suffering from bereavement. Other studies have attempted to explore morbidity after bereavement by looking at differences in contact with psychiatric services. The results are conflicting, with some studies that reveal no association^{26-28,64} being contradicted by others.^{29-32,55}

Other research has used more global measures of mental and physical health to confirm a deterioration after bereavement,^{33,53,55} although disconfirming evidence also exists.^{34,57,64}

Jones specifically explored the effect bereavement had on the incidence of cancer and revealed no association.³⁵

Conclusions

Bereavement may be understood in psychological terms that may be useful practically to GPs. The evidence proving the physical and mental vulnerability of the bereaved is hampered by inconclusive research. However, it seems possible to conclude that bereavement does have various adverse health consequences, which are outlined in the summary below. These conclusions form the basis of the second part of this review, which will include abnormal bereavement reactions, risk factors, a systematic review of interventions, and the GP's role in bereavement care, now and in the future.

Summary

- Psychological theories for bereavement have been developed that may be useful to the practising clinician.
- The recently bereaved show increased mortality, but this remains small in absolute terms.
- Bereavement can result in clinical depression.
- There is some evidence that there is increased anxiety, alcohol use, use of prescribed drugs, and suicide during bereavement.
- Studies of physical morbidity after bereavement are inconclusive.

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