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

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SUMMARY
In part 1 of this review, published last month, literature exploring the psychological bereavement theories and the health consequences of bereavement are summarized . The second part builds on this to outline the debate surrounding the characteristics of abnormal bereavement, while also focusing on risk factors for this morbidity. This leads on to a summary of the literature on bereavement care, particularly from a general practice point of view. Finally, areas for further research are highlighted.

Keywords: bereavement; risk factors.

Introduction

Bereavement has received considerable research attention over recent years, much of which will be of interest and relevance to the practising general practitioner (GP). This article is the second part of a review of this literature. Part 1 (July 1997, pp 443-448) concentrated on psychological bereavement theories and health consequences of bereavement. This part will use the methods outlined in part 1 to review the following areas: normal/abnormal bereavement, factors that put the bereaved at greater risk, and the role of the GP. In addition, a systematic review of bereavement interventions will be presented.

Normal and abnormal bereavement

The grief hath craz'd my wits[1]

The plethora of observational research in bereavement has resulted in the formulation of the concepts of normal and abnormal grief reactions. A confusing array of terms has resulted and as yet there has been no formally agreed categorization. *The Diagnostic and Statistical Manual of Mental Disorders* (DSM IV) mentions bereavement as 'a condition that may be the focus of the clinician's attention'.[2]

Interest in the concept of abnormality stems from a clinical desire to describe syndromes that would benefit from the medical model of diagnosis and management. However, failure to reach a professional consensus on what is 'abnormal' reflects a concern about the medicalization of grief.[3,5] Given this background, the following description will attempt to present the prevailing opinion; the reader should remain aware that the terminology will continue to change as the debate proceeds.

Normal bereavement

Attempts to define the 'normal' response to bereavement are repeatedly hindered by the need to use words that adequately satisfy every cultural background and professional philosophy. Within a Western society, perhaps the most complete definition is given by Kim and Jacobs.[4]

> Normal grief is a self limiting process consisting of sadness, longing for the deceased person, somatic complaints and subsequent recovery.[4]

Most bereaved individuals use their own resources to achieve this adaptation.[5,6] However, others deviate from this norm, prompting the concept of abnormality and possibly the attention of health professionals.

Abnormal bereavement

An in-depth analysis of the ongoing debate that surrounds the definition of abnormal bereavement is beyond the scope of this review. However, a summary of the more relevant general concepts will be presented, but excluding the pre-death subject of anticipatory grief.

Some authors have drawn from psychiatric experience to describe abnormal bereavement, thus allowing existing models of care with proven efficacy to be used. Others have explored bereavement symptomatology to define new syndromes. These different approaches complement each other and can be depicted schematically (Figure 1). The intersecting parts of Figure 1 depict overlapping symptomatology, uncertainty in disease definition, and misdiagnosis. The placement of particular individuals within this model is dependent on the nature, severity, and timing of their symptoms.

In terms of psychiatric disorders, the following have been suggested consequences of bereavement: depression,[7,4,8] anxiety,[4] post traumatic stress disorder,[9,10] and substance abuse.[11,12] This list excludes those conditions that may relapse following the stress of bereavement. Depression as a consequence of bereavement is also discussed in part 1 of this review (July 1997, pp 443-448).

Depression has received the most academic interest and this literature illustrates the difficulty of defining disease. Authors have used various criteria to differentiate the normal from the abnormal. The most clinically convenient criteria would be to

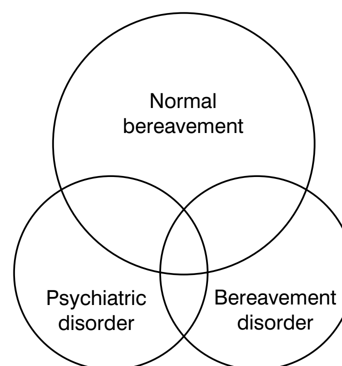

Figure 1. The interrelationship of normal and abnormal bereavement reactions.

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use time since loss as a marker. However, views vary regarding the most appropriate duration, from two months,[2,13] six months,[14] to over 12 months.[15] Equally, others have begun to use specific symptoms as discriminators; for example, negative perceptions of self,[16,17] functional impairment,[18] profound depression,[14] suicidal ideation,[18] and pervasive feelings of worthlessness.[18] 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.[9,16,19,21] 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.[22] Those syndromes that reached some international consensus will be described here (Table 1). Three texts are used to illustrate descriptive terms for these syndromes.[23-25]

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.

Table 1. Examples of bereavement disorders.

Reaction	Description
Absent	Individuals show no evidence of the emotions of grief developing, in spite of the reality of the death. This can appear as an automatic reaction or as the result of active blocking.
Delayed	This initially presents in a similar way to absent grief. However, this avoidance is always a conscious effort and the full emotions of grief are eventually expressed after a particular trigger. This may be seen in more compulsively self-reliant individuals.
Chronic	The normal emotions of grief persist without any diminution over time. It is postulated that this is most often seen in relationships that were particularly dependent.

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.[26-28]

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 2. Factors associated with bereavement outcomes.

Factor considered	Adverse association	Protective association
Individual factors		
Younger age	Beckwith et al,[28] Yancey et al,[61] Maddison et al,[62] Zisook,[63] Tudivier et al,[64] Breckenridge et al,[7] Bowling,[65] Schaefer et al,[66]Ball[67]	Mendes de Leon et al[68]
Male sex	Beckwith et al,[28] Mendes de Leon, Li,[69] Hesling et al,[70] Schaefer et al,[66] Stroebe et al,[71]	Yancey et al,[61] Zosook et al,[76] Jacobs et al,[72] Carey[73]
Poor general health	Vachon et al,[87] Mor et al,[12] Schaefer,[66] Zisook[63]	
Past history of mental illness	Parkes,[78] Zisook et al[63]	
'Adverse' personality types	Vachon et al,[87] Stroebe et al,[58] Parkes et al[74]	
'Protective' personality types		Vachon et al[87]
Education	Byrne et al[75]	Schaefer et al[66]
Relationship with deceased		
Shorter marriage	Beckwith et al,[28] Zisook[63]	
'Adverse' relationship types	Parkes[77]	
Circumstances at death		
Sudden death	Parkes,[78] Lundin,[79] Shanfield et al,[80] Byrne et al,[75] Clayton et al,[81] Raphael[82]	
Death at home		Ferrel,[83] Rees et al[84]
Multiple loss	Parkes,[78] Raphael[82]	
Stigmatized deaths	Cain,[85] Klien et al[86]	
Circumstances after death		
Poor social support	Yancey et al,[61] Vachon et al,[87] Tudivier et al,[64] Helsing et al,[88] Bowling,[65] Clayton et al[89]	
Few relationships	Beckwith et al,[28] Bowling[65]	
'Adverse' coping strategies	Jacobs et al,[90] Nolen-Hoeksema et al,[91] Cleiren et al[92]	
Economic difficulties	Vachon,[87] Byrne et al,[75] Jacobs et al[72]	
Low socio-economic status	Parkes[78]	

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, clarification[30]). Specialist authors have gone further and formulated approaches that provide greater guidance on helping the bereaved, either as general principles[31-35] 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.

Author	Year	Country	Intervention	Benefit	Comment
Professionally led individual therapy					
Raphael[26]	1977	Australia	One-to-one therapy by psychiatrist	Yes	P<0.02
Polak[93]	1975	US	Intensive crisis intervention	No	
Williams[94]	1979				
Kleber[95]	1987	Holland	Trauma desensitization, hypnosis, psychodynamic therapy	No	
Group therapy					
Barrett[96]	1978	US	Therapist led groups	Yes	Only for certain outcomes
Vachon[97]	1980	US	Volunteer led groups	Yes	Only for certain outcomes
Constantino[98]	1981	US	Therapist led groups	Yes	Small numbers and only for certain outcomes
Wallis[99]	1985	US	Therapist led groups of different types	Yes	Only for certain outcomes
Liberman[100]	1986	US	Volunteer led groups	No	Design bias
Sabatini[101]	1988/9	US	Therapist led groups	No	Small numbers
Liberman[102]	1992	US	Therapist led groups	Yes	Only for certain outcomes
Levy[103]	1993	US	Volunteer led groups	Yes	Small numbers and for only certain outcomes
McCallum[104]	1993	US	Therapist led group	No	Uncertain outcome measures and small numbers
Caserta[105]	1993	US	Volunteer led groups	No	Confounding variables poorly accounted for
Tudivier[106]	1995	Canada	Volunteer led group	Yes	Doctor contacts are sole outcome
Trained volunteer counselling					
Parkes[27]	1981	UK	Hospice style service	Yes	For 'at risk' groups
Cameron[107]	1983	Canada	Hospice style services	Yes	Small numbers
Reich[108]	1989	US	1.Education program. 2.Social interview	No	Small numbers
Relf[a]	1993	UK	Hospice style service	Yes	For 'at risk' groups
Carr[b]	1996	UK	Counselling service from oncology unit	Yes	But recognized significant confounding

[a]Relf M. Personnal communication, 1993. [b]Carr T. Personnal communication, 1996.

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

Number of contacts	All consultations	Home visits	Contact with own GP
None	24%	67%	34%
1	25%	17%	24%
2–4	37%	13%	31%
5–9	9%	2%	7%
10+	5%	1%	4%

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.[38] While this theoretical controversy continues,[39] 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.[40-45] 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[40,46,47]
- Routinely record death in the bereaved's notes[47,48]
- Letter of condolence[45,47]
- Written information about grief and the services available[47]
- Practical advice[49]
- A bereavement visit soon after death[40,45,47]
- The use of risk assessment in planning care[50,51]
- A follow up visit at 6–10 weeks[45,47,52]
- Links with other bereavement services[43,45,47]
- Professional bereavement counselling within practices[42]
- Psychologist-led group bereavement therapy within practices.[53]

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.[54-58] 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.[59]

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 Cartwight, completed in 1979.[44] 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.[48] Daniel's study showed that, although most patients (14/18) were offered some contact with the GP, only seven accepted it.[45] 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.[42] Blyth's audit of terminal care over one year concluded that all bereaved patients were visited at least once.[60] 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.[110]

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.[41] 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. Personnal 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.[44] Conversely, 23 out of the 34 in Blyth's sample felt that bereavement counselling from the GP was not necessary.[60] 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.[45] Gunnell's small study concurs with this view, with 8 out of 10 believing that the GP should visit.[48] 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 canvasses opinion from patients and professionals, and also evidence confirming patient benefit for any GP-based service.

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