Although the acute attacks do not appear to have serious long-term effects, the prognosis of familial Mediterranean fever is dictated by the associated amyloidosis. Amyloid deposits are sparsely distributed in many organs; there may be mild splenomegaly and a rectal biopsy specimen usually contains amyloid material. Other organs are not usually enlarged or compromised, except for the kidney. Onset of the nephrotic syndrome heralds the inevitable development of renal failure, the usual cause of death in patients with familial Mediterranean fever. The onset of amyloidosis may be in the first decade of life, and in some patients even antedates acute attacks by months or years. Before haemodialysis was available patients usually died about five years after onset of the nephrotic syndrome. Some patients have had cadaveric kidney transplants, but amyloidosis occurs in the transplant within three or four years.[8] [9] When survival is prolonged as a result of haemodialysis or renal transplantation amyloid deposits in other organs, such as the liver, the thyroid, and the adrenal, may become of clinical significance.[2] [10]

Until the early 1970s there was no effective treatment for familial Mediterranean fever. Corticosteroids, immunosuppressive drugs, and anti-inflammatory agents did not influence the attacks. Colchicine had been thought to have little effect when used to treat attacks, but in 1972 it was found to prevent them if taken regularly.[11] Most patients can have their attacks abolished or appreciably reduced in number and severity with doses of 1 or 2 mg daily. Proteinuria also appears to diminish in patients with amyloidosis after prolonged colchicine treatment.[12] Colchicine is thought to inhibit the activation and release of lysosomes from phagocytic cells. A raised serum concentration of AMP during acute attacks is evidence that this activation occurs in familial Mediterranean fever, and the AMP concentration does indeed fall to normal after colchicine treatment.[13] Although we must remain vigilant about the long-term safety of taking colchicine regularly, there are so far no reports to suggest that continuous treatment is dangerous.

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Regular Review

Bereavement counselling: does it work?

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Many well-conducted studies have confirmed the increased risk of psychiatric and psychosomatic disorders associated with the death of a loved person. Only in recent years, however, have studies been undertaken to ascertain the effectiveness of the various forms of counselling that have been introduced in the hope of reducing this risk.

Medical practitioners are often faced with the problem of deciding whether to make use of such services, how to choose between the various services available, and what actions they as doctors can take to prevent some of the damaging consequences of bereavement. In this paper I review some recent scientific studies of bereavement counselling in an attempt to provide answers to these questions. Only systematic comparative studies are considered, particular attention being paid to those using random allocation to obtain satisfactory control groups. There is some evidence that anticipation reduces the trauma of bereavement,[1] but I am not aware of any satisfactory evaluation of services that offer guidance before but not after bereavement. On the other hand, two services that offer help before and after bereavement have been evaluated and are reviewed below.

The basic research design that has been followed in most studies is simple. Bereaved people are identified either through the hospital where the death occurred or from official death notification. After random assignment to two groups, one group is offered the help of a bereavement service and the other is not. Refusal rates vary from 6% to 37%. After the service has been given both groups are contacted once or more by research interviewers who use quantitative measures of state of health or change in health to assess outcome. Differences between the groups are tested for significance by traditional methods. Studies vary in the type of bereavement; the geographical location, age distribution, religion, and socioeconomic status of the populations sampled; the types of bereavement counselling; the size of the sample; and the measures of outcome used. Not surprisingly, they also vary in the magnitude of the differences observed, some results reaching high levels of significance and others showing few or no differences between groups.

The services that have been evaluated are of three types: (*a*) professional services by trained doctors, nurses, social workers, and psychologists; (*b*) voluntary services in which selected and trained volunteers are supported by professionals; and (*c*) self-help groups in which bereaved people offer help to other bereaved people with or without the support of professionals. Each of these services may provide individual one-to-one counselling or group counselling.

Professional services providing individual support. Three well-conducted studies of such services are known to me: Raphael's study[2] of support given to "high-risk" widows in Sydney, Australia; Gerber's evaluation[3] of a service for elderly bereaved people in New York; and Polak's study[4] of a service for the families of people whose sudden death had been reported to the coroner in Denver, Colorado.

Convincing evidence for the effectiveness of bereavement counselling by a professional worker comes from Raphael's study[2] of 31 selected, high-risk widows, who were compared with 33 well-matching widowed controls. The assessment of risk was made by means of a questionnaire developed by Maddison and Walker,[5] which measures the extent to which the bereaved see their families as unsupportive, their bereavement as traumatic, their marriage as ambivalent, and their life as complicated by crises other than the bereavement.

In this instance the support was given by Raphael herself, a psychiatrist with much previous experience of work with bereaved people. Clients had from one to nine lengthy interviews in their homes (mean four interviews) during the period from six to 12 weeks after bereavement. Raphael aimed to provide "... support of grieving and mourning processes: encouragement for the expression of various bereavement affects, of grief, sadness, anger, anxiety, hopelessness, helplessness, despair; and facilitation of the mourning process with its review of the positive and negative aspects of the lost relationship.... The intervenor would become, temporarily, an additional member of the bereaved's social network, providing supportive interaction in areas of care where the bereaved perceived the basic social network as failing to meet their needs.... Subjects were not considered as 'ill' or 'patients' ... old unresolved losses were often very significant in the current bereavement and frequently needed to be worked through at the same time." These aims and methods of counselling were similar to the approaches adopted in most other studies.

Thirteen months after bereavement an index of health change showed differences between supported and unsupported groups that were significant at the 2% level. The greatest difference was in the number of new or worsening symptoms that had led to consultations with doctors. These were far fewer in the supported than in the unsupported group (21 and 47 consultations—$p < 0.001$). Most impressive results came from the widows who had perceived their families as "unhelpful." Among these the difference between supported and unsupported groups reached the 0·1% level of significance. The effectiveness of the questionnaire as a predictor of risk to health was confirmed by comparing the unsupported control group with a second control group of unsupported "low-risk" widows ($p < 0.001$). The high-risk group of widows who had been supported by Raphael showed no more deterioration in health than the unsupported low-risk group. We may justifiably conclude, therefore, that the effect of this type of intervention was to reduce the health risk from "high" to "low." In a sense, Raphael can be seen as having provided the support that, in other circumstances, would have been given by a helpful and supportive family.

In Gerber's study[3] a variable amount of support was given by a psychiatric social worker or a psychiatric nurse; 53% of contacts were by telephone and the remainder either at home or in the supporter's office. Supervision was provided by a psychiatrist, and no clients were seen after the sixth month of bereavement. As in most other studies, the support staff were thought to have encouraged the bereaved to express feelings of sorrow, anger, and guilt regarding the bereavement; to review the relationship with the dead person; to understand the nature of their emotional reactions; to "find an acceptable formulation of their future relationship to the psychic representation of the deceased"; to move towards relationships with others; to deal with legal, financial, and household problems; and to make plans for their future lives. Supporters were instructed to avoid interpreting defences and unconscious trends and to avoid excessive solicitude or overprotection of the survivor.

In comparisons of the 116 supported subjects with 53 unsupported bereaved controls at two, five, eight, and 15 months after bereavement, significant differences were mainly confined to the period during which the service could be assumed to be having its maximum effects—at five and eight months after bereavement. At these times the supported people received significantly fewer prescriptions of drugs, reported fewer consultations with physicians, and less often reported that they had felt ill without consulting a doctor. Effects of the service were most marked among Catholic men who had good previous health records. Jewish women with previously poor health who were contacted by the service tended to increase their rate of medical consultation, perhaps because the supporters urged them to visit their doctors.

The results of the study by Polak *et al*[4] were largely negative. As in Gerber's study a large proportion of contacts were by telephone. Families were seen for two to six sessions over a period of one to 10 weeks. The support team "focused on increasing the effectiveness of the family in coping with feelings, decisions and problems of adjustment." Unfortunately, interpretation of results is complicated by accidental mismatching of supported and control groups and by a refusal rate of 33% among the controls. The "closeness" of those in the supported group to the deceased person was significantly greater than that of the controls, and they suffered a drop in income after bereavement that was 43% greater on average than the drop reported by the control group. The economic losses were rated as significantly more important by the supported than by the control group and are likely to have influenced reactions to bereavement.

Most of the measures of outcome used by Polak to test the difference between the 37 supported and 65 control clients, who were followed up six months after bereavement, were measures of state of health rather than change in health. Not surprisingly in view of Gerber's findings on the influence of the previous state of health, no significant differences emerged between helped and unhelped groups. One of the two measures of health change, however, does suggest a difference between the groups. Polak made medical and psychiatric ratings before and after bereavement. Although the control group did not show a substantially greater increase in medical ratings after bereavement than the supported group (the increases were 26% and 21%) they had a much greater increase in psychiatric ratings (30% and 12%). The significance of this difference cannot, however, be tested from the figures published by Polak. In the light of these observations the findings cannot be said to support his conclusion that "the techniques of social systems intervention presently available are not adequate to produce effective social systems change."

Professional services providing group support. An evaluation of group support has been conducted by Jones (unpublished dissertation, University of California, 1979) in a small-scale study of 36 widows and widowers who were randomly assigned to group therapy or none. Jones's subjects were predominantly white, middle-class widows who had responded to a Los Angeles news release offering professional help with their bereavement. Despite the method of selection all were regarded as "normal grievers."

Some six to nine months after bereavement the index group had three hours a week of group "therapy" for eight weeks. The groups were led by a "licenced therapist" who assigned topics for discussion each week to highlight major themes of bereavement. A symptom check list and "personal orientation inventory" were used to measure health or psychological state before and after therapy (or over the same time period in the control group). Although no significant differences were found between supported and unsupported groups on these measures, there was evidence that subjects at high risk, particularly those with reactions of guilt or self-blame, showed significant improvement on several of the measures whereas less improvement took place in the controls and those at low risk.

Voluntary services. But do we need to use the time of psychiatrists and other paid professionals to provide services that would normally be given by a helpful and supportive family? The question is not entirely fair because some families evidently are perceived as unhelpful through no fault of their own, and some bereaved people are more difficult to help than others. At all events people who offer to help bereaved people whom they have never met are likely to need more than ordinary tact and good sense, a reasonable understanding of the nature of grief, and the ability to support a person in distress without themselves becoming overwhelmed.

These are, in fact, the qualifications sought for and developed by organisations such as Cruse (for widows, widowers, and their families) and they have been used in all of the three voluntary services which have been evaluated: Cameron's study (unpublished draft, 1979) of a service for the families of patients who died from cancer in Montreal; Kincey's study (MSc thesis, University of Manchester, 1974) of a service for spouses of patients who died in two hospitals in Manchester; and Parkes's study[6] of a service in south-east London. In each of these services most of the support was given by selected and trained volunteers (many of whom had professional qualifications of some kind but usually without psychiatric training) under close supervision from social workers and psychiatrists. Support was given in the client's home, and included an element of "befriending" as well as the types of help described by Raphael.[2] In Cameron's and Parkes's studies support had also been given before bereavement by the staff of the ward in which the patient had died, and the bereavement service was seen as part of a total pattern of family (or "hospice") care.

Cameron carried out telephone interviews with next-of-kin of 20 patients who had died $12\frac{1}{2}$ months previously in the palliative care unit of the Royal Victoria Hospital in Montreal. These were compared with the next-of-kin of 20 patients (matched for age, sex, relationship to deceased, and diagnosis) who had died in other wards of the same hospital without bereavement services.

The palliative care unit families showed appreciably less deterioration in health than the control families; they required fewer sedatives and tranquillisers, and were less preoccupied with thoughts of the dead person and less angry and guilty. Three measures of psychological adjustment showed significant differences ($p < 0.005$) favouring the palliative care unit families. The study can be criticised on the grounds that patients are selected for admission to different wards and we have no means of knowing how this may have biased the results.

The service studied by Kincey provided minimal help. Among the 30 widows and widowers included, 16 were assigned to volunteers and 14 to social workers. But only six were visited more than once and six of the 14 assigned to social workers were not visited at all. When this group was compared with a control group of 55 other bereaved spouses six to nine months after bereavement no significant differences in state of health were found (no measures of change in health were made).

Parkes's study of the service for relatives of patients dying at St Christopher's Hospice resembled Raphael's study in focusing on high-risk bereaved people and using measures of change in health to assess outcome. In this case the assessments of risk were made by nursing staff at the time of the patient's death with a predictive questionnaire developed in the Harvard bereavement study.[7] Risk factors include clinging to the patient before death, angry or self-reproachful behaviour, lack of supportive family, low socioeconomic status, young age, and an intuitive guess by nursing staff that the bereaved relative was likely to cope badly. After exclusion of a small "imperative need" group from whom the staff felt that it would have been unethical to withhold support, the rest of the high-risk relatives were assigned (by tossing a coin) to an experimental group (32) or a control group (35). Those in the experimental group were offered the help of the volunteer service and the controls were not.

Twenty months after bereavement both groups were interviewed in their homes by a research interviewer. No differences between the groups were found during the first year after the introduction of the service, but over the next three years significant differences favouring the supported group were found on two out of three measures of change in health—a check list of new or worse autonomic symptoms ($p < 0.05$) and a measure of increased consumption of drugs, alcohol, and tobacco ($p < 0.02$). One measure of change in physical health and three measures of state of health favoured the experimental group but the differences did not reach significant levels. An overall score distinguished the groups ($p < 0.03$).

As in Raphael's study, high-risk bereaved people who were unsupported had significantly worse health scores than the low-risk bereaved ($p < 0.02$), but there was little difference in outcome between the high-risk supported group and the low-risk unsupported group. We may conclude that the effect of this service, like Raphael's, was to reduce the risk in the high-risk group to about that of the low-risk group.

Self-help groups—These operate on the assumption that the person best qualified to understand and help with the problems of a bereaved person is another bereaved person. Pioneered in the United States by Silverman's Widow-to-widow Project, they are also found in Britain in the National Association of Widows and the "Compassionate Friends" (for parents who have lost a child). Combining self-help with professional support are the Association for the Study of Early Infant Deaths (which also supports research) and the new Stillbirths Association.

The only systematic comparative study of self-help in bereavement known to me is Vachon's study[8] of 162 Toronto widows under age 70. Sixty-eight randomly selected widows were offered one-to-one and later group support from widows "who had resolved their own bereavement reactions and were trained by the author and her [psychiatrist] colleague to reach out with an offer of help." A measure of psychological state (Goldberg's 30-item general health questionnaire) showed no significant differences between helped and unhelped groups at six, 12, and 24 months after bereavement but there were three measures of psychological change that favoured the supported group at the 12-month follow-up. Of particular interest was a subgroup of widows who had high scores on the general health questionnaire a month after bereavement and before any offer of help had been made. The members of this high-risk group who received support were better than those who received no support on five measures at six months after bereavement and at 24 months: only 24% still had high scores on the questionnaire, compared with 45% of the controls ($p < 0\cdot05$).

Although these results cannot be taken as conclusive owing to imperfect matching and attenuation of the sample (36% and 44% in the supported and unsupported groups at 24 months), they favour the hypothesis that self-help is of some value as a means of support in bereavement. This effect is most pronounced in those people who are most distressed by their bereavement. With support these are likely to be initiating new activities and finding new friends by a year and feeling less distress by two years after bereavement.

Dr Vachon is a nurse counsellor with great experience in support of the bereaved, and self-help groups that lack the professional backing that she is able to give are unlikely to provide so effective a service. The case for self-help without professional backing must therefore be regarded as unproved.

Conclusions—The evidence presented here suggests that professional services and professionally supported voluntary and self-help services are capable of reducing the risk of psychiatric and psychosomatic disorders resulting from bereavement. Services are most beneficial among bereaved people who perceive their families as unsupportive or who, for other reasons, are thought to be at special risk.

We should not assume that every bereaved person will need counselling, but those who do need it seem to benefit from opportunities to express grief, reassurances about the normality of the physiological accompaniments of grief, and the chance to take stock of their present life situation and to start discovering new directions. Both permission to grieve and permission to stop grieving may be needed. My own study suggests that a counsellor takes about a year to become proficient. Thereafter many volunteer counsellors come to rival professionals (who often have less experience in work with the bereaved) and may even be able to tackle some of the pathological forms of reaction to bereavement.

Medical practitioners have important parts to play in supporting volunteer counsellors and in providing support for bereaved people. They are often in a position to assess the need for counselling and to introduce a counsellor in such a way as to minimise any sense of intrusion (more often a problem in the mind of the care giver than of the bereaved person).

Telephone contacts and office consultations are no substitute for home visits. If help can be provided before as well as after bereavement, this may further improve the chances of success. The value of services that lack the support of trained and experienced members of the care-giving professions remains to be established.

Bereavement by death is not the only kind of bereavement that comes to the attention of members of the medical profession. A person may grieve for the loss of a limb, a home, a house, and much else. To establish the efficacy of bereavement counselling after death is just the first step in a field of preventive medicine whose implications are only now beginning to be appreciated.

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