



# Grief counseling

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## SUMMARY

Patients grieve the loss of loved ones, jobs, marriages, or even functioning. They seek comfort, understanding, respect, and especially hope. The "work of grief" progresses through stages. Mixed with the sadness can be feelings of anger, fear, and guilt. Psychotherapy can relieve self-destructive anger and guilt, advance the recovery phase, and stimulate psychological strength and personality growth.

## RÉSUMÉ

Les patients pleurent la perte des êtres chers, d'un emploi, la rupture d'un mariage et la perte de leur autonomie fonctionnelle. Ils recherchent du soutien, de la compréhension, du respect et surtout de l'espoir. Le cheminement à travers ce processus de deuil comporte plusieurs stades. La tristesse peut s'accompagner de sentiments de colère, de crainte et de culpabilité. La psychothérapie peut atténuer la colère et la culpabilité autodestructrices en accélérant le stade de récupération et en stimulant le pouvoir psychologique et la croissance de la personnalité.

Can Fam Physician 1995;41:1207-1211.

**L**OSS IS SO MUCH A PART OF BEING human that we tend to underestimate the impact of grief on the health of our patients. Increases in morbidity in terms of physical and mental health problems and greater health care use as well as increases in mortality have been substantiated.<sup>1</sup> Increased use of sedatives, tranquilizers, alcohol, and medications has been demonstrated among those who are grieving the death of a husband or wife.<sup>2</sup>

Holmes and Rahe<sup>3</sup> developed the Social Readjustment Rating Scale showing that people are more likely to become ill after a loss. Patients commonly grieve the loss of loved ones, such as parents, spouses, children, and siblings, and also the loss of jobs, marriages, or even functioning (loss of body part or use). Frequently the grieving process is a normal adjustment to the realities of daily living rather than a pathological state. People come to physicians looking for a wise sage, a human being who has experience dealing with the tragedies

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of life. They look for an empathetic, nonjudgmental, supportive listener whom they can trust. They often turn to physicians first.

It is sometimes difficult to find psychiatrists, social workers, or psychologists who have the time to counsel people who need help. This is especially true in rural areas. As a result, much of the responsibility falls on primary care physicians. Often physical complaints and medical conditions make the emotional problems more complicated to treat. Family practitioners are in an excellent position to integrate the psychological with the physical (taking into consideration the spiritual) to provide "holistic care."<sup>4</sup> This article attempts to heighten physicians' awareness of the grieving process and indicate how we can intervene.

## Acute phase

Patients in the acute phase of grief are seeking comfort, understanding, respect, and especially hope. They do not need to be judged, told what to do, or told to keep a "stiff upper lip." They need to be allowed to cry and express in words their feelings of loss. An appointment right after a loss enables a physician to assess the effect the death has on the patient's life and decide what appropriate action can be taken.

It is helpful in the acute stage to be a creative listener. Dr Carl Rogers in his book, *Client Centred Therapy*,<sup>5</sup> describes a technique of simply playing back to patients the essence of what they said, reflecting content and affect. Patients get the experience of being listened to and of hearing feedback from another person replaying their words and feelings. Rogers postulated "empathy," "unconditional regard," and "genuineness" as necessary conditions for psychotherapy.

People who are suddenly bereaved could require more support and counseling than those who have known their loved ones are dying. They need to be given the opportunity to talk through the death, to have repeated opportunities to share feelings and make real the events of the death, to work through the unfinished feelings about the deceased (especially the feelings of chaos and insecurity stimulated by unanticipated loss), and to learn how not to overreact to the insecurity and fear that remains after this type of death.<sup>6</sup> Emergency departments, coronary care units, and intensive care units should provide help for the bereaved. Early counseling can reduce morbidity among high-risk groups.<sup>7</sup>

#### **Anticipatory grief**

Anticipatory grief encompasses the processes of mourning, coping, interaction, planning, and psychosocial

reorganization that are stimulated by awareness of the impending death of a loved one and recognition of the associated losses that have already occurred; of the ongoing losses of progressive debilitation, increasing dependence, continual uncertainty, decreasing control; and of the losses yet to come. Physicians can help patients with the delicate balance of simultaneously holding onto, letting go of, and drawing closer to the dying person.<sup>8</sup> Certain people are more at risk of having problems because of highly ambivalent or dependent relationships.

#### **Unresolved grief**

Sigmund Freud described a clear difference between grief and melancholia. In grief the mourner comes to terms with a permanent detachment from the much loved person:

[The] work of grief is a progression through stages of anger, painful dejection, loss of interest in the outside world, inhibition of activity and the temporary interruption of the capacity to love. Melancholia results when the normal process is not completed.<sup>9</sup>

Often patients will offer other symptoms as a way of getting a foot in the door. They sometimes believe it is inappropriate to discuss psychosocial issues with their physicians. Sometimes their own denial is so strong that they themselves have blocked their true feelings, and the sadness comes out inadvertently in the course of an appointment for something else.

### **Easing the transition**

**B**ob, a 70-year-old retired man, came to the office with his wife, Gwen, during the last several months of her life while she was dying of cancer. Gwen had done all the bookkeeping, banking, paying of bills, housekeeping, and cooking. They had no children, so Bob was extremely dependent on Gwen for not only emotional support but also total support.

In a way, the grief started before her death as she became more and more disabled. We were able to talk about how Bob was taking on more responsibility. Slowly over time he learned more and more about household affairs. During this type of chronic illness, death and dying

can be talked about, and certain issues and fears can be expressed and discussed while the dying patient is still alive. This makes the transition easier. Attention was also focused on Bob during Gwen's last days.

As soon as Gwen died, I booked an appointment with Bob that same week. I saw him weekly for 3 weeks, if only for short appointments. At each session practical matters like lawyers, wills, and the future – as well as sad and lonely feelings – were discussed. Even after a year, he still visited once every few months. He cried each time he came in, and we talked about Gwen and his grief.

A patient comes in with a headache or bronchitis and, in the midst of a 15-minute appointment, starts to cry. There is too little time available to deal with the complex issues. It is helpful to attempt to manage the acute situation and then arrange for a follow-up appointment in a psychotherapy slot for a half-hour or full hour. It is important to establish that there is no danger of homicide or suicide and even see the patient for another short appointment next day if a longer session cannot be arranged quickly.

It is not unusual for patients to visit years later with unfinished, unresolved issues concerning a death from the past. Usually the grieving process lasts somewhere from 6 months to 2 years. But there are differences between cultural backgrounds. All people, depending on their cultures, belief systems, and personalities, will find their own ways to resolve the loss.

If, after a reasonable period, the person is still not over the death of a loved one, it is worthwhile to look for other factors preventing resolution. Mixed in with the sadness can be

feelings of anger, fear, and guilt. None of us likes to admit anger at a dead person, so these emotions are often disguised or repressed and prolong the period of grief or show up in other ways.<sup>10</sup> Sometimes the patient is clinically depressed and needs antidepressant medication.

### **Techniques of interventions**

A technique originally developed by Jacob Moreno and later adapted by Dr Fritz Perls in Gestalt therapy involves psychodrama or the patient's acting out a dialogue with the deceased.<sup>11</sup> The patient plays both roles by actually changing chairs and talking back and forth to the imagined person with the aim of contacting old feelings and linking them up to thoughts. The focus can be on expressing the loss, anger, fears, and resentment. Eventually working toward forgiveness of the deceased is helpful.

This technique has been used to deal with the loss of children, grief about abortions, and even miscarriages. The patient plays the part of herself and the unborn child.

## **Relieving anger and guilt**

A 22-year-old medical student had a history of sharp chest pain under his left breast lasting for minutes, often associated with light-headedness and precipitated by exertion. This had been going on for many months, and he was worried because his father had died from a myocardial infarction. A full examination, electrocardiography, and blood assessment found no organic cause for his chest pain.

I simply stated that perhaps there was a relationship between his father's death and his chest pain. He identified

strongly with his father. Sometimes the loss and missing someone is so great that we keep them around with physical or emotional symptoms, as a way of staying connected. His father had died in front of him, and he felt guilty that he could not save his father's life. He also was angry that his father "abandoned him" by dying. Unresolved anger often needs to be dealt with for resolution to be possible. After our discussion the student felt relieved and had no further symptoms at follow up 10 years later.

## **Achieving forgiveness**

Often patients feel guilty at somehow causing another person's death. Geraldine was always arguing with her mother. On the day of her mother's death, they had a serious fight shortly before the mother died. Twenty years later Geraldine still felt responsible for her mother's death. She was depressed and unable to enjoy life.

In therapy the events that preceded the death were reviewed and reframed. It was clear that the mother

really loved Geraldine and wanted the best for her daughter. Geraldine meant no harm to come to her mother even though she had been angry. She acted out having a conversation with her deceased mother and through this believed that her mother did not hold a grudge. Geraldine was able to forgive herself and her mother for what had been said and done. A heavy burden of guilt and unresolved resentment was lifted.

Sometimes patients feel unresolved because they never actually got a chance to say goodbye and see the person die. Deaths often occur in hospitals, with family and friends absent. Having them act out a conversation with the deceased and actually saying goodbye, even though totally artificial, can dramatically help to resolve unfinished feelings. This type of intervention can also be done using hypnosis.

The biggest problem faced by parents of a stillborn child is the failure of families, friends, and physicians to recognize that their grief has arisen from the death of a real person.<sup>12</sup> Always make a point of talking about grief after abortions, miscarriages, and deaths from sudden infant death syndrome. It is not uncommon to find parents even years later with unfinished sad feelings about the loss of their unborn child. Because recovering from the death of a child is perhaps the most difficult, suggest patients get involved in self-help community support groups to help reduce the psychological damage to themselves and remaining siblings.

The death of a parent is one of the most stressful occurrences for a child to endure. A reported 61% of bereaved children have suicidal thoughts and plans.<sup>13</sup> Children can experience developmental disturbances, psychiatric disorders, disturbed ego development, and physical complaints. Intervention with this group can prevent future psychiatric disturbance.

Because children tend to communicate nonverbally, drawings that allow children to express their feelings freely and their concerns without the pressures and risks of miscommunicating are an important tool for physicians. Physicians can ask children to draw a picture of the family and then ask them to talk about the picture. If serious concerns are raised, referral to professionals experienced in dealing with bereavement among children can be sought. Physicians can provide surviving parents and children with books and movies, which can stimulate further discussion in terms the child can understand.<sup>14</sup>

Instead of death being seen as part of life, deaths can be seen as somehow a mistake or deficiency. Even physicians can have feelings of guilt if they see any death as a failure on their part. If only they had done this or that or responded differently, the person might still be living. As physicians we must learn from our mistakes and be able to share our grief with our patients and their families.<sup>15</sup>

Counseling that focuses on the grief reaction can help to advance the recovery phase and stimulate new psychological strength and personality growth. Mourning is important, but when the mourning takes over, affects functioning, and is excessively prolonged, then intervention is necessary. Psychotherapy can focus on the resentment and anger suppressed or turned back on the self as well as help resolve self-destructive guilt.

### Someone to watch over me

Mary, a 37-year-old secretary, had a 2-month history of insomnia. Further inquiry revealed she was having bad dreams and was afraid to fall asleep. Mary's mother died in her country of origin and Mary did not receive notice that her mother was even ill until after she was dead. Mary felt guilty at not being there with her mother. When she saw her mother in her dreams, she got scared and kept waking up. We established that Mary had a good relationship with her mother and they loved each other very much.

Mary was asked to consider the possibility that her mother was not angry and came in the dream to express

her love and tell her that she would watch over and guide her when she needed support. There should be no reason for Mary to feel guilty about not being with her mother. We established that Mary's mother only wanted the best for Mary and would not want her to suffer because of her death. Mary was able to imagine talking to her mother and settling the unresolved feelings.

When Mary visited 2 weeks later, she was having no more insomnia and was sleeping comfortably through the night. She felt that her mother was with her as a spirit guide and she could depend on her watching over her when she needed it.

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Cholesterol-lowering agent

## INDICATIONS AND CLINICAL USE

As an adjunct to diet for the reduction of elevated total and LDL-C levels in patients with primary hypercholesterolemia, whether the elevated serum cholesterol is associated with triglyceride levels that are normal (Type IIa) or increased (Type IIb).

To determine which patients to treat, initially establish that the elevation in plasma lipids is not due to secondary conditions such as poorly-controlled diabetes mellitus, hypothyroidism, the nephrotic syndrome, liver disease, or dysproteinemias. Then ascertain whether elevated LDL-C level is the cause for elevated total serum cholesterol, particularly in patients with total triglycerides over 4.52 mmol/L (400 mg/dL) or with markedly elevated HDL-C values, where non-LDL lipoprotein fractions may contribute significantly to total cholesterol levels, without apparent increase in cardiovascular risk.

## CONTRAINDICATIONS

Hypersensitivity to any component. Active liver disease or unexplained persistent elevations of serum transaminases. Pregnancy and lactation (see PRECAUTIONS).

## WARNINGS

**The effect of lovastatin-induced changes in lipoprotein levels, including reduction of serum cholesterol, on cardiovascular morbidity or mortality has not been established.**

**1. Liver Dysfunction:** In controlled clinical trials, marked persistent increases in serum transaminases occurred in 1.8% of adult patients who received lovastatin for at least one year (see ADVERSE REACTIONS). Increases usually appeared 3 to 12 months after start of therapy and were not associated with jaundice or other clinical signs or symptoms. Serum transaminases fell slowly to pre-treatment levels when drug was interrupted or discontinued.

**Present clinical experience indicates that all patients should have liver function tests at baseline and every 4-6 weeks during the first 15 months of therapy, and periodically thereafter.** Patients who develop elevated serum transaminase levels, require particular attention, prompt retesting, and more frequent testing.

**Discontinue drug if transaminase levels show evidence of progression, particularly a rise to 3 times the upper limit of normal.** If elevations still persist, make further investigations, including liver biopsy if necessary.

Use with caution in patients who consume substantial quantities of alcohol and/or have a history of liver disease. Discontinue drug if active liver disease or unexplained serum transaminase elevations develop during therapy (see CONTRAINDICATIONS).

Moderate elevations of serum transaminases, reported with lovastatin, have also been observed with other, comparative lipid-lowering agents. These changes generally appeared within the first 3 months after initiation of therapy, were often transient, not accompanied by any other symptoms, and did not need interruption of treatment.

**2. Muscle Effects - CPK:** Transient elevation of creatine phosphokinase (CPK) levels commonly seen, have usually no clinical significance. - **Myalgia** and muscle cramps have also been observed. - **Rhabdomyolysis** occurred rarely, consider possibility in any patient with diffuse myalgias, muscle tenderness and/or marked elevation of creatine phosphokinase (10 times the upper limit of normal). In cardiac transplant patients receiving immunosuppressive drugs including cyclosporine, severe rhabdomyolysis that precipitated acute renal failure, has been reported. **Discontinue lovastatin if marked elevation of CPK levels occurs and institute appropriate therapy. - Myopathy:** Mostly seen in patients receiving concomitant immunosuppressive drugs that included cyclosporine, gemfibrozil or lipid-lowering doses of niacin. **Carefully consider benefits and risks of concomitant use with immunosuppressive drugs, fibrates or lipid-lowering doses of niacin. Consider interrupting lovastatin in any patient with a risk factor predisposing to development of renal failure or rhabdomyolysis, such as: severe acute infection, hypotension, major surgery, trauma, severe metabolic, endocrine or electrolyte disorders and uncontrolled seizures.**

## PRECAUTIONS

**General:** Before starting therapy, attempt to control hypercholesterolemia with appropriate diet, exercise, weight reduction in overweight and obese patients, and to treat underlying medical problems (see INDICATIONS). The patient should inform subsequent physicians of prior use of lovastatin. **Ophthalmological observations:** No unequivocal evidence exists that lovastatin causes human lens opacities, but lack of an effect on the lens has not been established. Pending further experience, it is recommended that patients undergo a lens examination before or shortly after initiation of lovastatin and annually thereafter. **Homozygous familial hypercholesterolemia:** Lovastatin is less effective in this rare condition, and appears to be more likely to raise serum transaminases in these homozygous patients. **Carcinogenesis:** In animal studies, increased incidence of hepatocellular carcinomas and adenomas, and pulmonary adenomas was noticed in mice receiving 312 times the maximum recommended human dose; but no evidence of a tumorigenic effect was observed in rats receiving 112.5 times the maximum recommended human dose. (See TOXICOLOGY section of Product Monograph.) **Use in pregnancy: Lovastatin is contraindicated** and there are no data on its use in pregnancy. Because the HMG-CoA reductase inhibitors are able to decrease the synthesis of cholesterol and possibly other products of the cholesterol biosynthesis pathway that are essential components for fetal development, lovastatin may cause fetal harm. Administer to women of childbearing age only when they are highly unlikely to conceive. If patient becomes pregnant, apprise her of potential hazard to the fetus, and discontinue drug. **Nursing mothers:** Whether lovastatin is excreted in human milk is unknown. However, because of the potential for serious adverse reactions in nursing infants, women taking lovastatin should discontinue nursing (see CONTRAINDICATIONS). **Pediatric use:** Safety and effectiveness have not been established; therefore lovastatin therapy in children is not yet recommended. **Use in patients with impaired renal function:** Exercise caution if renal function impairment is significant.

## Drug Interactions

**Concomitant therapy with other lipid-lowering agents:** Cholesterol-lowering effects of lovastatin and cholestyramine appear

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additive. Exercise caution when coadministering with other lipid-lowering agents, particularly gemfibrozil and niacin (see WARNINGS). **Coumarin anticoagulants:** Carefully monitor prothrombin time in patients on concomitant coumarin anticoagulants, because occasional bleeding and/or increases in prothrombin time have been reported. **Digoxin:** Digoxin plasma concentrations were not affected by coadministration of lovastatin in hypercholesterolemic patients. **Beta-adrenergic blocking drugs:** No clinically relevant interaction reported in patients on concomitant lovastatin. **Antipyrene:** Lovastatin had no effects on the pharmacokinetics of antipyrene. **Other concomitant therapy:** In clinical studies, lovastatin was used with verapamil, nifedipine and diltiazem, a number of diuretics and NSAIDs, without evidence of clinically significant adverse interactions.

**Drug/laboratory test interactions:** Lovastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). In differential diagnosis of chest pain in patients on lovastatin, determine cardiac and non-cardiac fractions of these enzymes.

## ADVERSE REACTIONS

Lovastatin was found generally well tolerated, and adverse reactions usually mild and transient, based on experience in over 1,300 patients (about 800 treated for 1 year and over 250 for 2 years or more). In controlled clinical trials, less than 1% were withdrawn due to adverse experiences attributable to lovastatin. Adverse experiences reported in controlled clinical studies are shown in table below.

	Lovastatin (n = 813) %	Placebo (n = 82) %
<b>Gastrointestinal</b>		
Constipation	4.9	-
Diarrhea	5.5	4.9
Dyspepsia	3.9	-
Flatul	6.4	2.4
Abdominal pain/cramps	5.7	2.4
Heartburn	1.6	-
Nausea	4.7	3.7
<b>Musculoskeletal</b>		
Muscle cramps	1.1	-
Myalgia	2.4	1.2
<b>Nervous System/Psychiatric</b>		
Dizziness	2.0	1.2
Headache	9.3	4.9
<b>Skin</b>		
Rash/pruritus	5.2	-
<b>Special Senses</b>		
Blurred vision	1.5	-
Dysgeusia	0.8	-

**Laboratory tests:** Marked persistent increases of serum transaminases noted (see WARNINGS). About 11% of patients had elevations of CPK levels of at least twice normal value, attributable to the non-cardiac fraction of CPK, on one or more occasions. Muscle pain or dysfunction was not usually reported; however, myopathy with large increases in CPK occasionally occurred (see WARNINGS and PRECAUTIONS). **Nervous system:** In the single case of peripheral neuropathy reported, relationship to lovastatin was uncertain. Intensive neurological testing in over 30 patients showed no evidence of neurotoxic effects of lovastatin. **Ophthalmological observations:** (see PRECAUTIONS).

## SYMPTOMS AND TREATMENT OF OVERDOSAGE

In the few cases of accidental overdosage reported, no patients had any specific symptoms and all recovered without sequelae. Maximum dosage taken was 1.04 g (fifty-two 20 mg tablets). **Treatment** should be symptomatic and supportive. Liver function should be monitored, and appropriate therapy instituted. Dialyzability of lovastatin and its metabolites in man, is unknown.

## DOSAGE AND ADMINISTRATION

Before initiating lovastatin, place patient on standard cholesterol-lowering diet, and continue on this diet during treatment. If appropriate, implement a program of weight control and exercise. **Usual starting dose:** 20 mg/day, as a single dose with evening meal (such a regimen has been shown to be more effective than morning dosing). Make dosage adjustments, if necessary, at intervals of not less than 4 weeks, to maximum of 80 mg daily, given as a single dose or divided between morning and evening meals. (Twice daily dosing tends to be slightly more effective than single daily dosing.) **Monitor cholesterol levels periodically and consider reducing dosage if cholesterol levels fall below targeted range, as recommended by the Canadian Consensus Conference on Cholesterol.**

**Concomitant therapy:** Cholesterol-lowering effects of lovastatin and cholestyramine appear additive. For use with other lipid-lowering agents, see WARNINGS and PRECAUTIONS.

## DOSAGE FORMS AND AVAILABILITY

MEVACOR® Tablets are octagon-shaped, flat, bevelled-edged, engraved with code on one side and product name on other.

MEVACOR® 20 mg light blue, scored tablet, engraved 731/731; available in blister packages of 30 and in bottles of 1000.

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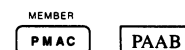
## PRODUCT MONOGRAPH AVAILABLE ON REQUEST

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Involving family members in the therapy can mobilize additional support. Often working on forgiveness and helping patients to express unspoken feelings eases the grief and helps patients to heal. ■

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