Why should primary-care physicians know anything about bereavement counseling? Dealing with loss is a vital part of primary care. If one looks at the work of Drs. Holmes and Rhea in developing the social readjustment rating scale,\(^1\) significant loss takes up many of the top 10 social readjustment events that affect one’s personal health. If proper coping strategies are applied, they can help prevent both physical and mental illness in the future.

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Bereavement Counseling: The Role of the Family Physician

At some point in every patient’s lifetime, he or she will experience a great sense of loss due to the death of a loved one. The primary-care physician can play a vital role in guiding these patients during their time of need.

By Michael A. Dworkind, MDCM, CCFP, FCFP

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Family physicians are regularly approached by patients dealing with the distress associated with grief and bereavement. The symptoms can be both physical and emotional, and may not always be directly associated with the grief experiences. This usually is the case if the grief reactions are maladaptive and prolonged, or when the bereaved person does not recognize the connection between the loss and the symptoms they are experiencing.

Contemporary society has transformed itself in some ways, so resources that have traditionally helped the bereaved are often absent or inadequate. The importance of religion in daily life, the disruption of the extended family and the lack of support of neighborhood communities have all played a role in making the family physician the potential center of strength for the bereaved. Furthermore, the death-denying nature of North American society, in general, shows its impatience by not offering ongoing support to the bereaved. People may use unhelpful coping strategies to assist friends and families in grief. Examples of unhelpful clichés are: “bury your feelings,” “replace the loss,” “grieve alone,” “just give it time,” and “don’t regret the past.”

This denial of grief starts in childhood with the avoidance of suffering. Even as we mature, there are maladaptive messages that address childhood memories of dealing with loss. For example, we are told: “big boys and girls don’t cry,” “stop that crying, there is nothing to cry about,” and “Oh, you’re just a little cry baby.” These messages convey the attitude that expressing one’s tears in grief is socially unacceptable. Within this social context, bereavement counseling potentially plays an important function in helping people express their feelings and adjust to their loss.

**Goals of Grief Counseling**

The family physician should guide and support the bereaved through the various tasks and phases of the process of grief. The bereaved can be helped to achieve certain goals, which include: completing unfinished business with the loss; becoming fully aware of the reality of the loss; dealing with the expressed emotional issues; overcoming various impediments in the readjustment over the loss; and having an opportunity to say the final goodbyes.

To achieve these goals, one must first recognize what is normal grief and what is complicated grief and/or depression. Abnormal grief reactions fall into several different types, such as chronic grief reactions, delayed or exaggerated grief reactions and masked grief reactions. Diagnostic criteria for these complicated grief disorders include those mentioned in Table 1.

Certain high-risk predictors have been identified in the literature. The grieving person may express the desire for their own death several months after the loss, and feel guilty they have survived and their loved one is gone. This high level of self-reproach is a significant predictor of abnormal grief, and may lead to serious depres-

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**Table 1**

**Diagnostic Criteria For Complicated Grief Disorders**

- Current experience (more than one year after loss) of intense intrusive thoughts.
- Pangs of severe and uncontrollable emotions.
- Distressing yearnings that are persistent and intense, with strong feelings of being alone.
- Excessively avoiding reminiscence of the deceased.
- Unusual sleep disturbance.
- Maladaptive levels of interest in personal activities.
sion, and even psychotic grief reaction with suicidal tendencies. This can be seen especially when the length of the terminal illness is brief, or when the loss is sudden and unexpected, as in the form of an accident or violent death. High-risk predictors also include low social class, and isolation of the person, especially if they are single parents with few relatives and friends. A spouse’s overly dependent state or a possible ambivalence in the relationship also is symptomatic, especially for the individual who has difficulty expressing feelings, is under particular financial stress, needs to move from the established home or has a past history of depression. These determinants suggest an increased risk of complicated grief.5,6

Normal grief reactions. Grief and depression are not the same, although there are common manifestations that overlap one another, such as sadness, guilt, and psychomotor retardation. However, grief is an adjustment reaction, and should not be treated routinely with antidepressants unless the grief reaction appears seriously profound. The grieving individual may have feelings of anxiety, anger, yearning, numbness, shock, and helplessness. Others may feel strong feelings of emancipation and even relief at the time of the loss, especially if there was significant anticipatory grief before the loss. Feelings of helplessness and guilt can be extreme, however, and there may be serious vegetative symptoms. These symptoms could include loss of appetite and significant weight loss. Where the functional impairments are extreme, the individual should be considered as being depressed.

The grief reaction depends on the relationship that existed with the deceased. Family relationships can be complex, with mixed feelings of love, anger, frustration, and regret.

Physicians often respond to grief by inappropriately prescribing antidepressants when, in fact, counseling plays a more important role. In some cases, medication may be counterproductive. Helping the individual patient with sleep disturbance by using low doses of sedating antidepressants is acceptable, without having to use higher antidepressant doses as pharmacotherapy.

To help differentiate between grief and depression, although both share the symptoms of sadness, sleep disturbances, and appetite disturbances, remember there is generally no significant loss of self-esteem or sense of guilt in normal grief reactions. The continuum of grief reaction and depression can occur in a situation involving significant loss, and might require referral to a mental health specialist (psychiatry/psychology). This is particularly helpful for assessment in cases where there are suicidal thoughts or where the reaction is devastatingly profound or unusually prolonged and inconsistent with normative grief responses.7,8

The Normative Grief Response

To better understand grief, it is important to identify the cognitive, emotional, perceptual, and behavioral changes that occur in acute grief reac-

Table 2
Common Behaviors In Normal Grief

- Sleep disturbance with dreams of deceased.
- Appetite disturbances usually decreased, but can be increased.
- Absent-minded behavior.
- Social withdrawal, especially avoiding reminders of the deceased.
- Searching and calling out; treasuring objects.
- Restless over activity.
- Unrelentless sighing and crying.
The most significant behavioral changes associated with acute grief are feelings of sadness, anger and guilt. These are frequently tied in with cognitive symptoms, such as confusion, preoccupation with the deceased and disbelief that they are actually dead.

The grieving individual will frequently have visual or auditory hallucinations in which they hear the voices of their loved ones. Certainly, dreaming of the deceased is common, and makes the bereaved feel somewhat depersonalized by the loss (Table 2).

Frequently, grieving people will come to the family physician complaining of physical manifestations of normal grief. This can range from anxiety symptoms, such as tightness in chest, breathlessness, dizziness, difficulty swallowing and dry mouth, to symptoms of depression, such as lack of appetite, lack of energy, difficulty concentrating and oversensitivity to noise. Some people, however, may share the cognitive manifestations of normal grief by simply describing the loneliness and emptiness of life without their significant other.

The timeline of grief varies considerably, and is unique from individual to individual. There are usually strong determinants of past experience of loss and cultural issues are important. The common scenario is of an intense grief experience of up to six months, then subsiding over the next 12 to 18 months (Figure 1). This has been described as normal, however, grief can appear as a wave of episodic intensity and variability, extending over many months with much variation (Figure 2).7,8

Anticipatory grief may be experienced by family and survivors when the dying process is prolonged. It occurs prior to the actual loss and can facilitate the first task of mourning, which is accepting the reality of the loss. This also could lead to anticipatory guilt feelings when the anticipatory grief predates the death by many months.
This leads to resentment and dysfunction in many cases. During this time, both patients and family experience intense swings of emotions. The physician can help families become aware of their reactions and how to better cope.

In his excellent book on bereavement counseling, Dr. William Worden describes four tasks of mourning:

Task 1. To accept the reality of the loss;
Task 2. To experience the pain of grief;
Task 3. To adjust to an environment in which the deceased is missing; and
Task 4. To withdraw emotional energy from the deceased and reinvest it in another relationship. Normally, each of these tasks needs to be accomplished before the next can be achieved, and each is linked to a specific goal. It is generally assumed that, to facilitate a healthy emotional withdrawal from the deceased and reinvest in another relationship, individuals must readjust in a world where the deceased is absent. This goal can only be achieved when the individual is helped to accept the reality of the loss and guided through the painful work of grief (Task 1). This goal can be facilitated by grief counseling if the individual is stuck on

<table>
<thead>
<tr>
<th>Misconception</th>
<th>Reality</th>
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<tr>
<td>I might upset them.</td>
<td>They're already upset; that is part of grieving.</td>
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<td>They need to keep busy.</td>
<td>Routine activities are important but new activities may confuse them.</td>
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<td>Getting rid of reminders helps; encourage only good memories.</td>
<td>Not thinking about it delays grief.</td>
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<td>I won’t mention it unless they do.</td>
<td>This tells them it’s wrong to think of the dead person or to have bad memories.</td>
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<tr>
<td>Once they’ve been angry or guilty, that should be the end of it.</td>
<td>This suggests it is not all right to mention the person; that there is something bad about them or their death.</td>
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<tr>
<td>It is morbid to want to touch or talk about the body.</td>
<td>They may feel hurt and sense your discomfort.</td>
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<td>Use terms like “passed away” or “gone to heaven.”</td>
<td>Phases are circular and each implication of the loss must be grieved.</td>
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<td>If they are not expressing grief, children aren’t grieving.</td>
<td>It is a good way to say good-bye and make the death seem real.</td>
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<td>I should tell them all the facts immediately.</td>
<td>These confuse and frighten children: “dead” is better.</td>
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<td></td>
<td>They may not know how to express feelings or think they have permission to grieve. They may delay grief to avoid upsetting others.</td>
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<td></td>
<td>They may not understand all aspects of the death or be able to handle the intensity.</td>
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One of the foremost researchers in the area of bereavement and grief counseling is the British psychiatrist, Dr. Collin J. Parkes, who once said: “Once the grieving person accepts the reality of the loss, it is necessary for the bereaved person to go through the pain of grief in order to get the grief work done. Anything that continually allows the person to avoid or suppress this pain can be expected to prolong the course of grieving” (Task 2).

It is for this reason that the use of anxyolitics, sedatives or antidepressants contributes to the suppression of emotional pain and incompletion of the work of grief.6

Family physicians can help the surviving fami-

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**Table 4**

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<tr>
<th>10 Principles Of Grief Counseling</th>
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<tr>
<td>1. Help the survivor actualize the loss.</td>
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<td>2. Help the survivor identify and express feelings.</td>
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<td>3. Assist the living without the deceased.</td>
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<td>4. Facilitate emotional withdrawal from deceased.</td>
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<td>5. Provide time to grieve.</td>
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<td>6. Interpret normal behavior.</td>
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<td>7. Allow for individual differences.</td>
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<td>8. Provide continuing support.</td>
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<tr>
<td>10. Identify pathology and refer appropriately.</td>
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</table>
ly member to complete Task 3 by becoming aware of the previous roles played by the deceased. The family physician also must be aware of the need to redefine the loss and give back control and autonomy to the surviving family members. One should help the bereaved recognize they might be grieving the loss of the hopes, dreams and unfulfilled expectations of the deceased.

In Task 4, among the myths that must be dispelled is that withdrawal of the emotional attachments somehow dishonors the memory of the deceased, and that there can only be one true love in the case of spousal loss. In reality, approximately 25% of widows remarry with a greater propensity for widowers in this category. By contrast, 75% of divorcees remarry.7

Allow Children To Grieve
Families often will try to protect children from experiencing grief, which is one of life’s important lessons. Children of all ages should be encouraged to participate in the dying process together as a family. Denying them this opportunity could have long-term negative consequences on childrens’ emotional development.3 Table 3 summarizes some of the issues in childhood grief and adult responses.5

When Does Mourning Finish?
The literature is clear that mourning can be a long-term process and, for some people, it never ends. As time goes on, the painfully emotional yearnings occur less frequently. Some studies show
that it takes anywhere from three to four years to reach stability in the lives of widows. In this chronic grief phase, the physical, mental and emotional symptoms improve and disappear slowly over time.2,7

Anniversary reactions are critical temporal aspects of grief work that may manifest themselves in subtle ways; for example, often without the individual’s awareness they are actually reliving the mourning process. When that time of year returns, even many years hence, the date acts as a reminder of those painful losses of the past.

Family physicians who record the dates of significant losses in the problem list of the individual patient will find this extremely helpful, especially when patients present with non-specific physical and emotional changes, which represent acute grief reactions. Patients may not recognize that their denial of stress, and their feelings of fatigue and malaise are really just an indication of a legitimate anniversary reaction to loss. These may present as acute spasms or upsurges of grief that occur without warning.

Gaining insight into this recurrent pattern over time can be extremely therapeutic for patients. In helping individuals through their painful memories of loss and exploring their responses to it, the physician can direct these energies by creating rituals (e.g., candle-lighting and prayers, family gatherings where the loss and bereavement can be legitimized and even celebrated). This may help reduce some of the intense grief feelings.

See Table 4 for 10 principles of grief counseling. These principles can help the family physician accompany their patients through the work of grief.

**Bereavement Counseling**

Does Bereavement Counselling Work?

In most studies, high-risk patient populations have better outcomes than controls when bereavement counseling is applied. Most grieving patients receive support and bereavement counseling from many other sources, including families, self-help groups and/or social workers, and pastoral care. Research has shown that factors determining a positive outcome are: the warmth of the therapist; the therapist’s ability to accept the opening grieving patient; and the degree to which the therapist explores the painful aspects of grieving.5,8

References


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Answer the questions in our quiz found on page 207 and send the response card to the University of Calgary for CME credits.