International Journal of Emergency Mental Health and Human Resilience, Vol. 17, No.2, pp. 548-551, ISSN 1522-4821

Family Physicians and Primary Bereavement Care

Jesus García[1]*, Victor Landa[2]

[1]Kueto Health Centre, Sestao, Bizkaia, Basque Country, Spain
[2]Basauri Health Centre, Basauri, Bizkaia, Basque Country, Spain

ABSTRACT: *The authors put forward the proposal that family physicians - in primary care - can establish with bereaved people a helping relationship, give them an ear, facilitate their emotional expression, give information about their bereavement, normalize their process, and orientate them. These psychotherapeutic non-specific factors may be remembered using the acronym REFINO (relationship, ear, facilitation, information, normalization, and orientation). However there is no evidence on the best bereavement intervention in primary care, so the discussion about the over-prevention or over-treatment of bereaved people and the damage that these can produce continues open. Family physicians should try with new and original bereavement interventions - especially in primary prevention - in primary care.*

Key words: *Bereavement, family physicians, general practitioners, grief, primary care*

Nurses, counsellors, social workers, psychologists, psychiatrists, family, friends, neighbours, and – especially – bereaved people who help other bereaved people are crucial in bereavement community care, but family physicians (FPs) are the bereavement community care givers *par excellence* (Woof & Carter, 1997, part 1; Woof & Carter, 1997, part 2; Saunderson & Ridsdale, 1999; Nagraj & Barclay, 2011).

Recently bereaved people visit their health centre 9-10 times per year, 80% more than the rest of the population (López, Bartolomé, Gómez, & García-García, 2001), and relatives of cancer patients are more likely to attend their FPs both before and after the death of their partners (King et al., 2013). Bereaved people think that bereavement support is an important part of the FP role (García-García et al., 1996; Main, 2000), and say that – in general – they only need some form of contact from their FPs after bereavement, for instance a letter of sympathy (Main, 2000), and a safe place where they can talk about death (García-García, Landa, Trigueros et al., 1996). Curiously, bereaved people are more likely to receive a prescription for antidepressant or hypnotic medication than their counterparts (King et al., 2013), although the evidence only supports the use of nortriptyline in depression occurring in the context of bereavement, and not the use of diazepam following recent bereavement (Forte et al., 2004; Bui et al., 2012).

Primary Care (PC) may be the ideal place to help and support bereaved people, providing preventive care where problems are likely to occur (Charlton & Dolman, 1995). Nevertheless FPs should be aware of over-eager and aggressive bereavement intervention, they should be accessible, but not intrusive (Mazza, 1998). Primary Bereavement Care (PBC) may take the form of tactful vigilance, quietly watching bereaved people for possible signs of approaching trouble, and intervening in a structured way only when needed (Caplan & Caplan, 2000).

The authors have proposed the Spanish acronym REFINO (relationship, ear, facilitation, information, normalization, and orientation) to remember the psychotherapeutic non-specific factors present in any meeting between FPs and bereaved people in PC (García-García, 2005; García-García & Landa, 2006; Landa & García-García, 2011).

*Correspondence regarding this article should be directed to: jesusangel.garciagarcia@osakidetza.net

RANDOMIZED CONTROL TRIALS IN PRIMARY BEREAVEMENT CARE

There are only two randomized controlled trials in PBC, and both of them are congruent in their results. There were no differences between intervention [information pamphlet (Guldin, Vedsted, Jensen et al., 2013) or structured PBC (Garcia, Landa, Grandes et al., 2013)], and control groups [usual care (Guldin et al., 2013; Garcia et al., 2013)]. Bereaved people improved through time in both the intervention and control groups. One of the trial even showed that some of the control group felt better than the intervention group (Garcia, Landa, Grandes et al., 2013).

Guldin, Vedsted, Jensen, Olessen & Zachariae's 2013 Study

In this interesting Danish study titled: "Bereavement in general practice: a cluster-randomized clinical trial", the matter was to know if the "dissemination of information about bereavement and risk factors for complicated grief to FPs would (i) improve detection of complicated grief, (ii) ensure that more complicated grief patients receive proper treatment and (iii) alleviate grief symptoms more efficiently than usual care" (p.135). The intervention consisted of information pamphlets delivered to both FPs and patients by mail. FPs received information about assessment of complicated grief and supportive bereavement care, and patients were encouraged to contact their FPs if they showed signs of depression or complicated grief, or if they were worried about their bereavement reaction. The authors found some indications of an effect of the intervention compared with usual care, but their results were only statistically near significant. They concluded that "these results underpin the need for more research to test potential moderators of treatment response and to improve the identification and treatment of complicated grief in PC" (p.141).

Garcia, Landa, Grandes, Pombo & Mauriz's 2013 Study

In this Spanish study titled: "Effectiveness of Primary Bereavement Care in widows: a cluster randomized controlled trial involving family physicians", the following hypothesis was considered: "although all recently bereaved widows included in the study improved over time, those that received the primary bereavement care would improve more rapidly" (p.289). The intervention was a face to face standardized

bereavement intervention in PC – summarized in a detailed manual (available from the authors on request) drawn up by the research team – delivered by FPs trained in it. The authors found that there were no significant differences in favour of the intervention group, and in fact control widows experienced more improvement in somatization, general health, and general emotional outcomes. They concluded that "early manual-based bereavement intervention in widows, provided by FPs trained in it, does not produce better outcomes than usual care provided by FPs not trained, with the same appointment schedule, and on some measures, may actually worsen bereaved outcomes" (p.306). Although these results may look disappointing, they are not. They are in fact very enlightening because they show us that even if you dedicate more time and effort, sometimes you obtain the same or even worse results (Fortner, 1999), proving once again that in health care sometimes "less is more" (Grady & Redberg, 2010). Years ago, Von Fortner (1999) in his dissertation "The effectiveness of grief counselling and therapy: a quantitative review", one of the first meta-analysis in bereavement intervention, drew attention to "a statistical method for determining the theoretical proportion of participants who were worse after treatment than they would have been if they had been assigned to the control group, an effect termed treatment-induced deterioration" (p.14). Later on, Grady & Redberg (2010) in their impressive paper "Less is more. How less health care can result in better health", attracted our attention to the same idea:

If some medical care is good, more care is better. Right? Unfortunately, this is often not the case. Across the United Sates, the rate of use of medical services varies markedly, but measures of health are not better in areas where more services are provided. In fact, the opposite is true - some measures of health are worse in areas where people receive more health services (p.749).

LEVELS OF PREVENTION IN PBC

The preventive levels for mental health defined by Caplan and Caplan (2000) in community psychiatry, are used to define the objectives in PBC.

Caplan & Caplan (2000) primary prevention level "seeks to reduce the frequency of new cases of mental disorder in a population (incidence) by combating harmful factors in a population of currently healthy people" (p.12). The target population of primary prevention in PBC encompasses low, moderate and high risk but healthy bereaved people. The objective in this level is to help bereaved people to cope with their grief in the most natural and healthy way possible, including growing through it and not becoming ill. There is an enormous discussion about bereavement intervention in primary prevention, but if – in this prevention level – FPs are not proactive it may be dangerous because the people that could benefit more from PBC sometimes do not receive it. Now Schut & Stroebe (2011) recognize that this question is not as clear as they initially thought:

There is also sufficient evidence to show that unsolicited help based on routine referral and delivered shortly after loss is not likely to be effective. Using such scientific knowledge when designing the intervention programme might increase the likelihood that an evaluation will show positive outcomes. However, we should not lose sight of the complex ethical issues that adopting such strategies may raises, even if they are scientifically-based. For example, although in-reach (the bereaved people seeking help themselves) is associated with better intervention results than outreach (an organization offering help to the bereaved person), a service that only responds to requests for help may exclude those who are, for various reasons, unable to seek professional support (p.7).

Caplan & Caplan (2000) secondary prevention level "seeks to reduce the rates of old and new cases of mental disorder in the population (prevalence) by early diagnosis and by prompt and effective treatment" (p.12). In this level FPs are responsible for early diagnosis of complicated grief to establish prompt therapy and/or reference to another professional, and follow-up and/or give counselling to bereaved people with previously diagnosed complicated grief.

Caplan & Caplan (2000) tertiary prevention level "seeks to reduce the rate of residual disability in people who have in the past suffered from mental disorder by means of programs of rehabilitation to improve their role functioning" (p.12). In this level FPs are responsible for following-up and supporting people with long-term bereavement issues.

UNAVOIDABLE BEREAVEMENT INTERVENTION IN PRIMARY CARE

The following statement was written by a widow who lost her spouse after a very long illness:

In my opinion, health workers intervene, whether they want to or not, whether they realize it or not; because when a person is grieving any encounter with the health professional turns into an intervention. Bereaved people become so vulnerable and sensitive, that gestures as simple as saying good morning to them or calling them by their name are essential. A look, a sign that shows understanding without words or a silence that accompanies and respects their desire for nothing. Those little details are so significant and important that they deserve to be given a name: unavoidable interventions. Neglecting these unavoidable encounters could make bereaved people feel really uncomfortable, adding pain to the great pain that already exists (Montse, 2012).

Bereavement interventions in PC – in western societies – are unavoidable. When FPs ask bereaved people "How are you?" in a professional frame, this is an unavoidable bereavement intervention (UBI), and the psychotherapeutic non-specific factors are present. UBI is far away from a structured bereavement intervention given by a counsellor or a psychotherapist, or tested in a randomized control trial; it might be closer to the bereavement intervention that occurs unwanted in a control bereaved group, and it is for that reason that it is so difficult to evaluate its effectiveness.

THE PSYCHOTHERAPEUTIC NON-SPECIFIC FACTORS AND THE ACRONYM REFINO

Nearly 80 years ago, Rosenzweig (1936) noting that all forms of psychotherapy had cures to their credit, invoked the famous "Dodo Bird verdict" from Alice in Wonderland, "Everybody has won and all must have prizes", to characterize psychotherapy outcomes. He suggested that therapy works for reasons other than those championed by the major theories, and suspected that in any therapeutic situation there were inevitably certain unrecognized factors. Factors that may be even more important than those being purposely employed, and that account for the result that apparently diverse forms of psychotherapy prove successful in similar cases, such as the therapeutic relationship, the possibility for catharsis or the indefinable effect of the therapist's personality factors. Afterwards, Frank (1973; 1974), in his classic "Persuasion and healing", posits that all psychotherapeutic methods are elaborations and variations of age-old procedures of psychological healing: the therapeutic relationship, a rationale that offers an explanation of the cause of the patient symptoms, convincing to the patient and the therapist, activation of the patient's favourable expectancies, and provision of a new social learning experience. Later Greencavage & Norcross (1990) described the psychotherapeutic non-specific factors that were considered more important to the psychotherapists with greater influence at that time: the relationship between the client and the therapist (with a proportional weight of 56%), opportunity for catharsis (38%), acquisition of new behaviours (32%), patient hope for improvement (26%), provision of rationale (24%), and the

therapist personality (24%). Now, despite a noticeable increase in the quantity and quality of psychotherapy outcome studies, research has revealed surprisingly few significant differences in outcome among different therapies, and with several exceptions there is little evidence to recommend the one type over another in the treatment of the specific problems (Wanpold et al., 1997; Luborsky et al., 2002). We can say with Luborsky et al (2002) that "The Dodo Bird Verdict is alive and well, mostly". The common factors approach seeks to determine the core ingredients that different therapies share in common, with the goal of creating more efficacious treatments based in those commonalities. This search is predicated on the belief that commonalities are more important in accounting for therapy outcome than the unique factor that differentiates them (Greencavage & Norcross, 1990). All these common factors arise in any FP and bereaved people encounter in PC and they can be remembered using the acronym REFINO: relationship, ear, facilitation, information, normalization, and orientation (García-García, 2005; García-García & Landa, 2006; Landa & García-García, 2011).

Relationship

To establish a suitable professional relationship is to have a strategy and objectives, provide time and space to the bereaved people, to try to be empathetic, genuine and natural, to be respectful (to avoid snap judgments), to deal with the bereaved as an equal, and to give care in one direction.

Ear or "lending an ear"

To listen in an active way is to listen attentively to verbal and non verbal, to what is said and what is not said, with the focus on "here and now", it is intense, listening to the bereaved and observing yourself, and at the same time not getting involved in the emotional twister.

Facilitation

To facilitate bereaved people is to encourage communication and emotional expression through open questions, low reactivity, eye contact, silences, echoing, nodding agreement, summarizing, waiting, being patient, "making room" and giving permission, and creating a safe atmosphere.

Information

To inform the bereaved is to explain "western bereavement" but that they are "unique", to reassure that the natural way is to adjust, to speak about the cemetery, the wish to die, etc., and sometimes using leaflets: "every person goes through a unique form of bereavement..."

Normalization

To normalize bereaved people is to reassure them that what they feel is normal and natural in their situation, validating their reactions, confirming them, and freeing them from guilt, taking care of the pacing of the meeting, and emphasizing that they do not need to forget and can continue talking to the deceased.

Orientation

To orientate is to guide, suggest or prescribe certain behaviours or rituals, dissuading from sudden or important decisions, promoting minor decisions and giving advice in family reorganization.

CONCLUSION

Effectiveness of preventive interventions in bereavement care is both an old and a very up-to-date story that still remains an open question (Fortner, 1999; Schut & Stroebe, 2011; Currier et al., 2008; Neimeyer, 2010; Schut, 2010; Hoyt & Larson, 2010; Wittouck, et al., 2011). Clinicians working in PC need more answers, and researchers investigating in PC need to conceive new and imaginative bereavement interventions with clearly a tactful but definite outreach strategy. Meanwhile, and considering the unavoidable bereavement interventions in PC, the authors suggest the psychotherapeutic non-specific factors – REFINO – as a first approach to bereaved people in PC.

In conclusion, an ideal bereavement intervention model in PC would use FPs trained in basic bereavement care, willing to discuss feelings with bereaved people, and using a less structured intervention; minimal and natural responsiveness in cases of normal grief (REFINO), deeper intervention in high risk cases, and much deeper in complicated grief, where referral to a mental health specialist could be indicated (García, Landa, Grandes et al., 2013).

Acknowledgements

We want to express our gratitude to Patsy Rose, Alba Payás and Sira and Ruth Garcia, who helped us to translate, edit and refine this article.

Conflicts of Interest Statement

The authors declare that there is no conflict of interest.

REFERENCES

Bui, E., Nadal-Vicens, M., & Simon, N.M. (2012). Pharmacological approaches to the treatment of complicated grief: rationale and brief review of the literature. *Dialogues in Clinical Neuroscience, 14*, 149-157.

Caplan, G., & Caplan, R. (2000). Principles of community psychiatry. *Community Mental Health Journal, 36*, 7-24.

Charlton, R., & Dolman, E. (1995). Bereavement: a protocol for primary care. *British Journal of General Practice, 45*, 427-430.

Currier, J.M., Neimeyer, R.A., & Berman, J.S. (2008). The effectiveness of psychotherapeutic interventions for bereaved persons: a comprehensive quantitative review. *Psychological Bulletin, 134*, 648-661.

Forte, A.L., Hill, M., Pazder, R., & Feudtner, C. (2004). Bereavement care interventions: a systematic review. *BioMed Central Palliative Care, 3*(1), 3.

Fortner, B.V. (1999). *The effectiveness of grief counseling and therapy: a quantitative review.* Memphis, TN: The University of Memphis

Frank, J. (1973). *Persuasion and healing: a comparative study of psychotherapy*. Baltimore: The Johns Hopkins University Press.

Frank, J.D. (1974). Therapeutic components of psychotherapy. *The Journal of Nervous and Mental Diseases, 159*, 325-342.

García-García, J.A. (2005). Primary Bereavement Care: Does it work? *Proceedings of the 7th International Conference on Grief and Bereavement in Contemporary Society* (p.45). London, U.K: Cruse Bereavement Care. Retrieved from: http://www.crusebereavementcare.org.uk/CoursesEvents/IntntConf/Garcia-Garcia,%20Jesus%20Angel.pdf

García-García, J.A., & Landa, V. (2006). The provision of grief services by primary care physicians. European Journal of Palliative Care, 13, 163-166. Retrieved from http://uiapb.rediapp.net/UIAPBv2/pdf/articulo%20Eur%20J%20PallCare.pdf

Garcia, J.A., Landa, V., Grandes, G., Pombo, H., & Mauriz, A. (2013). Effectiveness of Primary Bereavement Care in widows: a cluster randomized controlled trial involving family physicians. *Death Studies 37*, 287-310.

García-García, J.A., Landa, V., Trigueros, M.C., Calvo, P., & Gaminde, I. (1996). El duelo por la pérdida del cónyuge: un estudio mediante grupos de discusión en atención primaria [The bereavement over loss of a partner: A focus group study in primary care]. *Atención Primaria, 18*, 475-483.

Grady, D., & Redberg, R.F. (2010). Less is more. How less health care can result in better health. *Archives of Internal Medicine, 170*, 749-750.

Grencavage, L.M., & Norcross, J.C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 21*, 372-378.

Guldin, M.B., Vedsted, P., Jensen, A.B., Olessen, F., & Zachariae, R. (2013). Bereavement in general practice: a cluster-randomized clinical trial. *Family Practice, 30*, 134-141.

Hoyt, W.T., & Larson, D.G. (2010). What have we learned from research on grief counselling? A response to Schut and Neimeyer. *Bereavement Care, 29*, 10-13.

King, M., Vasanthan, M., Petersen, I., Jones, L., Marston, L., & Nazareth, I. (2013). Mortality and Medical Care after Bereavement: A General Practice Cohort Study. *PLoS ONE, 8*. doi:10.1371/journal.pone.0052561.

Landa, V., García-García, J.A. (2011). Cuidados Primarios de Duelo [Primary Bereavement Care]. *Guías Clínicas*. Retrieved from http://www.fisterra.com/guias-clinicas/duelo/

López, M., Ela, M., Bartolomé, N., Gómez, J., & García-García, J.A. (2001). Is the use of the health care system increased by grief? *Proceedings of the 7th Congress of the European Association for Palliative Care* (p.45). Palermo, Italy: EAPC.

Luborsky, L., Rosenthal, R., Diguer, L., Andrusyna, T.P., Berman, J.S., Levitt, J.T., et al. (2002). The Dodo Bird Verdict is alive and well – mostly. *Clinical Psychology: Science and Practice*, *9*, 2-12.

Main, J. (2000). Improving management of bereavement in general practice based on a survey of recently bereaved subjects in a single general practice. *British Journal of General Practice, 50*, 863-866.

Mazza, D. (1998). Bereavement in adult life: GPs should be accessible, not intrusive. *British Medical Journal, 317*, 538-539.

Nagraj, S., & Barclay, S. (2011). Bereavement care in primary care: a systematic literature review and narrative synthesis. *British Journal of General Practice, 61*, 42-48.

Neimeyer, R.A. (2010). Grief counselling and therapy: the case for humility. *Bereavement Care, 29*, 4-7.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6*, 412-415.

Saunderson, E.M., & Ridsdale, L. (1999). General Practitioner' beliefs and attitudes about how to respond to death and bereavement: qualitative study. *British Medical Journal, 319*, 293-296.

Schut, H. (2010). Grief counselling and therapy: have we learned enough? *Bereavement Care, 29*, 8-9.

Schut, H.A., & Stroebe, M. (2011). Challenges in evaluating adult bereavement services. *Bereavement Care, 30*, 5-9.

Wanpold, B.E., Mondin, G.W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "All must have prizes". *Psycollogical Bulletin, 122*, 203-215.

Wittouck, C., Van Autreve, S., De Jaegere, E., Portzky, G., & Van Heeringen, K. (2011). The prevention and treatment of complicated grief: A meta-analysis. *Clinical Psychology Review, 31*, 69-78.

Woof, W.R., & Carter, Y.H. (1997). The grieving adult and the general practitioner: a literature review in two parts (part 1). *British Journal of General Practice, 47*, 443-448.

Woof, W.R., & Carter, Y.H. (1997). The grieving adult and the general practitioner: a literature review in two parts (part 2). *British Journal of General Practice, 47*, 509-514.