Grief and Loss:
An Approach for Family Physicians

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In today’s world, families are under increasing stress, from financial and time constraints, to family breakdown, substance abuse, and threats of violence. Family physicians are seeing an increase in psychosocial issues such as anxiety and stress-related disorders, often co-existing with and complicating medical problems such as diabetes or pneumonia. The psychosocial issues are often more difficult to diagnose and manage than are the medical problems—and all take place in the family context. Very often, the family is the key to dealing effectively with the whole spectrum of complaints, requiring a psychosocial assessment. In the crowded family medicine curriculum, this vital area of knowledge and skill is often ignored in favour of more clear-cut procedural skills.

To educate family physicians about dealing with families, a group of family medicine educators, practitioners and mental health professionals affiliated with the Department of Family and Community Medicine at the University Of Toronto founded the Working with Families Institute (WWFI) in 1985. The WWFI has developed various training experiences for trainees and practising physicians.

**Goals**

The goal of these modules is to provide a learning resource for physicians dealing with common medical and psychosocial issues that have an impact on families. The modules seek to bridge the gap between current and best practice, and provide opportunities for physicians to enhance or change their approach to a particular clinical problem.

The modules have been written by a multidisciplinary team from the Faculty of Medicine, University of Toronto. Each module has been peer-reviewed by external reviewers from academic family medicine centres across Canada. The approach is systemic, emphasizing the interconnectedness of family and personal issues and how these factors may help or hinder the medical problems. The topics range from postpartum adjustment to the dying patient, using a problem-based style and real case scenarios that pose questions to the reader. The cases are followed by an information section based on the latest evidence, case commentaries, references and resources.

**How to Use the Modules**

The modules are designed for either individual learning or small group discussion. We recommend that readers attempt to answer the questions in the case scenarios before reviewing the case commentaries or reading the information section.

The editors welcome feedback on these modules and suggestions for other modules. Feedback can be directed to Dr. Watson at dfcm.wwfi@utoronto.ca.

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Bill Watson
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Toronto, 2014
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Grief and loss are commonly encountered in family practice. Patients grieve the loss of loved ones, jobs, marriages, pets and even physical or psychological functioning. Patients may mourn the loss of their good health and seek comfort, understanding, respect, and especially hope. The "work of grief" is a progression through stages of shock, anger, painful dejection, loss of interest in the outside world, inhibition of activity and the temporary interruption of the capacity to love. In addition to a profound sense of sadness, there may be feelings of anxiety, anger, fear, depression, and guilt. Patients, their families, and physicians may underestimate the impact of loss on health, which may cause physical symptoms such as pain, headache, dizziness, fatigue, and disturbances of sleep and digestion, as well as psychological symptoms. Family physicians (FPs) are in a unique position to influence prevention, early detection, and morbidity of these disorders. Psychotherapy can relieve the self-destructive anger and guilt, advance the recovery phase, and stimulate psychological strength and personality growth.

How can we identify those individuals who are at risk for grief reactions in our practice? What techniques can FPs utilize to help patients go through the stages of grieving? What supports can the physician provide to families who are experiencing difficulty adapting to loss? How can FPs be aware of their own feelings around loss and how they impact on patient care?

OBJECTIVES

After completing this module, you will
1. have a heightened awareness of the grieving process.
2. be able to develop an approach to help patients and families deal with loss.
3. be able to assess the impact of a patient’s loss on your own feelings and behaviour.

Key Features
1. Grief and loss are commonly encountered in family practice.
2. Patients, their families and physicians may underestimate the impact of grief and loss on physical and mental health.
3. Family physicians are in a unique position to prevent, diagnose and help their patients throughout the grieving process.

Core Competencies
1. Adopt a patient-centered approach.
2. Determine the patient’s agenda and illness experience.
3. Identify and articulate patient goals and priorities and negotiate patient priorities.
CASE STUDIES

Case 1: Bob, aged 70
Bob, who is retired, comes to the office with his wife, Gwen, who is dying of cancer. Gwen has traditionally looked after the bookkeeping, banking, paying of bills, housekeeping, and cooking. Bob is completely illiterate. Since they had no children, Bob is extremely dependent on Gwen, both for emotional support and the daily tasks of living.

- How would you deal with this couple during the last few months of Gwen’s life?
- What are the issues that you feel are most important?
- How would you help Bob prepare for his wife’s impending death?
- What would you say and do?

Case 2: John, aged 65
John has been your patient for 15 years. He presents at the office complaining of dizzy spells. The nurse measures his pulse as 80 beats per minute and regular, and his blood pressure (BP) as 92/80 mm Hg. When you see him in the office a few minutes later, he looks ill and says he is feeling dizzy, as though he is “going to faint.” His pulse is 160 bpm and his BP is 90/72 mm Hg. He looks sad, and when asked what is wrong, breaks into tears and tells you about his close female friend of 30 years who died a year ago. This is the anniversary of her death.

- What questions do you want to ask John?
- What exact words you would use?
- How would you explain the connection between his grief and his physical reaction?
- Would you examine John or do any further tests?
- When would you bring him back for follow-up?
- How would you help John resolve his unexpressed feelings of loss?

Case 3: Mike, aged 22
Mike, a medical student, presents with a history of sharp chest pain. It is under his left breast, lasts for minutes, and is often associated with light-headedness and sometimes precipitated by exertion. This has been present for many months. He is worried because his father died from a myocardial infarction after Mike unsuccessfully tried to resuscitate him. He identifies strongly with his father.

- How would you approach this medical student?
- What would you say and do?

Case 4: Pat, aged 39
Pat is married, has a four-year-old daughter, and is pregnant with her second child. At 38 weeks’ gestation, she calls your office in the morning because she
feels no baby movement. When seen in the office later that day with her husband, she is very upset and on the verge of tears. You examine her abdomen and hear no fetal heart. You arrange an immediate ultrasound examination, which confirms that the baby has died in utero.

- **What is the possible impact on you the doctor when you learn that the baby died?**
- **How would you deal with the immediate shock of the baby’s demise, and how would you give this news to the parents?**

You arrange immediate admission to the hospital and consult with the obstetrician on call to begin induction of labour. After seven hours of labour on intravenous oxytocin, Pat delivers a perfectly formed, stillborn baby girl.

- **How would you ask the mother about her feelings?**
- **What important things would you like to discuss?**
- **What immediate steps might you take to support the parents and help them through the grieving process?**

After discharge from hospital, Pat comes to your office within the next week for a follow-up visit. She tells you she is deeply disturbed by the whole event. She keeps seeing the dead baby and has difficulty sleeping. She can’t face talking to her relatives and friends about the experience. She doubts whether she will ever have another child. She asks you what went wrong and how this could have happened. The pathology report indicates the absence of any abnormality in the child.

- **What further issues do you think would be important to talk about?**
- **What assistance could you receive from your hospital (i.e., bereavement programs, community services, support groups, individual counselling)?**
- **When would you invite Pat back to the office? Would you invite her husband as well?**
INFORMATION POINTS

1. After major losses, there may be increased morbidity in both physical and mental health problems, increased health-care utilization, and increased mortality. In the conjugally bereaved, there is an increased use of sedatives, tranquillizers, alcohol, and medications. Thomas Holmes developed the Social Readjustment Rating Scale, which showed that people are more likely to become ill after a loss.

Most people who suffer a loss often adapt to their loss within the first 2 to 12 months, but a small percentage can experience complicated grief, which includes symptoms similar to a major depressive episode or post-traumatic stress disorder.

Many people experience physical/somatic manifestations like insomnia, loss of appetite, headaches, and nausea. Often they have cognitive reactions such as rumination, inability to concentrate, a sense of the deceased’s presence, and a tendency to try to rationalize the death. Anxiety is a common and often overlooked component of grief. Behavioural reactions like crying, social withdrawal, accidents, changes in physical activity, and activities that provide a connection to the deceased, like visiting the gravesite or wearing black, are common. Spiritual reactions may include a loss of faith and an existential search for meaning, increased focus on rituals, or changes in spiritual practice. Some patients become more religious after suffering a major loss.

On the macro scale, bereaved employees cost American businesses $44.5 billion per year due to lost productivity, increased utilization of health care services, absenteeism, and accidents related to poor concentration.

We live in a “grief illiterate” culture where in the absence of healthy mentoring we are often awkward or even ashamed around the expressions of grief. Perhaps more importantly, those who need to support us are equally as awkward (often including physicians). We can become more skillful in grieving as we experience more losses in a conscious and supportive manner.

2. The process of bereavement involves realigning roles, taking on new responsibilities, developing a new identity, and re-establishing a balance in the family system. When the family system becomes unstable, unhealthy behaviours become established in an attempt to restabilize the system.

Grief is a process, not an endpoint. The goal of grief is not to forget about the loss, a commonly stated goal of survivors; rather, the goal is to remember the deceased, understand the changes created by the loss, and determine how to reinvest in life.

The way patients respond to loss is complex and individualized. The various responses to loss are based on each person’s culture, life experience and personality.
Some bereaved individuals appear to be better served through the suppression of emotions or through employing methods of distraction. For these individuals, a traditional emphasis on grief work could complicate their natural grieving process rather than assist it.\textsuperscript{9} It may be more adaptive for some individuals who have experienced traumatic events to suppress memories rather than engage in grief work. Not all bereaved individuals experience extreme distress from their loss and most bereavement is self-limiting without formal intervention.\textsuperscript{10}

Many studies imply that those patients who were self-identified and specifically seeking help for their bereavement had much larger effect sizes than studies where participants were recruited by the investigators. Those patients who were at high risk or experiencing complicated grief appeared to get the most benefit from counselling.\textsuperscript{11} Bereaved mothers, men who lose spouses, those who experience violent traumatizing losses such as suicide, terrorist attacks, warfare, homicide and accidental death, individuals with previous psychiatric histories, and those showing unremitting or increasing levels of distress after a reasonable period of time are likely to benefit from counselling.\textsuperscript{12} It is not helpful to provide counselling for someone who is not motivated or interested in seeking help for their loss.

3. It is very important to understand the social, spiritual, gender, and ethnic contexts in which the family lives, as these will define how the patient and family relate to their grief. Dialogue about which traditions, roles, and beliefs are useful for the family often helps them move through the bereavement process. See Table 1 for sample questions you may ask to help your understanding of the impact on the survivors.

### Table 1. Assessment of grief

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Types of losses experienced and dates</td>
</tr>
<tr>
<td>2.</td>
<td>How has the family, both present and past generations, handled loss?</td>
</tr>
<tr>
<td>3.</td>
<td>How has the family discussed the loss?</td>
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<tr>
<td>4.</td>
<td>How has sadness been expressed in the past?</td>
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<tr>
<td>5.</td>
<td>Are outward expressions of emotions accepted, encouraged, or suppressed in the family? Is there a gender distinction?</td>
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<tr>
<td>6.</td>
<td>How has the family managed the present loss?</td>
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<tr>
<td>7.</td>
<td>Has open discussion about the loss been encouraged or accepted?</td>
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<tr>
<td>8.</td>
<td>Who takes on which roles in the bereavement process?</td>
</tr>
<tr>
<td>9.</td>
<td>Have children been included in the process?</td>
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<tr>
<td>10.</td>
<td>What types of mourning rituals were used in the family?</td>
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For interventions to be effective, they must be tailored specifically to the person’s unique personal factors. In the grief reaction, several factors should be highlighted (see Table 2). In order to fully appreciate the impact of the loss, the physician must view the loss through the bereaved person’s frame of reference. For example, those who are strongly dependent on an individual who dies often have more difficulty adjusting to the loss. It is also important to appreciate the roles that the deceased person played within the family unit, and the subsequent losses from these unoccupied roles. The general health of the bereaved, especially mental health and coping behaviour, will also be an important factor that will influence the response to grief.

**Table 2. Factors influencing the grief reaction**

<table>
<thead>
<tr>
<th>Psychological</th>
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<tbody>
<tr>
<td>• The unique nature and meaning of the loss sustained or the relationship</td>
<td>Adapted from Rando, 1984[13]</td>
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<tr>
<td>severed</td>
<td></td>
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<tr>
<td>• The individual qualities of the relationship lost</td>
<td></td>
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<tr>
<td>• The role that the deceased occupied in the griever's family or social systems</td>
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<tr>
<td>• The individual's coping behaviours, personality, and mental health</td>
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<tr>
<td>• The individual’s level of maturity and intelligence</td>
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<tr>
<td>• The individual’s past experiences with loss and death</td>
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<tr>
<td>• The individual’s social, cultural, ethnic, and religious/philosophical</td>
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<tr>
<td>backgrounds and beliefs</td>
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<tr>
<td>• The bereaved's age</td>
<td></td>
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<tr>
<td>• The deceased's characteristics</td>
<td></td>
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<tr>
<td>• The sudden versus the anticipated death</td>
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<table>
<thead>
<tr>
<th>Social</th>
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<tr>
<td>• The individual’s social support system and the acceptance and assistance</td>
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<tr>
<td>of its members</td>
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<tr>
<td>• The bereaved's educational, economic, and occupational status</td>
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<table>
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<tr>
<th>Physiological</th>
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<tr>
<td>• Drugs and sedatives</td>
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<tr>
<td>• Nutrition</td>
<td></td>
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<tr>
<td>• Rest and sleep</td>
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<tr>
<td>• Physical health</td>
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<tr>
<td>• Exercise</td>
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5. Patients in the acute phase of grief are suffering from shock, disbelief, and denial. They are seeking comfort, understanding, respect, and especially hope. They don't 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 their feelings of loss. Making an appointment right after a loss enables an assessment of the impact of the death on the patient's life, and of what appropriate action may be taken.  

6. In the acute stage, being an empathic and validating listener is helpful. In his book *Client-Centered Therapy*, Carl Rogers described a technique in which the therapist simply plays back to the patient the essence of what he or she said, reflecting both content and affect. Through this technique, the patient has the experience of being listened to and of hearing feedback from an independent person replaying his or her words and feelings. Rogers postulated "empathy," "unconditional positive regard," and "genuineness" as necessary conditions for psychotherapy.  

7. People who are suddenly bereaved, as in the case of accidental death may require more support and counselling than those who have known their loved one is dying, as in the case of terminal cancer. They need to be given the opportunity to talk through their experience of the death, to have repeated opportunities to share feelings and make real the events of the death. In addition, they need to work through their unfinished feelings toward the deceased, especially those of anger and guilt, chaos and insecurity, triggered by unanticipated loss. Emergency departments, coronary care, and intensive care units should provide help for the bereaved. Morbidity can be reduced in high-risk groups by early counselling and crisis intervention.  

Grief interventions are more effective for high-risk individuals. The presence of suicide ideation following suicide bereavement is more often associated with a history of mental disorder and suicidal behaviour and suicide ideation indicates a high risk for adverse bereavement outcome. Grief therapy likely reduces the risk of maladaptive grief reactions among suicide ideators. Therefore, suicide ideators may benefit from grief therapy following a loss through suicide.  

8. Anticipatory grief encompasses the processes of mourning, coping, interacting, planning, and psychosocial reorganization that are stimulated by the awareness of one’s own or a loved one’s impending death and the recognition of the associated losses that have already occurred; the ongoing losses of progressive debilitation, increasing dependence, continual uncertainty, and decreasing control, and the losses yet to come. The physician can help the patient with the delicate balance of simultaneously holding on to, letting go of, and drawing closer to the dying person. Certain people are more at risk because of highly ambivalent or dependent relationships. When caring for a dying patient, always address the issues of those who will be left behind and how they will cope after the person has died. Scheduling family meetings can help bring out the issues that need to be addressed.
9. Patients will often present to the FP with a variety of somatic symptoms as a way of legitimising the visit to a physician: this is the so-called “ticket in the door.” They may feel it is not appropriate to discuss psychosocial issues with their physician, but it is acceptable to have a physical complaint. 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. For example, a patient comes in with a headache or bronchitis, and in the midst of a 15-minute appointment starts to cry. While there may not be time available to deal with the complexity of the issues, it may be helpful to attempt to manage the acute situation and then arrange for a follow-up appointment for a longer session (30-60 minutes) in the next few days.

Sometimes ‘active listening’ may also reveal ‘disenfranchised grief’ experienced by those who have encountered loss but cannot mourn publicly. The loss is not validated, i.e. someone experiences and feels a loss, but for whatever reason feels unable to talk about it or share the pain, as in pregnancy loss, loss of a private (perhaps unacceptable) relationship, or a work-related loss.

It is critical for the physician to establish whether there is a danger of homicide or suicide, even seeing the patient for another short appointment the next day if a longer session cannot be arranged within a convenient time.

10. It is not unusual for patients to present years later with unfinished, unresolved issues around a death in the past. While the time for the grieving process is considered by most to be from six months to three years, there are substantial differences in cultural backgrounds. Every person depending on his or her culture, belief system, and personality will find his or her own way to resolve the loss. If, after a reasonable period of time, the person is still not over the death of a loved one, then there may be other factors preventing resolution. A rule of thumb is that as long as a grieving behaviour is not physically or psychologically dysfunctional, harmful, or representative of more severe pathology, it can be viewed as not abnormal and seen as part of the process of grief.  

Sometimes grief that is avoided or not acknowledged throughout our lives may be reactivated during the present loss. There may be an overreaction and feeling of being overwhelmed because suddenly a lifetime of unexpressed grief and unexamined losses come flooding forward.

11. Anniversary reactions are common and should be anticipated. These are brief upsurges of grief that occur at certain times of the year such as holidays, birthdays, or important family events, or in the presence of certain stimuli such as songs, videos, or locations. Grieving patients who are experiencing an inexplicable increase in symptoms may later realize, with appropriate counselling, that it is the anniversary of a significant event.
It is common for grievers to find ways to keep the memory of their departed loved one alive. Some mourners continue to talk to the dead, especially when visiting the deceased’s grave. Other mourners continue to feel the presence of their love one who died and keeps the memory alive by thinking about how they would have acted in certain circumstances or talk about the departed as a role model to look up to. Sometimes mourners maintain the bonds with the departed by continuing to talk to friends and relatives who may have known the deceased. People often have photos or personal objects of the deceased around to feel connected. Emotional loneliness, the missing of the deceased, and the feeling of being utterly alone even in the company of friends and family are difficult to remedy.

One study found that mourners often have intrusive images. This research looked at the incidence of positive intrusive memories of the lost person, intrusive images of the death event, re-enactment fantasies, and negative images of the future. Positive intrusive memories of the lost person, re-enactment fantasies and unpleasant images of the future had an association with complicated grief. Re-enactment fantasies and unpleasant images of the future had a unique link with depression and intrusive images of moments surrounding the death and unpleasant images of the future had a unique link with anxiety.20

Richard and Rose Sword described working with people suffering from post-traumatic stress disorder often connected to a major loss or traumatic event. They observed that these people spent a lot of time living in the negative past and seeing the future as negative. They worked with these individuals to create positive images of the past, develop self-soothing and social connecting behaviour and in this way enabled patients to create a positive future.21

12. Since no one likes to admit anger at a deceased person, feelings of sadness, anger, fear, and guilt may be disguised or repressed and prolong the period of grief or show up in other ways, such as physical symptoms or depression.22 When grief is prolonged or affecting functioning, explore if the patient is feeling guilty about things they should have done or did not do when their loved one was alive. Perhaps there is anger that the person abandoned them, or angry feelings at God. Sometimes the patient may be clinically depressed and require antidepressant medications. When a patient presents with depression, it is always important to explore past losses and see if they have been resolved.

13. The biggest difficulty faced by parents of a stillborn child is the failure of families, friends, and doctors to recognize that their grief has arisen from the death of a real person.23 Always make a point about talking about grief after abortions, miscarriages, and stillbirths. It is not uncommon to find parents even years later with unresolved sadness about the loss of their unborn child. Since the loss of a child is perhaps the most difficult death from which to recover, it may be helpful to suggest involvement in self-help community support groups, which have been shown to support the healing process in parents and remaining siblings.
14. “Children of all ages grieve and grief is particular to age groups. Children cope with grief according to their developmental stage and may revisit a grieving situation as they reach new developmental stages: for example, a death witnessed by a toddler can resurface and need to be re-addressed in a seven-year old. Children should not be protected from grief, funerals or issues of death and dying. We need to mentor our children about grief instead of protecting them not only from death but also from the little losses that happen throughout our lives and which can prepare us for the greater ones. Children may express their grief through extremes of behaviour—from being aggressive to being very passive. Monitor children at school for grief problems manifesting as school problems.”

The death of a parent is one of the most stressful occurrences for a child to endure. The child’s developmental capacity and age are key considerations as they profoundly influence the grief experience. It is reported that 61% of bereaved children have suicidal ideation. Children can experience developmental disturbances, psychopathology, disturbed ego development, and physical symptoms. Intervention with this group can prevent future psychopathology.

Several factors that increase the risk of emotional and behavioural problems in bereaved children include a mother’s death, a surviving parent who has difficulty functioning, inconsistent discipline, a parent’s sudden or traumatic death, and concomitant stressors present in the family before the death.

Because children tend to communicate nonverbally, they may be encouraged to use their own drawings that allow them to express their feelings and concerns freely, without the pressures and risks of vocalizing confused and chaotic feelings. If the caregiver raises serious concerns, then referral to professionals experienced in dealing with bereavement in children can be sought. Physicians can provide surviving parents with information concerning normal reactions, books, and movies, which may stimulate further discussion in terms the child can understand.

15. Patients view FPs as an important support in grieving and bereavement. In a qualitative study of patients’ attitudes and expectations in a family practice, many of the patients interviewed expected some form of contact from their physician following a family death. Many would have appreciated a letter of sympathy and over half expressed some form of dissatisfaction with their FP. The majority viewed bereavement support as an important part of the FP’s role. Patients look for an empathic, non-judgemental, compassionate, supportive listener whom they can trust. The FP is in an excellent position to integrate the psychological, the physical, and the spiritual to provide “holistic care.” The quality of the working relationship between patient and therapist is extremely important. The stronger the alliance, the better the outcome for complicated grief.
16. A technique originally developed by Jacob Moreno and later adapted by Dr. Fritz Perls in Gestalt Therapy involves psychodrama or “role playing”. The patient imagines the dead person in an empty chair and then acts out a dialogue between himself and the person who died. The patient acts out both roles by actually changing chairs and talking back and forth to the imagined person with the aim of contacting old submerged feelings and linking them to thoughts. The patient acts out what he imagines the dead person would say and do. By playing the dead person’s part, the patient can develop insight into what is still unfinished and unresolved. They are asked to answer the questions or issues that come up when they are in the opposite chair. The clinician guides the patient to switch and the focus is on self-awareness. The emphasis can be on expressing the loss, anger, fears, and resentment. Eventually working toward forgiveness of the deceased and/or forgiveness of self is helpful.

This technique has been used to deal with the loss of children and also with grief about abortions and even miscarriages. The patient plays the part of herself and the unborn child. Sometimes patients feel unresolved because they never actually got a chance to say good-bye and see the person die. Deaths often occur in hospitals, without family and friends present. Having them act out a conversation with the deceased and actually saying good-bye, even in a totally artificial situation, can be a dramatic benefit in resolving unfinished feelings. This type of intervention can also be done using hypnosis. Use of this technique requires further training and skill development before it can be used therapeutically.

17. In a small community in the past, grievers would have people around to offer support as part of the grieving process. Now the Internet is becoming like that extended community. It is like a new cultural experience. This cyber compassion may save mourners from feeling isolated but also provide an opportunity to highlight their loved ones in public. Bereaved people often want to keep the person in this world in some tangible way. Cyber comfort has become more common. Although there is usually a need for face-to-face communication, if that is not possible Internet sites act as a substitute.

There are many websites that offer grief support and provide text-based information, message boards, online resources, and online support groups:
http://www.griefnet.org
http://www.compassionatefriends.org/
http://www.grieflink.asn.au

The National Hospice and Palliative Care Organization
http://www.caringinfo.org/

The Hospice Foundation of America URL:
http://www.hospicefoundation.org/

Several research studies show that Internet programs dealing with grief can be helpful. One study used three intervention modules, including interactive exercises supplemented by video testimonials, all of which were designed to normalize feelings of grief. Two additional modules offered education and
referral and the last module contained a list of websites and books of potential interest to bereaved individuals.5

18. There is a saying that “what doesn’t kill you strengthens you.” Sometimes it may help to explore how the loss may have resulted in some form of psychological value/gain for the bereaved. In their work, Davis and Nolen-Hoeksema found that the three most common themes to bring solace were a growth in character (e.g., “I have become stronger, more competent, more compassionate”), a new perspective (e.g., “I am more aware of life around me”), and an increased sense of connection and strengthening of relationships (e.g., “I realize how little time we have and how much we need to spend it showing our love for each other”). 33 Thus, the ability to perceive benefits or personal growth stemming from the loss may facilitate positive adjustment during bereavement.

Bereaved persons who find a measure of meaning in the loss experience seem to fare better in the grieving process. Thus, therapists working with clients struggling to find sense in loss would be well advised to utilize strategies that focus on meaning-making and help the bereaved integrate their experiences into a purposeful and coherent life narrative. 34 There is an absolute connection between grief and love where grief can act as a reminder of love and love acts as a container for grief.

Mindfulness-Based Cognitive Therapy (MBCT) is defined as “the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment.” 35 Pre-existing mindfulness practice can be helpful in dealing with strong, raw feelings such as grief. Patients in the acute stage of the grieving process, however, may be in too raw a state of distress dealing with the recent stressors themselves to participate fully in the learning process. In cases of prolonged grief disorder MBCT may be effective in reducing symptoms of prolonged grief disorder.36 Many mindfulness approaches focus on the concepts of kindness and self-compassion which are valuable resources for coping with grief. 37

One randomized trial with “complicated grief therapy” utilized meaning-making exercises such as an evocative retelling and recording of the story of the loss and projection of new life goals.38 These therapeutic strategies were found to be substantially more effective than standard interpersonal therapy for grief. 39

It may be valuable to explore the patient’s past and present connection with a faith community, or even a ‘community’ in general. Participation in community can bring a sense of commonality and can act as a conduit to people with similar beliefs and values, which can be a valuable source of strength and meaning. People may choose to be alone for a period of time and this is considered a normal part of the grieving process. When patients are ready to be with others and are encouraged to do so, connection or re-connection through community can minimize feelings of isolation that could result from prolonged periods of being alone.
Many faiths and cultures have rituals and traditions on how to deal with death. Shivas, wakes, burial services, cremations, are ways different traditions formalize the process of mourning. The role of funerals and memorial services are very important ways to process death. Children should be encouraged to attend these rites. Community expression of grief is often helpful to the family. In some cultures, memorial services are held in hospitals, agencies and palliative care programs for the bereaved family and for staff.

19. Physicians often interpret death as a mistake, failure, or deficiency, instead of seeing it as part of the continuum of life. We often see grief as interfering with life rather than be intrinsic to life. There may even be feelings of guilt and fears of medico legal action for delayed diagnosis or misdiagnosis. Physicians need to recognize these reactions in themselves. The more healers work through their own personal experiences with loss, the better they will be able to help their patients on the road to recovery. As we become better able to recognize our own emotions, we may be more open to the difficult and complex responses of others. As caregivers, we need to be self-aware and develop respect for our own grief.

Too often, we are taught to build a defensive wall around ourselves in order to protect ourselves from the pain and suffering to which we are exposed. We objectify relationships, treating people as diseases or diagnostic challenges. We sometimes learn to do this by mimicking our peers and our teachers. We talk to patients from a distance, from the door of the hospital room, not getting involved or allowing for intimacy. We are told our warmth or intimacy might be misunderstood or be too threatening. We become poor communicators and can be perceived as cold and insensitive. We justify our behaviour by saying we show our caring not by what we say or how we act toward the patient, but rather by our expertise.

Ironically, it is through our warmth and sharing of ourselves that we become better healers and communicators and more at peace with ourselves. If we “really” connect, understand and are understood, then a bond takes place that brings us closer and more in contact, reversing our isolation. Our challenge as health care practitioners and human beings is to maximize communication and to take our healer/patient relationship from an I-it connection to an I-thou relationship. The I-thou relationship implies unconditional regard, empathy, genuineness, and respect.

The denial of death and avoidance of talking about death is common in the medical community. Peer consultations and support provide an opportunity to process these responses rather than suppress them. In addition, physicians need to develop their own personal understanding of their sense of finiteness and their own experience of death. In doing so, they are able to assess their level of comfort in working with patients who are bereaved. Take care of yourself or you cannot take care of anyone else. Ask for support when you need it. If we cannot bear our own grief, it will be hard to work in the presence of another person’s grief.
Sogyal Rinpoche says, “If you are in a position to help others, it is through your own suffering that you will find the understanding and compassion to do so.”

20. Counselling 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 process becomes overwhelming, it affects overall functioning and requires some form of intervention if excessively prolonged. Helping the patient and the family to express repressed or unspoken feelings facilitates the healing and grieving process. Psychotherapy can focus on the resentment and anger suppressed or turned back on the self, as well as help resolve any guilty feelings that may be self destructive. Involving family members in the therapy can mobilize additional needed support. Referral to a therapist or a social worker experienced in this area may be indicated for complicated or prolonged mourning. The physician should also become educated about cultural practices and beliefs related to the grieving process.

21. Ethical communications by FPs with dying patients certainly impact on the grieving process. End-of-life discussions with the dying person and their families are associated with less aggressive medical care near death and earlier hospice admissions, which are associated with better quality of life and bereavement adjustment. End-of-life discussions also affect the way survivors face the loss and also have an impact on the way surrogate decision making affects survivors.

Grief starts with the symptoms of the illness and the diagnosis of any illness. Begin counselling with the patient and the family as early as possible: this will often help reduce a patient’s suffering and make the bereavement phase easier on the family. Focus on issues such as life meaning, the contributions of the dying person and the legacy left behind. Good end-of-life care has incorporated the concept of ‘good’ grief (i.e. a healthy expression of our life force) as part of a ‘good’ death.
CASE COMMENTARIES

Case 1: Bob, aged 70

In situations of chronic illness or cancer where death is anticipated in the near future, death and dying should be talked about, and certain issues and fears should be expressed and discussed while the dying patient is still alive. This makes the transition to life without a loved one easier.

In Bob’s case, his grief starts before Gwen’s death, as she becomes more disabled. Bob should be encouraged to take on more responsibility and slowly, over time, he can be taught about the household affairs. His support system should be expanded during this time to include extended family, friends, and community workers. During Gwen’s last days, Bob also needs attention and support, and an appointment could be booked with him in the week following his wife’s death.

Spouses and relatives left behind are at risk for becoming severely withdrawn and often suicidal. Assessing Bob’s suicide risk is critical.

Bob could be seen weekly, if only for short appointments. At each session, practical matters such as lawyers and wills, what life will be like in the future, and how the patient is eating and sleeping and spending his time may be addressed. The emergence of strong emotions including sadness, loneliness, anger, and guilt should be normalized and acknowledged, as well as practical coping strategies to deal with the emotions explored.

The patient should be followed over the next one to two years. This will allow the physician to explore how he is coping with his new responsibilities and his wife’s death.

Case 2: John, aged 65

John’s physical symptoms are a somatic expression of his unresolved grief. To the extent that patients hold in feelings and do not have the skill or opportunity to verbalize them, they often present with somatic complaints. The physician’s role is to present a safe place for the patient to verbalize the unexpressed or unresolved issues around the death. The FP is in a unique position to assess the physical symptoms and rule out serious illness.

After inquiring about how sad he looked, it is important to rule out a clinical depression. The patient denies being depressed, claims his appetite is fine, says his sleep is restless as always, asserts he is crying less often than one year ago, and feels uncomfortable about this strange sad feeling. He is very introverted and has told no one else about these feelings. Table 3 lists interventions for family members grieving the loss of a loved one.
Table 3. Therapeutic interventions for families \(^4^6\)

| • Allow and encourage storytelling and journal-writing. |
| • Ask detailed questions about the deceased, the relationship, the feelings, and the pain (active listening). |
| • Provide education about the grieving process. |
| • Explore farewell rituals. |
| • Assess suicide risk. |

*Adapted from McDaniel, 2005 \(^4^6\)*

After talking for about 20 minutes about the details of his relationship, and his sense of loss, John’s pulse returns to 80 bpm and he feels better. A 20-minute appointment is scheduled for two weeks later. Although he is still sad, he has had no further dizzy spells. He talks about his mother’s death and the fact that he still has unresolved grief about her dying. The connection between his mother’s death and his partner’s death should be explored. Very often a person’s first loss influences all other losses.

A 20-minute appointment is booked for one month later. John admits that he is still experiencing sadness and missing his girlfriend, but he has had no further symptoms.

He is seen again two months later. He seems more relaxed and has been getting out more, but is still mourning. Six months later, he admits to having sexual difficulties with his new girlfriend of the past few months. An appointment is made to discuss aspects of sexual functioning and the issue of his friend’s death. The possibility of guilt or a sense of being disloyal is explored. By bringing the guilt out in the open, he feels relieved. The physician suggests seeing him with his partner, and a sensate focus exercise is advised. When he returns a few weeks later, he reports that his sex life has improved. Follow-up at consistent intervals indicates increased contentment with his life and no complaints about his sexuality.

**Case 3: Mike, aged 22**

A full exam, electrocardiography, and blood work are performed. No organic cause is found for Mike’s chest pain. The physician states simply that perhaps there is a relationship between his father’s death and his chest pain. He identified strongly with his father. The physician explains that sometimes the loss and missing someone are so great that physical or emotional symptoms arise, as a way of staying connected with the deceased. Mike’s father died in front of him, and Mike felt guilty that he couldn't save his life. Mike is reassured that there was nothing he could have done. He also is angry that his father “abandoned him” by dying. Unresolved anger often needs to be dealt with in order for there to be resolution. His anger and fears are discussed, and he has a chance to verbalize them. Normalizing his feelings seems to help. It is clear that he loved his father very much and an opportunity to dialogue with his
dead father through the empty chair technique (see information point 16), is reported to be helpful. After the discussion, the student feels relieved and has no further symptoms at follow-up ten years later.

**Case 4: Pat, aged 39**

As this case involves a family, both parents and their four-year-old should be included in the follow-up. It is important for them to understand and accept the death. They must be given an opportunity to review what happened and to talk about the whole experience. The four-year-old may be addressed separately and encouraged to say good-bye to her sibling through drawings and rituals that are age-appropriate.

Pat is given a chance to identify and express her feelings of anger, guilt, and sadness. She feels that the death was all her fault. She has begun to wonder what she could have done differently. She feels somehow that she is being punished for something and she doesn’t know what. She raises the whole question of an abortion she had when she was 22. Even though she is not religious, she wonders whether a divine power is teaching her a lesson because she had an abortion. She is given an opportunity to express her anger at God for taking her newborn child. Her religious beliefs are explored and she is encouraged to talk to a minister from her own faith. She is asked to return in one week.

Pat feels that she is inadequate and somehow defective. She feels that she has let her husband down. She questions her ability ever to have another child. She is fearful of having to go through this again. She needs a great deal of reassurance that the loss is not her fault. She needs to hear that she didn’t do anything wrong and similarly, that doctors couldn’t have done anything to save the baby. She must be allowed to talk about the hopes and dreams she had for this child.

One of the most difficult tasks encountered is the disbelief at and unreality of the child’s existence. Not only the parents, but also everyone in the community encounter these issues. Sometimes it is helpful to allow the parents to hold the dead child, name him or her, and have a formal funeral so that there can be some closure and an official chance to mourn. Both parents need to be reminded that they have every right to mourn, as has any parent who has lost a child.

Pat’s severe grief continues for many months, and she has difficulty carrying on her daily activities. The question of postpartum depression is addressed and medication considered. Therapy continues almost weekly, and finally Pat is asked to imagine seeing her dead infant and to develop a dialogue with the stillborn child. She is encouraged to tell the child how angry she feels at her for dying. Pat apologizes and asks the child’s forgiveness for being unable to bring her into the world. Pat talks to the child about how her hopes and dreams were shattered. Then she is asked to play the role of the dead child, and to talk back to Pat. When Pat takes the role, she tells herself that she is forgiven. The imaginary discussion with her dead child seems to help, and over the ensuing months of therapy, Pat slowly forgives herself, God, and the child for the loss.
She gradually is able to consider another pregnancy. The family needs a great deal of support during the subsequent pregnancy.
REFERENCES


RESOURCES

Every FP should be aware of what is available in their particular area at any given time. Some hospitals and funeral homes have bereavement support groups.

**Support Programs**

Bereaved Families of Ontario is a mutual aid/self-help organization staffed by bereaved persons. When a child or a parent dies, the organization offers many support groups for different age groups. Call (416) 440-0290, [www.bereavedfamilies.net](http://www.bereavedfamilies.net)

Bereaved Families of Ontario/Toronto (Toronto Chapter), 36 Eglinton Avenue West, Suite 602, Toronto, ON M4R 1A1. Call (416) 440-0290 (416) 440-0290

Durham Grief Resource Centre is a division of Armstrong Funeral Home, which offers bereavement support groups, educational seminars, and a resource newsletter. Call (905) 433-4711.

New Directions is a volunteer-driven agency committed to empowering separated, divorced, and widowed women to rebuild their lives. Call (416) 487-5317.

Survivor Support Program offers counselling and support for adult members of families in which there has been a death by suicide. Call (416) 595-1716.

The Centre for the Grief Journey, 3243 Grassfire Crescent, Mississauga, ON, L4Y 3J8. Phone: (905) 624-8080, [info@griefjourney.com](mailto:info@griefjourney.com)

Ontario Health Promotion, bereavement support. [www.ohpe.ca](http://www.ohpe.ca)

Coping Centre, 1740 Blair Road, Cambridge, ON. This organization has links to other resources. Call 519-650-0852 or 1-877-554-4498.

Alan Wolfelt, The Centre for Loss and Transition, 3735 Broken Bow Road, Fort Collins, CO 80526 Literature and resources for grief. Call (970) 226-6050 [www.centreforloss.com](http://www.centreforloss.com).


Temmy Latner Centre for Palliative Care, Mount Sinai Hospital, 600 University Avenue, Toronto, ON. Call (416) 586-4800, ext. 7884

Max and Beatrice Wolfe Centre for Children’s Grief and Palliative Care (division of Temmy Latner Centre for Palliative Care). Call (416) 586-4800 ext. 6664, [www.tlcpc.org](http://www.tlcpc.org).

Pregnancy and Infant Loss (PAIL) Network. Call 1-888-301-PBSO (7276), (905) 427-1807
Wellspring Sunnybrook, 2075 Bayview Avenue, Toronto, ON.
Call (416) 480-4440

Wellspring Halton-Peel, 2545 Sixth Line, Oakville, ON, L6J 4Z4.
Call (905) 257-1988, 1-877-499-9904

Books
Child Bereavement Charity [www.childbereavement.org.uk](http://www.childbereavement.org.uk) resources/literature for bereavement in children and youth.

