

Approach to grief in primary health care

Abordagem do luto na Atenção Primária em Saúde

Abordaje del duelo en Atención Primaria de Salud

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Abstract

Grief is the experience caused by the death of a loved one and represents a natural response to the stress of loss; it involves psychological and physiological symptoms that lead to increased morbidity and mortality. Bereaved patients are seen more often in primary health care (PHC) and receive more psychotropic medication; despite this, grief is neglected in health promotion activities, and teams often do not know how to approach it effectively. There is evidence that family physicians may not have the appropriate skills to deal with grief. Therefore, the objective of this study was to guide PHC professionals in the mourning approach. An integrative review was carried out in several databases in June 2021, which included published articles, without determining the time period, in Portuguese, English and Spanish. At the end of the literature search, 49 articles were selected for evaluation. Most people adapt to loss without the need for clinical interventions; there is no evidence for the benefit of using benzodiazepines and antidepressants for bereaved patients who do not meet the criteria for mental illness. In addition, the preference is for a biopsychosocial approach. Scientific evidence shows that there are few studies on which professionals working in PHC can support their practice. Despite these limitations, the available studies serve as the basis for guidelines for approaching grief.

Keywords: Bereavement; Disenfranchised grief; Grief; Primary health care.

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Resumo

O luto é a experiência causada pelo falecimento de uma pessoa próxima e representa uma resposta natural ao estresse da perda; envolve sintomas psicológicos e fisiológicos que acarretam aumento da morbidade e mortalidade. Os pacientes enlutados consultam mais vezes na Atenção Primária em Saúde (APS) e recebem mais medicação psicotrópica; apesar disso, o luto é negligenciado nas atividades de promoção da saúde, e frequentemente as equipes não sabem como abordá-lo de forma eficaz. Há evidências de que os médicos de família e comunidade podem não ter as habilidades apropriadas para fornecer suporte ao luto. Por isso, o objetivo deste estudo foi orientar os profissionais da APS na abordagem ao luto. **Métodos:** Realizou-se uma revisão integrativa em diversas bases de dados em junho de 2021, que incluiu artigos publicados, sem determinação de período temporal, em português, inglês e espanhol. Ao final da busca na literatura, 49 artigos foram selecionados para avaliação. **Avaliação e recomendações:** A maioria das pessoas irá se adaptar à perda sem a necessidade de intervenções clínicas; não há evidência para benefício do uso de benzodiazepínicos e antidepressivos a pacientes enlutados que não apresentem critérios para doença mental. Além disso, a preferência é pela realização de uma abordagem biopsicossocial. **Considerações finais:** As evidências científicas demonstram que há poucos estudos nos quais os profissionais que atuam na APS possam embasar sua prática. Apesar dessas limitações, os estudos disponíveis servem como base para orientações de abordagem ao luto.

Palavras-chave: Luto; Luto contido; Pesar; Atenção primária à saúde.

Resumen

El duelo es la experiencia provocada por la muerte de una persona cercana y representa una respuesta natural al estrés de la pérdida; implica síntomas psicológicos y fisiológicos que conducen a un aumento de la morbilidad y mortalidad. Los pacientes en duelo consultan con más frecuencia en Atención Primaria de Salud (APS) y reciben más medicación psicotrópica; a pesar de esto, el duelo se descuida en las actividades de promoción de la salud y los equipos a menudo no saben cómo abordarlo efectivamente. Existe evidencia de que los médicos de familia y comunitarios pueden no tener las habilidades adecuadas para soportar el duelo. Por tanto, el objetivo de este estudio fue orientar a los profesionales de la APS en el abordaje del duelo. Se realizó una revisión integradora en bases de datos en junio de 2021 que incluyó artículos publicados, sin determinar el período de tiempo, en portugués, inglés y español. Al final de la búsqueda bibliográfica, se seleccionaron 49 artículos. La mayoría de las personas se adaptará a la pérdida sin necesidad de intervenciones clínicas; no hay evidencia del beneficio de usar benzodiazepinas y antidepressivos para pacientes en duelo que no cumplen con los criterios de enfermedad mental. Además, se prefiere un abordaje biopsicosocial. La evidencia científica muestra que existen pocos estudios sobre los que los profesionales que trabajan en la APS puedan apoyar su práctica. A pesar de estas limitaciones, los estudios disponibles sirven como base para abordar el duelo.

Palabras clave: Aflicción; Luto contenido; Pesar; Atención primaria a la salud.

INTRODUCTION

The Associação Nacional dos Registradores de Pessoas Naturais (Arpen-Brasil; National Association of Registrars of Natural Persons), which represents records offices, identified approximately 1.4 million deaths in 2020.¹ Furthermore, it is estimated that for each death five people will be bereaved;² thus, it is believed that in Brazil in 2020, 7 million people suffered directly from grief. Doctors who work as general practitioners are familiar with grief, as they lose, on average, 20 patients annually.³

Grief is the experience caused by loss, usually of a close person, representing a natural response to the stress of loss and involving psychological and physiological symptoms.⁴ Although grief is characterized by intense emotional pain (including sadness, anger, anxiety and guilt), when acute, it is not considered a mental illness.⁵ In the acute form, reactions vary between patients, and may include denial, intense crying, anxiety, dizziness, feelings of unreality, sadness, hopelessness, irritability, apathy, reduced concentration, anorexia, changes in weight or sleep, tiredness, palpitations, chest pains and several other psychological and physical symptoms.⁶ Furthermore, the symptoms of grief and its trajectory are unique to each individual and can be influenced by several factors, such as nature of the loss, relationship with the deceased, religious beliefs and cultural norms. Symptoms typically peak 1 to 2 months after the loss and resolve within 6 to 12 months.⁵

Loss leads to an increase in morbidity and mortality, especially in situations of great dysfunction and during the first months of grieving.⁷ A study developed by Nielsen et al. in Denmark, using a scale that

quantifies grief in different degrees of severity, it identified patients who suffered most from grief; these patients, when compared to those who had less impact of grief on their quality of life, consulted primary health care (PHC) more often and received more psychotropic medications.⁸ These data had already been suggested previously in a 2016 study that identified the increase in the prescription of antidepressants, hypnotics and anxiolytics after the loss of a family member; an increase in PHC consultations was also observed in the year following the death.⁹ Furthermore, complicated grief is associated with major depressive disorder in 21 to 54% of patients.^{10,11}

Complicated grief, the treatment of which will not be discussed in this review, is the development of mental problems, such as depression or anxiety or specific disorders related to grief, associated with delay or incomplete adaptation to an emotional state similar to the previous one.^{6,12} It can be represented by symptoms similar to those of depression, but often occurs within 1 to 2 months after bereavement. It can be difficult to identify and differentiate from depression, as there is great variation in the experience of grief between individuals.⁶

Despite this, and considering that the family and community doctor (MFC) works in a context conducive to addressing grief, scientific evidence shows that there is little research on which professionals working in PHC can base their practice.³ The approach to grief in PHC varies: some professionals follow well-structured proactive protocols, with planned home visits, telephone consultations or letters of condolence; others are reactive in their approach, waiting for the bereaved to seek health services.³

In the context of the gateway and longitudinality of PHC, and considering aging and the greater prevalence of chronic-degenerative diseases, the MFC is increasingly faced with clinical situations that will follow their lethal course inexorably, causing different degrees of physical, emotional, social and spiritual suffering in people and their families.¹³ Professionals who work in this context have the advantage of having the patient's trust and being able to establish a dialogue with family members before the loss of sick family members. Furthermore, they understand family dynamics and are often involved in end-of-life care for patients.¹⁴ Assisting this process of ending life and mourning is a challenge in terms of resources and time, especially in PHC, but the biopsychosocial-spiritual approach allows the reframing of the process of care, illness and death.¹³ Grief is neglected in health promotion activities and teams often do not know how to approach it effectively. Thus, grief support has been advocated as an area of prevention in PHC, with suggestions that MFCs should adopt protocols for active monitoring of their bereaved patients.⁴

The health professional's ability to deal with death and grief, and consequently to care for the bereaved, will depend on the emotions triggered by their own experience when providing this care, such as guilt, fear, anger, helplessness, sadness and emotional distance. This contact brings to light personal experiences, such as experiences of loss or illness, and personal questions about death and the meaning or purpose of life.¹³ Therefore, it is important not only to exercise the PHC health professional's ability to deal with these feelings related to mourning, but also guide the patient in this task; with this, they will be able to help their grieving patient in a more constructive way.¹⁵

Adequate grief support, especially during terminal illnesses, helps prevent abnormal responses.¹⁶ It is important to emphasize that the outcome of mourning is accommodation, not acceptance or recovery. Grief changes people, and failure to return to an individual's baseline state is not a sign of abnormal grief. Instead, a more realistic goal is a life in which the person has adapted to the loss.¹⁷ Although grief can be considered a psychological process, it impacts all aspects of life, including physical, emotional and social.¹⁸

After the above, it is clear that approaching this stage of the life cycle makes it possible to create bonds and trust with the patient, family members and the multidisciplinary team, allowing a clear dialogue about finitude.¹³ A study published in 2018 demonstrated that the psychotherapeutic approach by the PHC doctor in the period immediately after the start of bereavement reduces the risk of mental illness in the long term.¹⁹ This stance also reduces the team's overload and allows the different stages of grief to be experienced.¹³ There is evidence that doctors working in PHC may not have the appropriate skills to provide grief support, as briefly mentioned previously. A British study identified that only 30% of doctors received educational guidance on grief support and only 9% believe that the training was sufficient.²⁰ Therefore, the limited training of these professionals in providing this type of approach must be considered.²¹

It is unclear how much PHC should be considered as part of social resources for the bereaved, what constitutes best practice, or how PHC teams can identify who truly needs preventive intervention. There are several guidelines and book chapters covering the topic, but most have a limited evidence base. Furthermore, it must be considered that, although grief can be a traumatic event, there is fear of treating it with drugs unnecessarily.³

As explained, doctors working in PHC have the opportunity to provide ongoing support before and after bereavement. However, many PHC professionals do not receive adequate training for this approach.⁸ The aim of this study was to guide PHS professionals in approaching grief.

METHODS

An integrative review was carried out where the search strategy involved the following databases: Medical Literature Analysis and Retrieval System Online (Medline), Latin American and Caribbean Literature in Health Sciences (LILACS) and Scientific Electronic Library Online (SCIELO). The literature review took place in June 2021 and focused on the following descriptors, and their combinations in Portuguese and English, associated with Boolean operators:

1. *Bereavement OR Disenfranchised Grief OR Grief, AND*
2. *Primary Health Care.*

The inclusion criteria defined for the selection of articles were: articles published, without determining the time period, in Portuguese, English and Spanish; full articles that portrayed the theme related to the study topic. After reading the summary of the manuscripts found in the aforementioned research, 25 articles related to the topic were selected.

The electronic addresses of the following organizations were also searched: *American College Of Physicians Journal Club, McMaster PLUS, Journal of American Family Physician, BMJ Best Practice, Cochrane Library, DynaMed PLUS, Epistemonikos, Evidence-Based Medicine Guidelines, UpToDate, Guidelines International Network, PubMed Clinical Queries* and *Trip Database*; when necessary, the references of the manuscripts read were also evaluated. Thus, another 24 articles were selected.

All references identified by the research underwent an initial screening that consisted of reading the title and abstract of the articles; when appropriate to the scope of this study, they were read in full. Of the 49 manuscripts initially selected, after complete reading, only 28 were minimally suitable for the objective of this review. Only eight articles specifically addressed the approach to grief in PHC; no randomized controlled trials were identified in the search.

ASSESSMENT

Most people will adapt to the loss of a loved one without the need for clinical interventions, as most bereaved people have a support network capable of helping them adapt to the loss without resorting to health professionals. Despite this, there is a tendency for all patients to appreciate gaining knowledge about the loss and receiving support.³ Thus, clinicians can facilitate adaptation to grief primarily by providing information about typical grief symptoms and their trajectory, as well as providing grief support according to the cultural context. It is crucial that these patients undergo assessment to estimate the risk of suicide, mood disorders (particularly major depressive disorder), post-traumatic stress disorder and substance abuse disorder, especially alcohol abuse.⁵

One of the main points to consider when approaching grief is that there is not enough scientific evidence available to demonstrate the benefit of using antidepressants, unless there is a diagnosis of underlying depression.^{2,6,22} According to the World Health Organization (WHO) manual for the management of conditions especially related to stress, there is also no evidence to universally offer psychological interventions or the use of benzodiazepines to bereaved patients who do not meet the criteria for a mental illness.^{2,22,23}

The principle of grief support is the very recognition of this feeling: allowing the right to mourn. One of the approach strategies consists in questioning the bereaved person about how they have felt in consultations for demands not initially related to grief.²⁴ According to Charlton and Dolman,⁴ the principles of approaching grief consist of the following actions (Figure 1):



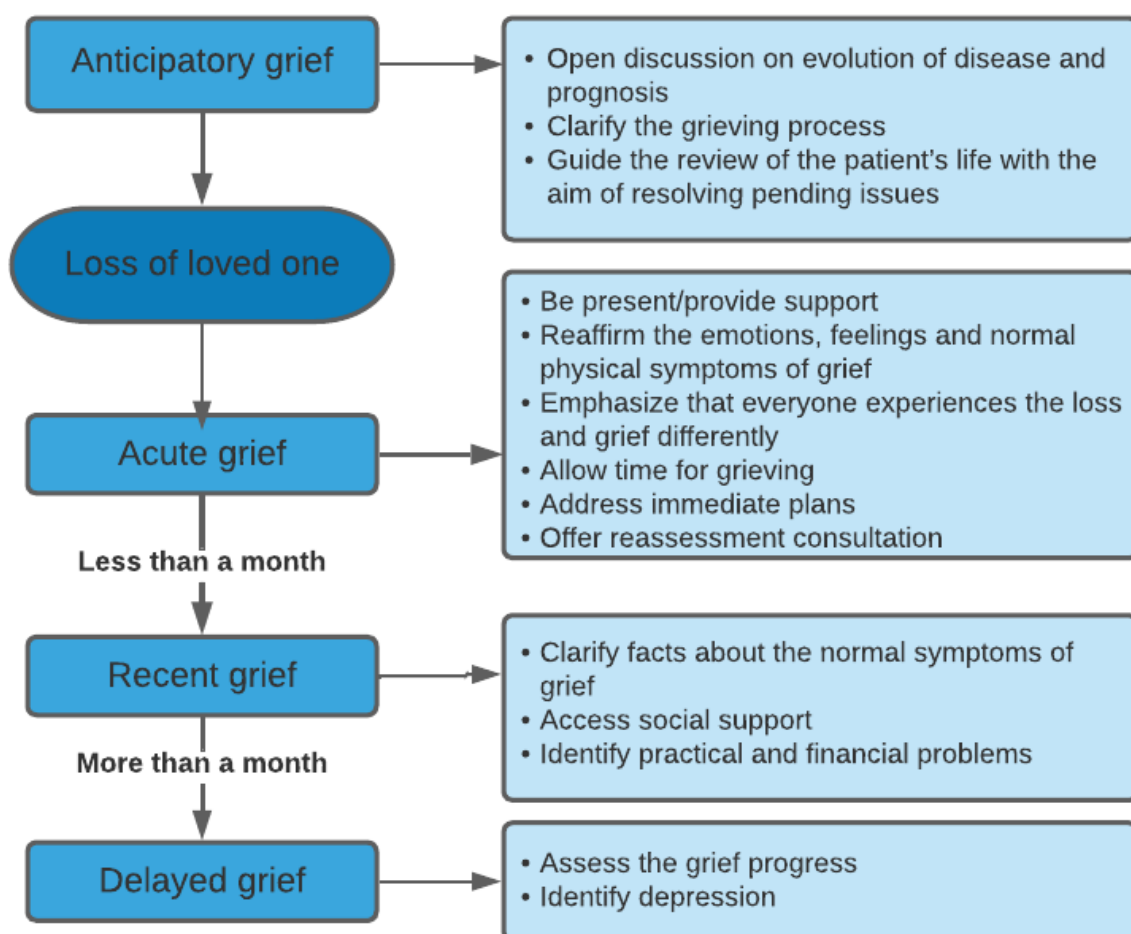
Figure 1. Approach to grief.⁴

- Death records: maintain a record of local deaths so that families can be accessed through active search to evaluate adaptations after the loss;⁴
- Information: provide explicit information about how the patient can seek help after the loss of a loved one;⁴
- Bereavement consultation: when a death occurs, a designated member of the team, preferably the one who has a better bond with the bereaved person, should be allocated for a preventive

consultation, if possible at home, aiming to identify abnormal patterns of suffering. In this consultation, it is suggested to listen to the patient and allow them to express themselves;⁴

- Monitor and review: it is advisable to carry out a review consultation, often a few weeks after the loss,¹⁸ to assess progression through the recognized stages of grief and thus prevent pathological grief resulting from lack of appropriate follow-up.⁴

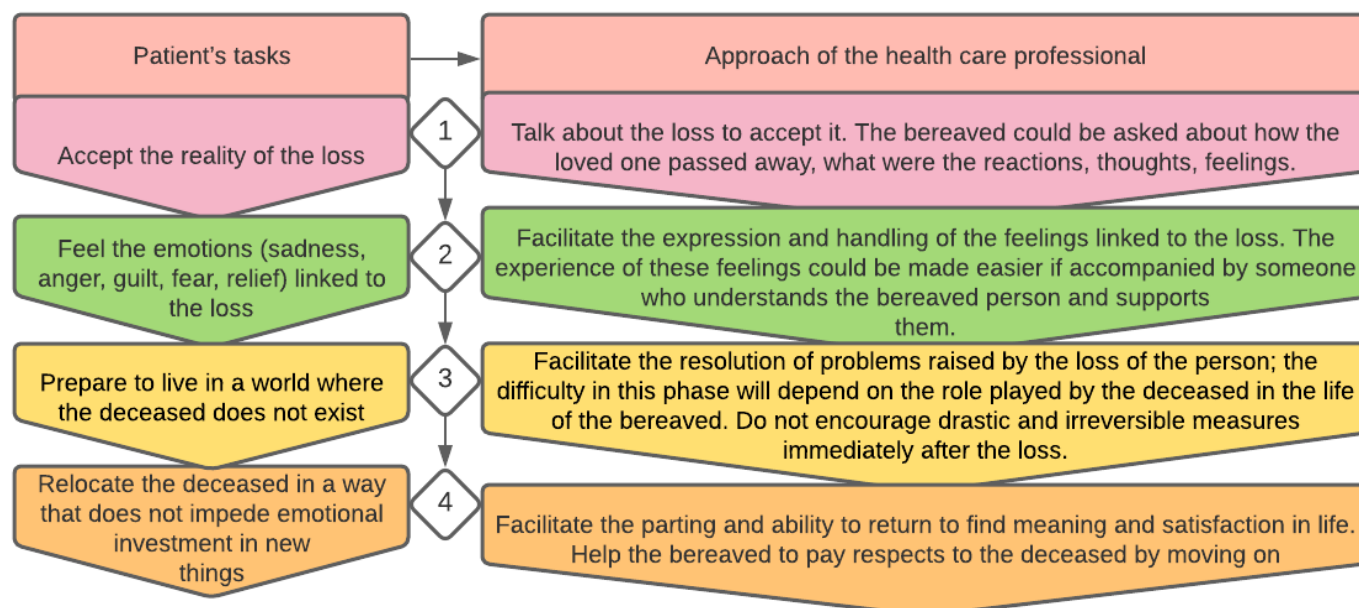
Thus, the first task of addressing grief consists in contacting the bereaved family members, whether by telephone or in person; although there is no specific period in which this action must occur, it is recommended that it be done as soon as possible, except on the day of the funeral.^{4,14,25} Contacts with the bereaved, whether through formal or informal consultation, have objectives according to the time elapsed in mourning as shown in Flowchart 1.^{6,25}



Flowchart 1. Objectives of the consultation according to the time of grief elapsed.^{6,25}

One of the models for approaching grief is based on the stages of grief described by Kubler-Ross, namely denial, anger, bargaining, depression and acceptance. It is important to highlight that not all people will go through all the stages and some will never reach acceptance.²⁶ In grief, there is no formula for mitigating pain, but it is possible to be present and show the bereaved person that they are not alone and that feeling loss is necessary.²⁷ In 1991, on the basis of these phases, Worden proposed

four mourning tasks and stated that with their completion, the bereaved person is on the path to healing (Flowchart 2).²⁸ Later, in 2002, Vega and Liria²⁹ proposed the role of the PHC professional in each of these tasks described by Worden²⁸ (Flowchart 2). Therefore, it is suggested to support the patient as described in this image.



Flowchart 2. Tasks that must be completed by the bereaved patient, and how the PHC health professional can help.^{28,29}

RECOMMENDATIONS

Pharmacological treatment in grief should be an exception, not the rule. The use of benzodiazepines to treat the symptoms of preparatory grief can promote and intensify denial, delaying or preventing the affective and cognitive processing of the loss.^{5,23} As stated, for bereaved individuals who do not show mental illness, we generally should not use benzodiazepines or antidepressants.^{2,6,22,23} Thus, as stated, the biopsychosocial approach is preferred.^{2,5,28,29}

FINAL CONSIDERATONS

The available studies demonstrate important gaps in our knowledge on the topic evaluated, especially when we consider studies carried out in PHC. Well-conducted studies on the approach to grief in PHC are scarce, and the majority of articles identified are published more than 10 years ago; Furthermore, we must consider that most of the available guidelines are based on expert opinion, and not on data from randomized clinical trials. Even case-control or cohort studies, less reliable assessments, are not available in large quantities in the literature, especially if we consider assessments related to the capacity and skill of PHC doctors in relation to the approach to grief and its effectiveness in relation to outcomes in bereaved patients. Therefore, addressing loss situations in PHC is a major challenge in terms of resources, methodology and availability. Furthermore, in the few available studies, convenience sampling was used and the study design was retrospective. It is also important to note that there is

generally no control group for comparison. Despite these limitations, the studies found serve as a basis for guidelines on how to approach grief. Although well-conducted studies are necessary to determine more clearly the best strategies for approaching grief, it is necessary that the topic be not only discussed but also practiced.

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CONFLICT OF INTERESTS

Nothing to declare.

REFERENCES

1. Portal da Transparência. Registros [Internet]. 2020 [accessed on Jun 24, 2021]. Available at: <https://transparencia.registrocivil.org.br/registros>
2. Shear K, Frank E, Houck PR, Reynolds 3rd CF. Treatment of complicated grief: a randomized controlled trial. *JAMA* 2005;293(21):2601-8. <https://doi.org/10.1001/jama.293.21.2601>
3. Nagraj S, Barclay S. Bereavement care in primary care: a systematic literature review and narrative synthesis. *Br J Gen Pract* 2011;61(582):e42-8. <https://doi.org/10.3399/bjgp11X549009>
4. Charlton R, Dolman E. Bereavement: a protocol for primary care. *Br J Gen Pract* 1995;45(397):427-30. PMID: 7576849
5. Hallenbeck J. Grief and bereavement [Internet]. 2018 [accessed on May 3, 2021]. Available at: <https://www.dynamed.com/topics/dmp~AN~T922660>
6. Casarett D, Kutner JS, Abrahm J, End-of-Life Care Consensus Panel. Life after death: a practical approach to grief and bereavement. *Ann Intern Med* 2001;134(3):208-15. <https://doi.org/10.7326/0003-4819-134-3-200102060-00012>
7. Buckley T, Sunari D, Marshall A, Bartrop R, McKinley S, Tofler G. Physiological correlates of bereavement and the impact of bereavement interventions. *Dialogues Clin Neurosci* 2012;14(2):129-39. <https://doi.org/10.31887/DCNS.2012.14.2/tbuckley>
8. Nielsen MK, Christensen K, Neergaard MA, Bidstrup PE, Guldin MB. Grief symptoms and primary care use: a prospective study of family caregivers. *BJGP Open* 2020;4(3):bjgpopen20X101063. <https://doi.org/10.3399/bjgpopen20X101063>
9. Sampson EL, Lodwick R, Rait G, Candy B, Low J, King M, et al. Living with an older person dying from cancer, lung disease, or dementia: health outcomes from a general practice cohort study. *J Pain Symptom Manage* 2016;51(5):839-48. <https://doi.org/10.1016/j.jpainsymman.2015.12.319>
10. Prigerson HG, Maciejewski PK, Reynolds 3rd CF, Bierhals AJ, Newsom JT, Fasiczka A, et al. Inventory of complicated grief: a scale to measure maladaptive symptoms of loss. *Psychiatry Res* 1995;59(1-2):65-79. [https://doi.org/10.1016/0165-1781\(95\)02757-2](https://doi.org/10.1016/0165-1781(95)02757-2)
11. Horowitz MJ, Siegel B, Holen A, Bonanno GA, Milbrath C, Stinson CH. Diagnostic criteria for complicated grief disorder. *Am J Psychiatry* 1997;154(7):904-10. <https://doi.org/10.1176/ajp.154.7.904>
12. Wiles R, Jarrett N, Payne S, Field D. Referrals for bereavement counselling in primary care: a qualitative study. *Patient Educ Couns* 2002;48(1):79-85. [https://doi.org/10.1016/s0738-3991\(02\)00068-x](https://doi.org/10.1016/s0738-3991(02)00068-x)
13. Vieira RR, Robortella AR, Souza AB, Kerr GS, Oliveira JAC. Vida e morte na atenção primária à saúde: reflexões sobre a vivência do médico de família e comunidade ante a finitude da vida. *Rev Bras Med Fam Comunidade* 2016;11(38):1-7. [http://dx.doi.org/10.5712/rbmf11\(38\)1281](http://dx.doi.org/10.5712/rbmf11(38)1281)
14. Hashim SM, Eng TC, Tohit M, Wahab S. Bereavement in the elderly: the role of primary care. *Mental Health Fam Med* 2013;10(3):159-62. PMID: 24427183
15. Stott NC, Pill RM. Health promotion and the human response to loss: clinical implications of a decade of primary health care research. *Fam Prac* 1987;4(4):278-86. <https://doi.org/10.1093/fampra/4.4.278>
16. Firth P, Anderson P. Teamwork with families facing bereavement. *European Journal of Palliative Care* 1994;1(4):157-61.
17. Rando TA. *Treatment of Complicated Mourning*. Champaign: Research Pr; 1993.
18. Zeitlin SV. Grief and bereavement. *Prim Care* 2001;28(2):415-25. [https://doi.org/10.1016/s0095-4543\(05\)70031-2](https://doi.org/10.1016/s0095-4543(05)70031-2)
19. Fenger-Grøn M, Kjaersgaard MIS, Parner ET, Guldin MB, Vedsted P, Vestergaard M. Early treatment with talk therapy or antidepressants in severely bereaved people and risk of suicidal behavior and psychiatric illness: an instrumental variable analysis. *Clin Epidemiol* 2018;10:1013-26. <https://doi.org/10.2147/CLEP.S157996>
20. Lloyd-Williams M, Lloyd-Williams F. Palliative care teaching and today's general practitioners--is it adequate? *Eur J Cancer Care (Engl)* 1996;5(4):242-5. <https://doi.org/10.1111/j.1365-2354.1996.tb00242.x>

21. Davidsen AS. Talking therapy as part of the general practitioner's normal working day. *Ugeskr Laeger* 2010;172(27):2025-9. PMID: 20594536
22. World Health Organization. Guidelines for the management of conditions specifically related to stress [Internet]; 2013 [accessed on Oct 24, 2021]. Available at: https://apps.who.int/iris/bitstream/handle/10665/85119/9789241505406_eng.pdf
23. Periyakoil VS, Hallenbeck J. Identifying and managing preparatory grief and depression at the end of life. *Am Fam Physician* 2002;65(5):883-90. PMID: 11898960
24. Lloyd-Williams M, Wilkinson C, Lloyd-Williams FF. Do bereaved children consult the primary health care team more frequently? *Eur J Cancer Care (Engl)* 1998;7(2):120-4. <https://doi.org/10.1046/j.1365-2354.1998.00082.x>
25. Dudley ST. Helping patients cope with grief. *Am Fam Physician* 2019;100(1):54-6. PMID: 31259495
26. Kübler-Ross E. Questions and answers on death and dying: a companion volume to on death and dying. New York: Touchstone Book/Simon & Schuster; 1997.
27. Santos EM, Sales CA. Familiares enlutados: compreensão fenomenológica existencial de suas vivências. *Texto Contexto Enferm* 2011;20(spe):214-22. <https://doi.org/10.1590/S0104-07072011000500027>
28. Worden JW. Grief counseling and grief therapy: a handbook for the mental health practitioner. 2nd ed. New York: Springer Publishing Company; 1991.
29. Vega BR, Liria AF. Intervenciones sobre problemas relacionados con el duelo para profesionales de Atención Primaria (II): intervenciones desde Atención Primaria de Salud. *Medifam* 2002;12(4):276-84.