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,

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.

therapist personality (24%). Now, despite a noticeable increase in the quantity and quality of psychotherapy outcome studies, research has revealed surprisingly few signifcant 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 specifc 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 effcacious treatments based in those commonalities. This search is predicated on the belief that commonalities are more important in accounting for therapy outcome 0003≥1re