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Article

Bereavement in the elderly: the role of primary care

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ABSTRACT

Bereavement in the elderly is a concern to primary care physicians (PCPs) as it can lead to psychological illness such as depression. Most people are able to come to terms with their grief without any intervention, but some people are not. This case highlights the importance of early recognition of bereavement-related depressive illness in elderly people. PCPs need to optimise support and available resources prior to, and throughout, the bereavement period in order to reduce the family members' burden and suffering.

Keywords: bereavement, depression, primary care physician

Introduction

Bereavement is a state of having suffered a loss,[1] whereas grief is a natural response to loss.[2] Elizabeth Kubler-Ross proposed that grief follows a sequence of phases that includes initial shock or denial, followed by anger. Subsequently, acceptance occurs prior to resolution of grief.[3] However, in some cases, grief persists long after resolution should have occurred and therefore becomes abnormal.

Case

A 73-year-old man had recently lost his wife after she suffered a short battle with advanced periampullary cancer. They had had a long, loving relationship over 50 years. He had always accompanied her for regular medical follow-ups for diabetes mellitus and hypertension as well as throughout the final stages of cancer. He was also the main caregiver when his wife was admitted to the hospital and was at her side when she passed away. Two weeks after her death, the family physician made a bereavement call by telephone. The elderly man's daughter revealed that her father was still grieving but denied that he showed any signs of self-neglect or harm. During the telephone conversation with the patient, the bereaved man admitted that he was still mourning his wife's death but believed that he was able to cope with his family's help.

A month later, the physician contacted the patient's daughter again. She reassured the primary care team that her father was doing well. However,

during the physician's phone interview with the patient, the physician noted sorrow in his tone. The primary care physician (PCP) immediately requested to meet the patient. During the meeting, the patient talked only of his late wife, relating all the memories they had shared together during their 50 years of marriage. He also admitted to strong feelings of guilt towards his late wife's death and that it overwhelmed him. He felt guilty for not being able to relieve his wife's suffering and he felt that he should have done more for her. Since his wife's death, he had also experienced difficulty sleeping – he would fall asleep at 2 am and would wake up at 5 am – and his appetite was poor.

He was usually left at home alone while his daughter went to work. He admitted to going to visit his wife's grave three to four times a day; he would visit her grave at sunrise and would only head home at sunset. His mood was extremely low and he sometimes felt so sad that he did not realise where he was or what he was doing. He admitted to even having driven his car without knowing where he was headed. He confessed to feeling hopeless, but denied any desire to end his life. He has no history of medical illness before his wife's death and had gone for regular checkups.

During the consultation, the patient exhibited poor eye contact (his eyes were also red as though he cried often) and appeared unkempt. His appearance was completely altered from before his wife's death. His hair was not combed properly and his clothing was dishevelled. He appeared tearful and depressed and conversed more quietly and slower than usual – he also paused frequently during the interview. He denied, however, any suicidal intentions or psychotic symptoms. His blood pressure was 126/70 mmHg and other physical examination was unremarkable.

With the patient's permission, the PCP contacted his daughter to discuss ways to help him cope with his grief. The daughter knew her father visited her mother's grave several times a day, but she had thought it a 'normal' part of the grieving process. She also professed that her father would not 'burden' her with his feelings.

A diagnosis of major depression was made and the patient was started on a course of antidepressants – 5 mg of oral escitalopram daily. The dose was increased to 10 mg a day after ten days. He was also given supportive counselling where he was encouraged to express his feelings. The family physician reassured the patient that he had done his best in helping his late wife. The daughter was also informed of the diagnosis of depression and she was advised to ask her other siblings to help with taking care of their father.

Discussion

The period of bereavement is a stressful life event for anyone. Each person will experience bereavement in different ways[4] and reactions to bereavement are strongly influenced by culture and ethnicity.[5,6]

Most bereaved people are able to overcome their grief, but in 10% of cases, grief becomes prolonged or complicated.[7] Symptoms of complicated grief include searching, yearning, preoccupation with thoughts of the deceased, crying, disbelief and feeling stunned by the death.[7,8] Sometimes, complicated grief can be present with delayed grief or absence of grief.[9] Such symptoms are present for at least six months.[7,8] With prolonged grief, a sense of hopelessness will also develop.[7]

Somatic symptoms such as headache, chest pain or palpitations may also be features of complicated grief.[1,3] Hence, whenever elderly patients present with multiple somatic complaints following loss, it is important to recognise the possibility of underlying depression. On the other hand, some elderly patients going through bereavement may have no reactions of grief or they may displace hostility towards those still living.[10] In a population study among the elderly, those between the ages of 75 and 84 years have a higher risk of developing complicated grief compared with a younger age group. It is also worth noting that those aged 85 years and over were less likely to have abnormal grief.[11]

Previous reports emphasise that complicated grief is a distinctly separate concern from anxiety and depression but it is still related.[7,8,11] Although the incidence of complicated grief is low in the general population (4.8%), the morbidities associated with complicated grief are more severe, which includes anxiety disorder (17.2%), depressive illness (9.7%),[11] poor quality of life and risk of suicide. Among the elderly, bereavement may also have an effect on their cognitive function. A study among elderly Brazilians found that bereaved people were more likely to perform poorly in terms of attention, information processing and verbal fluency. The differences in cognitive function were found to be significantly linked with the mood of the bereaved.[12]

Grieving people tend to find it difficult to ask for help, even from close family members.[13] In the case highlighted above, the patient did not wish to be a burden to his daughter, which may have contributed to his feelings of being alone and disconnected. There is also a tendency for family members to dismiss these psychological symptoms and underestimate the severity of the distress.[13] In this case, the patient's daughter was unaware that his emotional reactions were serious enough to warrant

medical attention. It is therefore important for PCPs to be proactive and to regularly check on the elderly bereaved person's condition after the death of a family member.

PCPs play a crucial role in identifying risk factors for abnormal grief even before the death of a family member occurs. Among the risk factors that contribute to complicated grief and which need to be recognised early are old age, caregiver stress, low socio-economic status and poor social support.[1,5,14] Apart from providing palliative care to patients, PCPs should also support and help to prepare the family members who are at risk of bereavement-related problems.[5] Many researchers agree that a proportion of bereaved people need active intervention and PCPs are most suited to provide such care.[8,15] They have the advantage of having the trust of, and an established rapport with the caregivers prior to their loss. Furthermore, they understand the family dynamics and are often involved in end-of-life care for the patients. In addition, provision of good quality end-of-life care helps to minimise the burden of care and feelings of regrets by caregivers.[16] This also expedites the caregiver's psychological recovery during the bereavement period.

During the early bereavement period, PCPs should make a bereavement call in order to assess the caregiver's coping abilities as well as to identify those who are in need of intervention. Although there is no fixed rule on the appropriate timing of a bereavement call, it is generally recommended that the call should be made as soon as possible, except on the day of funeral.[9]

A useful tool for PCPs to screen for complicated grief is the Brief Grief Questionnaire, which consists of five items and requires approximately three minutes to complete.[7] The self-assessed Inventory of Complicated Grief (ICG) can also be administered to gauge the severity of complicated grief.[7,11]

Charlton and Dolman recommended the implementation of a bereavement protocol in primary care practice.[9] The bereavement protocol is a clinical pathway that includes providing information about bereavement to caregivers, creating a practice death registry, case note entries of the dates and information of the loss, early initiation of bereavement consultation and regular review. The protocol is aimed to prevent complicated grief as well as offering early support for the bereaved.[9] A key worker within the primary care team should be assigned to ensure continuous support for the bereaved and the responsibility should be shared among the primary care team members. The key worker should also consider the relationship which may already exist between the bereaved and the relevant primary care team members. Nonetheless, some healthcare providers fear that this effort might be too intrusive and medicalise the grief, which is a normal and private life event.[15]

Following the diagnosis, the patients may receive either bereavement counselling or be prescribed antidepressants, depending on severity. Previous research proves that a preventive intervention in the form of counselling is effective in the early bereavement period for those who are at high risk of abnormal grief.[3] Counselling not only allows the counsellor to identify the bereaved person's emotional and social needs but also enables the bereaved to express their feelings about the loss, facilitating them to resolve their grief.[7,9]

In a qualitative study among practicing general practitioners (GPs), three important factors have been recognised as referral criteria for bereavement counseling.[17] The first factor is the nature of death, whether the death is unexpected, traumatic, resulting from a short terminal illness or when the bereaved is a minor. The second factor is whether the bereaved will receive a low level of social support. Abnormal reactions to death, such as prolonged or intense grief, are also regarded as an important factor. In addition, those with abnormal coping mechanism, such as using drugs or substance abuse, should prompt the GP to refer the patient for counselling. However, Wiles *et al* highlight that it is difficult to deliver the intervention when the bereaved person's discernment is poor.[17]

In cases of severe complicated grief, PCPs may need to liaise with psychiatrists for Complicated Grief Therapy (CGT), apart from administering pharmacological treatment.[7] CGT is a targeted psychotherapy combining strategies from Interpersonal Therapy (IPT), Cognitive Behavioural Therapy and Motivational Interviewing. In a published RCT trial comparing CGT and IPT, significant improvement was seen in the CGT trial (51%) compared with IPT (28%).[18] The effectiveness is even greater when CGT is given in combination with antidepressant therapy. There are few clinical trials assessing the effectiveness of antidepressant therapy among patients with complicated grief; however, small trials have shown the efficacy of escitalopram and paroxetine in improving symptoms of complicated grief.[19,20] Nonetheless, PCPs who are considering administering such medications for elderly patients would need to weigh the benefits against the risks for prescribing them.

Conclusion

PCPs play a crucial role in preventing, identifying and managing abnormal grief, especially in high-

risk groups such as the elderly. They need to be prepared and develop ways to identify those at risk of bereavement-related problems, especially psychological morbidities such as depression. It is essential that PCPs assess family members before they experience an imminent loss and do so regularly, especially during the first year after bereavement. Assessment should include identifying the needs of family members, either in the form of financial help, bereavement support or counselling. The use of bereavement protocol may also be beneficial in the high-risk groups such as the elderly.

We suggest future research should be encouraged to evaluate the effectiveness of these interventions amongst the elderly. Further research is also recommended to explore the perceptions of elderly patients receiving these interventions during the period of bereavement.

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