



Review of Grief Therapies for Older Adults

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Abstract

Purpose of Review The objective of this review is to provide background on common theories of grief, describe the impact of grief on older adults and to introduce various modalities that are currently used and/or being researched for treatment. The objective is also to condense information and identify what has been found beneficial versus what has been found lacking. A brief examination of overlap of other disorders is done. It also will suggest what further research is necessary on this subject, and highlight what research is being done during the COVID-19 Pandemic.

Findings The latest research of grief primarily involves refining the definitions of grief. More concrete definitions of grief will help for better screening tools, and thus target interventions more appropriately. There is considerable need for applying it to the unique and real-world COVID-19 pandemic.

Summary Grief disorders are relatively common and the symptoms overlap other disorders. Since the treatments differ, identifying grief disorders is important, especially in the elderly who are more susceptible to grief disorders. Therapy improves grief better than medications, but medications will help with any co-occurring disorders. No clear superior therapy has been identified but research continues. The pandemic has highlighted the need to refine the definitions of grief disorders and to treat them effectively.

Keywords Prolonged grief · Older adults · Treatment · COVID

Introduction

By 2060, there will be almost 100 million older adults in the United States, who will comprise 25% of the US population [1]. This is referred to as the “silver tsunami” [2]. The biggest wave of older adults are the baby boomers. The youngest of that cohort will be 65 by 2030. Grief impacts older adults more than other age groups because they have more family, more connections, and they have lived longer.

In the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV, bereavement was an exclusion for the diagnosis of major depressive disorder (MDD) [3]. This “bereavement exclusion” was removed in DSM-5 [4] and triggered concerns for over-diagnosis of MDD in the presence of grief. DSM-5 includes a “persistent complex bereavement disorder”; however it is under further study [4]. Additionally, in 2018 there was a

recognition in International Classification of Diseases (ICD)-11 by the World Health Organization that grief has varying degrees of severity, resulting in significant impairments in social and occupational functioning. The classification of “prolonged grief disorder” [5] (PGD), which identifies grief lasting longer than 6 months which “exceeds expected social, cultural or religious norms for the individual’s culture and context”, was added to ICD-11, as well” [5].

Losses Unique to the Geriatric Population

A meta-analysis [6] identified that approximately 1 out of 10 bereaved adults is at risk of developing PGD and the impact of PGD in older adults is estimated to be higher than that of the non-geriatric population.

Older adults have experienced many losses over their lifetime including parents, siblings, spouses, friends, and even children. In 1986 a study identified up to 10% of adults >60 years old suffered the loss of an adult child [7] and with life expectancies increasing, the number is surely higher today. A qualitative Belgian study examined the effects of elderly parents losing an adult child to cancer [8]. A common

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theme of these participants was loneliness due to the uniqueness of losing an adult child. They also expressed a lack of desire to express their grief, because they did not want to be a burden on the remaining family. They coped by keeping objects, photos, and visiting gravesites, and having conversations with the deceased. This study did not identify any particular treatment that was used to help this population, and even described family's attempts at protecting the parent from the child's impending death by restricting visits to hospitals. Some were not allowed to attend funerals or were heavily medicated, increasing the risk for developing PGD. This study highlights the need for better recognition and management of grief in older adults. More recently, the COVID-19 pandemic has created similarly uncommon circumstances regarding grief. The particular challenges of COVID-19 and grief will be discussed later in this report.

Grief

Types of Grief

Other than the pervasive feelings of loss, “grief” can have a wide variety of presentations. Identifying different types of grief, informs monitoring and treatment of grief [9]. Anticipatory Grief or “pre-death grief” is the grief one feels when caring for a person whose demise is impending. Acute Grief is what is experienced when the loss happens. Integrated Grief is the re-organization of attitudes, feelings, outlook after the loss, which is usually 6–12 months after the loss. Complicated Grief, or Prolonged Grief Disorder (PGD), is a failure to adapt to the loss. It includes a pervasive longing for the deceased. The definition is listed in more detail in Table 1. In DSM-V, a Persistent Complex Bereavement Disorder (PCBD) is identified, which is a “Condition for Further Study”. It identifies persistent yearning and preoccupation with the deceased as features of this condition.

Different Theories of Grief

In order to understand what grief is, we will now examine some different constructs. There are many conceptual frameworks of grief. Notable ones are described below.

Sigmund Freud

Psychoanalytic models of grief involve attachments to parental figures and the mourning process. This process is a gradual releasing of the attachment, or “love object” and is a painful process which must be experienced [10].

John Bowlby

Attachment theory evolved from psychoanalytic models. It involves the idea that children's attachments to parents, and then later other adults are instinctual, necessary for survival, and biologically driven. The quality of the attachment can vary between three types: secure, resistant, and avoidant [11]. When the attachment is broken, an intense struggle between the attachment and the missing object ensues, which goes through three stages: protest, despair and detachment. Experiencing these stages results in a reorganization of the attachment and a return to former interests [10].

Elisabeth Kübler-Ross

This widely used model of grief evolved by observation of patients that were facing their own impending death. These five stages are experienced, in no particular order, when people experience grief. Unresolved stages can be re-visited until resolved. They are listed here: [10, 12]

- Denial
- Anger
- Bargaining
- Depression
- Acceptance

Irvin Yalom

Existential psychotherapy recognizes four basic human issues that all people struggle with: mortality, “existential isolation”, freedom, and meaninglessness. The basic concepts are that death is inevitable, that we are all born alone and die alone, that we are in charge of our own destinies, and that we are afraid that our life is meaningless unless we make something of it. These struggles around “death anxiety” manifest in different ways depending on personality and innate coping skills [13].

Commonalities among All Theories

The above identified theories all have some things in common; an expected temporal component that, depending on the type of loss, a clinician can expect the bereaved person to follow. There is an acute phase that can last up to 6 months, or what is culturally accepted as “normal” [14]. The relationship to the loss is also important, and research shows that losing a child can extend the grief phase up to ten years [14]. There is a varying course of intensity of grief which is unpredictable, however it is expected to result in coming to terms with the loss and experiencing life normally, without the loved one in it [14].

Table 1 ICD-11 prolonged grief disorder (PGD) definition

Criterion	Details
A. Event	Death of someone close at least six months ago
B. Core items	≥1 of either: persistent and pervasive longing for the deceased, or persistent and pervasive preoccupation with the deceased
C. Accessory items	Accompanied by ≥1 example of intense emotional pain, e.g. <ul style="list-style-type: none"> • Sadness • Guilt • Anger • Denial • Blame • Difficulty accepting the death • Feeling one has lost a part of one's self • An inability to experience positive mood • Emotional numbness
D. Impairment criteria	Substantial impairment in personal, family, social, educational, occupational, or other important areas of functioning as a result of the symptoms
E. Cultural features	The grief response has persisted for an atypically long period (≥6 months) and clearly exceeds norms for the individual's social, cultural, or religious context

Prolonged Grief Disorder

No matter which construct of grief we imagine a patient is experiencing, an unsuccessful return to normal life within a broad time frame is likely to be PGD (Table 1).

Although there can be an overlap between grief and depression, grief is not depression (<https://www.dana.org/article/grief-vs-depression/>). Freud wrote about the differences in his 1917 essay *Mourning and Melancholia*. Melancholia can increase suicide risk whereas Mourning eventually resolves as the person adjusts to the loss of attachment (and possibly re-

attaches to something else.) Individuals experiencing grief retain their self-worth and are able to experience positive emotions. Shear writes an excellent article on how depression differs from grief [14]. Table 2 illustrates some of the differences and similarities among these disorders [15].

Measures of Grief

There is still research needed to refine the ICD-11 definition of PGD, and the DSM-V definition of PCBD. This leaves opportunity for screening tools, cutoffs, and sensitivities to vary

Table 2 Symptom overlap of grief, prolonged grief and major depressive disorder

Grief	PGD	MDD
Arises in response to a death	Arises in response to a death	Can arise spontaneously
Sadness	Sadness	Sadness
Guilt	Guilt	Guilt
Anxiety	Anxiety	Anxiety
Nightmares	Nightmares	Nightmares
Appetite/Sleep changes are acute, if present	Appetite changes Sleep changes	Appetite Changes Sleep changes
Intense yearning in the acute phase, however, should noticeably improve within 2 weeks	Intense yearning and intense preoccupation for the deceased that does not improve	Intense yearning can be present as an expression of depression
Functioning well	Impaired functioning	Impaired functioning
Not suicidal	Suicidality can be present	Suicidality can be present
Can experience joy	Lack of positive emotions	Lack of positive emotions
Typical grieving period is 6 months to 2 years with gradual improvement seen	Lasts more than 6 months and usually sustained, does not remit nor improve	Minimum of 2 weeks, can be recurrent. Can have "good days" but not typical
No response to medication	No response to medication	Does not resolve naturally
Can resolve naturally	Difficult to resolve naturally	Responds to medication
Responds to therapy	Responds to targeted therapy	Responds to therapy

[16]. Table 3 identifies many tools, but is not comprehensive. Given the overlap between depression, grief, and PGD, as shown in Table 2, the sensitivity of screening tools is difficult to assess. The importance of identifying PGD is exemplified in a case report of a grieving woman, who on her deceased son's birthday, was admitted to an inpatient unit with a diagnosis of mania with psychotic features and treated according to those guidelines. After her discharge she made a suicide attempt, was re-admitted and identified as having PGD/PCBD [17].

Out of the study tools identified in the table, ICG, BGQ, and PG-13 seem to be the most commonly used tool in clinical settings. This is a developing field and one can suppose that the length of time of existence, ease of use, and reported sensitivity/specificity, respectively could be responsible for their relative popularity.

Treatments for Grief

Normal grief resolves externally through social support and internally through re-arranging the loss to their daily routine, and it takes time to do so. Each person will move through their bereavement differently, and at a different pace, and have differing needs of social support. Those that have little social support can be helped by adding support through groups, whether in person or online. Individual therapy has been shown to help, as well.

Since PGD can appear from a multitude of causes, researchers have been examining a wide range of populations and situations.

- Refugees (specifically female refugees)
- Parents
- Elderly Spouse
- Where the remains were never found
- University Students
- Cancer, for deceased and for caregiver
- Cognitive decline
- In children with PTSD
- Community-dwelling caregivers
- Internet-based treatments

When the clinician has determined that PGD is present in their patient, the following section describes some modalities that have been shown to be helpful.

Psychotherapies

There are many talk therapies available to treat PGD. Some are very structured, some are relatively brief, and some are tailored to specific populations or age ranges. A common observation is that there are not many studies on types of therapy nor are they high-powered. This is a call to generate more research in this area.

Cognitive Behavioral Therapy (CBT)

This therapy is adaptable to a range of diagnoses and is a widely accepted, well known treatment. An example is illustrated in a randomized controlled clinical trial from Germany [21] where CBT was adapted for PGD and administered to a small group of people, mostly widows ranging from 18 to 78 years old. The intervention lasted on average nine months. The intervention used psychoeducation regarding normal grief vs. PGD, used elements from PTSD exposure therapy, and cognitive restructuring. Their results showed the intervention was highly effective in reducing the severity of grief.

Meaning-Centered Grief Therapy (MCGT)

This therapy is a manualized combination of CBT and existential therapy that lasts for 16 weeks. One study on parents with PGD of children under 25 years old who died from cancer showed improvement in PGD, whether the children had recently passed or not [22]. Interventions were in person or through videoconferencing. Although this study did not focus on geriatric parents, the devastation and likelihood of progressing to PGD is the same and can be applied to geriatric patients.

Interpersonal Psychotherapy (IPT)

This is a structured treatment that has an introductory, middle, and termination phase, which typically spans 12–16 weeks. The introductory phase assesses the relationship with the deceased, and the quality of the relationship. The middle phase addresses the grief and any positive and negative aspects of the relationship. The termination phase assesses the improvements in therapy, future goals and expectations, and feelings regarding the end of the therapy. IPT was originally developed to treat depression and was shown to be effective when used in combination with antidepressants [23].

Complicated Grief Treatment (CGT)

Developed at Columbia University, this is a 16 week program [24] that targets PGD and has manualized training with tools and handouts available to patients [25]. In comparison to IPT, CGT has shown in one study to be superior with almost double the response rate using CGT compared to IPT [26]. Their research shows that 70% of participants improve after the treatment. This treatment was conducted across age groups.

Specific, PTSD-Related Treatments

The two treatments listed below are identified because PGD has a crossover of symptoms with PTSD. These can help treat

Table 3 Grief screening tools

Author/year	Scale	No. Items	Clinical or research	Sensitivity / specificity
H G Prigerson et al., 1995	Inventory of Complicated Grief-Revised (ICG-Revised) [18]	19	The scale was validated in many heterogeneous samples and applied across a variety of characteristics. Seen in research more than clinical.	Specificity and sensitivity differ depending on cutoff, however both are 80% [19]
Horowitz et al., 1997, p. 904	Structured Clinical Interview for DSM-III (SCID – NP) complicated grief module for DSM-III-R-NP	30	This interview was tested in a homogeneous sample of spouses and further validated with one heterogeneous sample.	Sensitivity for this algorithm was 0.60 and specificity 0.99 [19]
Prigerson and Jacobs, 2001	Inventory of Traumatic Grief (ITG, later called Inventory of Complicated Grief – Revised ICG-R) and Traumatic Grief Evaluation of Response to Loss (TRGR2L)	30	included a variety of kinship and characteristics of the loss	sensitivity: 0.86, specificity: 0.76 [19]
Shear, et al., 2006	Brief Grief Questionnaire (BGQ)	5	originally developed to screen for CG for survivors of 9/11	No sensitivity nor specificity data exist [19]
Guerin et al., 2009	Complicated Grief Questionnaire for People with Intellectual Disabilities (CGQ-ID)	15	Observer-based assessment tool. Tested in bereaved people with ID who lost a parent	No sensitivity nor specificity data exist [19]
Prigerson et al., 2009	Prolonged Grief Disorder-13 (PG-13)	13	Tested in a homogeneous sample of bereaved spouses, later in heterogeneous samples (overall five studies).	a sensitivity of 1.00 and a specificity of 0.99 [19]
Lee, 2015, p. 399	Persistent Complex Bereavement Inventory (PCBI)	16	A self-report scale containing 16 items and is used in research of PCBD	Information on a cut-off value or a diagnostic algorithm is not provided [19]
Rubin and Bar-Nadav, 2016, p. 88	Two-Track Bereavement Questionnaire for Complicated Grief (TTBQ-CG31)	31	A self-report tool validated in only one study including a heterogeneous sample.	No sensitivity and specificity data are reported.
Newsom et al., 2016	Indicator of Bereavement Adaption – Cruse Scotland (IBACS)	(1) a semi-structured interview d (2) a 12-item self-report scale	Research tool	sensitivity of 0.68 and specificity of 0.85, using a cutoff value of >32. [19]
Boelen and Smid, 2017	Traumatic Grief Inventory SelfReport Version (TGI-SR)	18	A self-report tool developed for the assessment of symptoms of PGD and PCBD in both clinical and research settings	The authors recommend “using a score of ≥ 54 as indicative of clinically significant PCBD and PGD”. The cut-off was not validated with an external criterion [19]
Holland, et al., 2017	Bereavement Risk Inventory and Screening Questionnaire (BRISQ) [20]	34 (with possible changes pending, depending on the next phases of research)	Being developed in three phases	Intended to be a Screening tool

the common elements of PGD. Further refinement of PGD is warranted.

Life Review Therapy (LRT)

This is based on Erik Erikson's developmental theory, where the 8th stage of integrity vs despair is addressed by reviewing past accomplishments and conflicts. Life Review Therapy (LRT) showed improvement of depression and spiritual well-being in bereaved families and patients with terminal cancer [27, 28].

Integrative Testimonial Therapy (ITT) An internet-based writing therapy called Integrative Testimonial Therapy (ITT) was used with German survivors of World War II. It combines cognitive-behavioral therapy and life review elements, and found moderate decreases in PTSD symptoms [29].

Group/Peer Modalities

A study conducted by the Veterans Administration introduced a group model of bereavement for older veterans, mostly male, who have lost a spouse. This model was based on the dual process model of bereavement and Complicated Grief Treatment (CGT). It consisted of eight guided sessions in a group setting. This therapy showed a significant reduction in grief and depression symptoms [30].

Other, Non-Pharmacological Modalities

The majority of the current research has focused on developing screening tools and analyzing psychotherapeutic interventions for PGD. Fewer studies have specifically investigated social support, faith based, or non-Westernized interventions. Most studies are conducted in English. There is a tremendous, personalized variety of grief responses corresponding with varying attachments which would be better addressed by researching interindividual and intercultural variations in grieving.

Pharmacology

There is little evidence showing antidepressants alone treating PGD. In 2017 at Columbia University, a randomized clinical trial of Complicated Grief Therapy + Placebo vs. CGT + Citalopram showed that although citalopram improved symptoms of depression, it was ineffective in changing grief scores as measured by the Clinical Global Impression scale [25].

Since PGD and MDD can co-occur, the study remarks that citalopram would be effective for MDD.

A literature review [31] of studies using pharmacological treatments for PGD did show some effectiveness of antidepressants in treatment of PGD, yet were underpowered [31].

Of note some studies have found a benefit with tricyclic antidepressants, as well as paroxetine, which are unwise to use in geriatric population due to excess sedation and risk of falls. The review also mentioned three escitalopram studies that showed improvement, but all of the studies were, again, underpowered and therefore it cannot be said that the results are significant [31].

The same review article [31] identified a study that examined the use of benzodiazepines during ITP and CGT, and showed an improvement in the ITP group but interestingly, not the CGT group. Overall, benzodiazepines are contraindicated in the geriatric population due to over sedation and risk of falls, and increase in cognitive impairment and incidence of dementia [32].

Since there is a clinical overlap of PGD and MDD, the clinician may be tempted to administer antidepressants. In this published geriatric case report, administering an unneeded selective serotonin reuptake inhibitor in an elderly person can cause hyponatremia [33]. Clinicians should be cautious of potentially inappropriate prescribing leading to side effects and employ non pharmacologic interventions, whenever possible.

COVID-19

The COVID-19 pandemic has caused death on a scale that surpasses most natural disasters in recent history. Research on the COVID-19 pandemic is prolific at this time. Mortality increases with age, and one study identified an age greater than 60 as the threshold for an *exponential* increase in risk [34]. The geriatric population has been devastated by the COVID-19 pandemic and has caused a wave of grief among spouses, children, siblings, and friends. Two articles described that isolation measures to slow down the spread of COVID stopped the natural process of grieving. The prevention of "saying goodbye", along with the added stress/anxiety/isolation surrounding the pandemic has contributed to stresses that may precipitate PGD in large numbers [35, 36]. One article described it as "disenfranchised grief", and cited a greater risk of PGD because of the pandemic [37].

Anticipation of greater risk of PGD is common. An online research study of Chinese participants after deaths due to COVID-19 by Tang and Xiang showed higher scores on an online assessment of grief for PGD and PCBD [38]. "Bereavement overload" was identified in another article and it called for "national bereavement response plans" to guide healthcare professionals in times of massive traumatic deaths [37].

In an online, cross-sectional study of Chinese citizens in 2020 who have lost a loved one due to COVID, found no difference was found in levels of grief symptoms using a 6-month threshold. More severe prolonged grief symptoms were associated with losing a close person by COVID-19, losing a

partner, child, parent, and grandparent, feeling more traumatic about the loss, and feeling closer with the deceased. [38].

The Bereavement Network Europe (BNE) is taking steps to advance mental health support for bereavement across Europe particularly during the COVID-19 pandemic including: improving access to a network to use a common framework for research and care, creating a web-based platform to raise awareness on PGD, and developing a toolkit to implement/regulate best practice standards and evidence-based guidelines for bereavement care. The BNE will hold a conference in 2022 with the aim to unite bereavement researchers, clinicians and organizations in Europe [39].

The “death anxiety” construct is a feature of many disorders, including PGD. It is an anticipatory grief-like feature that is unique to humans because they know they are going to die. During the pandemic, one paper examined measures of “death anxiety” and showed positive correlation to fears about contracting the virus, and showed an increase due to constant reminders and worries about dying from the virus [40]. Since anxiety is a common theme in PGD, using the paper’s suggestion of Cognitive Behavioral Therapy may be a future component of PGD treatment.

Discussion

Prolonged Grief Disorder as a diagnosis is still in the early stages of definition. The geriatric population is in more need than ever to identify and treat this disorder due to the geriatric population boom. More research is needed and being done, and especially now that the COVID-19 pandemic has expanded the need to identify PGD in other than the geriatric population. The overlap between other major diagnoses makes it easy to miss in a clinical setting and it is important to distinguish it due to the different treatment recommendations for each.

Many tools are available, mostly for research at this time however of use to the primary care provider is the Brief Grief Questionnaire. Its simplicity and brevity make it a good start for screening for PGD, with the option for further refinements. For clinicians not doing research, the longer questionnaires can be shelved until there are more refined definitions of PGD.

The ICD-11 relies heavily on what is “culturally normal”. With so many “norms” and cultures, this area is too broad. Therefore, more concrete, measurable identifiers would improve identification of this condition greatly. An assessment based on attachment theory could be beneficial as grief appears to be tightly entwined into the level of attachment with the deceased.

Psychotherapy, in general, is effective for PGD. However, there is little research on PGD therapies, and no modalities has been shown to be superior. The Complicated Grief Therapy is a convenient, manualized therapy with training materials that

can be purchased. Any clinician wishing to further their experience with PGD therapy would benefit from this training. Further research with adequately powered studies and different patient populations is needed to determine the effectiveness of structured PGD therapies. There is a lack of research into group therapies, culturally-targeted therapies, and religiously-targeted therapies.

Conclusion

Older adults are disproportionately affected by grief. While the majority experience normal grief, clinicians should screen for PGD and MDD. They are not uncommon and may warrant specific psychotherapies. More research is needed to address PGD to address the “cultural norm” mentioned in ICD-11, especially since COVID-19 has crossed all boundaries into all populations regardless of local “cultural norms”.

Declarations

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Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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