

Bereavement in Old Age



Theory, research & evaluation of bereavement and grief therapies to improve the outcome of the grieving process in old age.

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Introduction

With approaching old age it is a natural life cycle that the death of a loved one has been experienced; a grandparent, parent and family elders. The risk of experiencing death of a spouse, siblings and friends increase with the ageing process. One of the most stressful events we experience during our lifetime is the death of a spouse (Hatch, 2018). Throughout our lives we experience many changes. However, our vulnerability increases with the experiences that challenge our coping skills (Arbuckle, & De Vries, 1995). It is beneficial to understand the strategies needed to help the elderly deal with the loss of a loved one. This includes an understanding of the compounding factors that effect well-being, physical and mental health.

Interventional support is needed within the aging population who are grieving the death of a loved one. This report looks at the research on the theories that may provide strategies to help the elderly community deal with bereavement and improve wellbeing.

Bereavement and the elderly



Bereavement is a process we experience after the death of a person that is significant in our lives (Stroebe, Schut, & Stroebe, 2007). To experience bereavement later in life is one of the most painful and stressful events and can threaten healthy aging, (Mercan, Barlin, & Cebeci, 2016) social and cognitive functioning (Shah & Meeks, 2012), increases the risk of depression (Cole & Dendukuri, 2003; Lindwall et al., 2006), causes sleep disruption (Monk et al., 2008) and increases mortality (Boyle, Feng & Raab, 2011). The effects of bereavement on the individual can vary. The age, sex, the individuals personality traits, the circumstances surrounding the death (Moss & Moss, 2013) and the

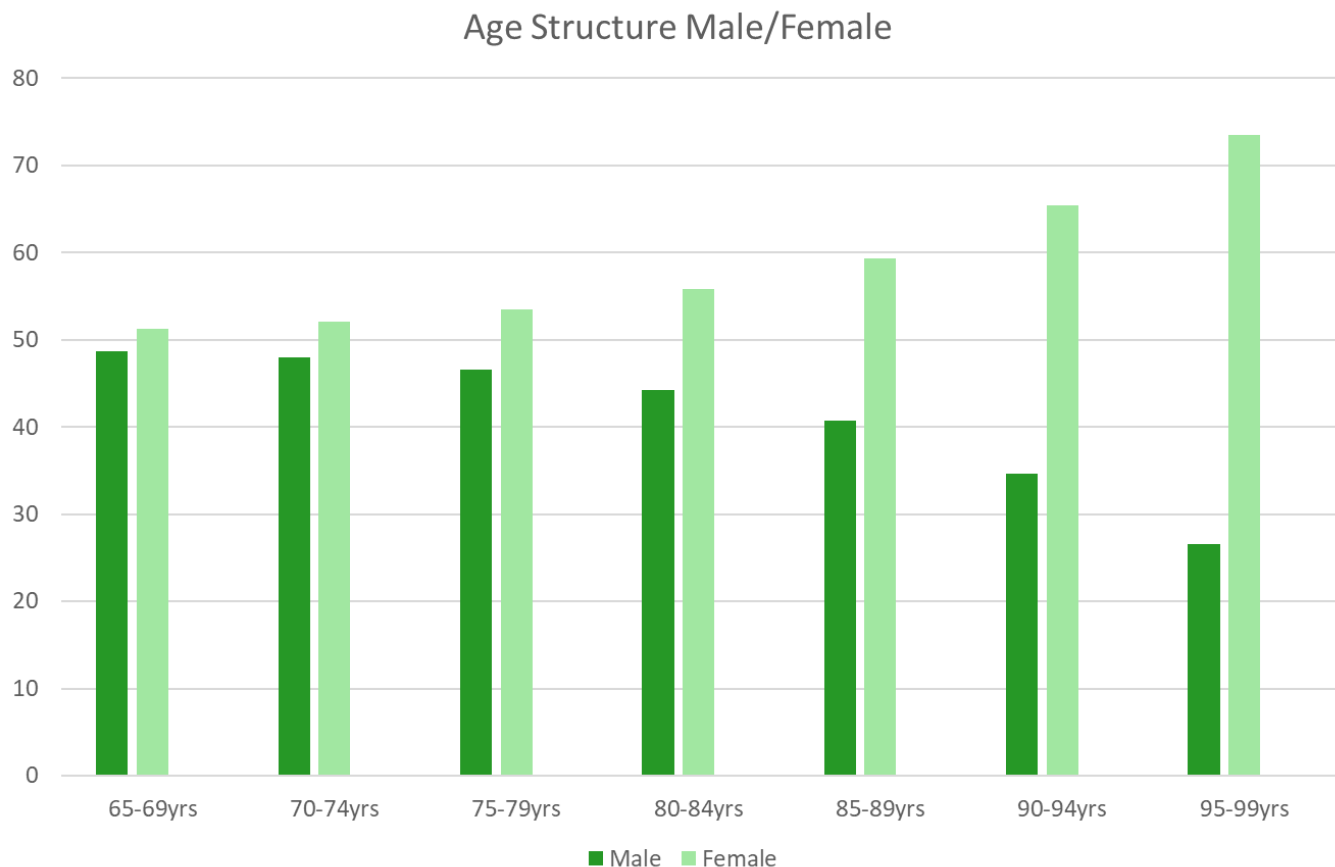
depth of the relationship between the deceased and the bereaved plays a role in the bereavement process (Mash, Fullerton, Shear & Ursano, 2014).

Feelings that may be experienced during bereavement by the elderly:

- Loneliness.
- Depression.
- Isolation.
- Sleep disturbance
- Reduced Cognitive & Executive Function.
- High mortality / suicide.
- Anxiety
- Shock
- Yearning

Demographic Information of an Aging Population

In the UK there are approximately 12 million people aged 65yrs and above, of which, 46% are males and 54% are female. The graph illustrates in five year increments how the age structure and sex ratio widens with age. In the age group of 65-69yrs 49% of the population is male and 51% are female. By the age of 95yrs this gap has widened to 27% male and 73% female.



It is clear that as we age the gap between surviving females and males widens. This is an indicator that women are more likely than men to be widowed (Worldometers, 2019). With the increase of an elderly population it is pertinent to develop strategies for supporting those who are suffering the loss of a loved one, to reduce the negative outcomes that are associated with bereavement.



In the next 50 years it is projected that there will be a further 8.6 million people aged 65yrs and over (ONS, 2018). It is further projected that 29% of female babies born in 2018 will live to 100yrs of age and 23% of male babies will live to 100yrs (ONS, 2018).

This statistic further highlights that there will be more widows than widowers and further supports the importance of developing strategies to help the aging population.

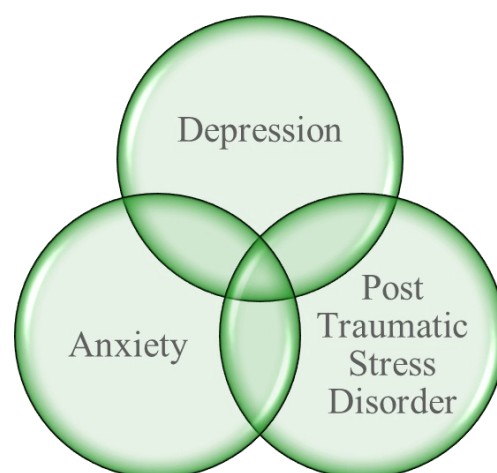
Detrimental effects of bereavement in the elderly population

Bereavement is a prominent risk factor among the elderly population for depression (Cole & Dendurki, 2003). Frontal executive function plays a role in the management of stress, and, poor cognitive and executive function is associated with late life suicide and suicidal behaviour is linked to depression (Dombrowski et al., 2008; Keilp et al., 2001). Stressful life events, such as suffering a bereavement is salient to death by suicide in the elderly population (Conwell, Van Orden & Caine, 2011) and suicide rates in the older population is pervasive. This can be contributable to many factors, psychiatric illness, in particular depression, is the most common and is present in 71-97% of suicides in older adults (Conwell, Van Orden & Caine, 2011).

A sharp increase in depression after bereavement has been observed (Norris & Murrell, 1990). Socially isolated adults are at greater risk of mental health problems after suffering a bereavement (Perng & Renz, 2018). Loneliness is challenging for older bereaved adults. Those who have a greater social support network are less affected by loneliness (Utz, et al., 2013). Holt-Lunstad, Smith & Layton (2010) found that there is a 50% increase in survival for those who have stronger social relationships. The demands of adjustment is a process older bereaved adults are forced to confront, combined with the distress of separation. Older widows have been found to have less resilience when confronted with problems in everyday life and physical symptoms are higher when having to confront stressors related to the home after the death of a spouse (Hahn, Cichy, Small & Almedia (2014).

Complicated Grief & Healthy Grief

Some adults continue the grieving process for an extended period of time. This is known as complicated grief (Bonanno, 2004). Complicated grief opposed to normal grief see the bereaved unable to come to terms with the death of a loved one, instead, the bereaved experience an intense yearning, find it difficult to move on, experience distressing memories (Prigerson et al., 1995) and disbelief (Boelen & Jan van den Boit, 2005). Complicated grief can show an overlap of symptoms (see image); these symptoms are not necessarily comorbid (Newson et al., 2011)



Characteristics of Complicated Grief

- Complicated grief has inflated rates of depression and anxiety; these symptoms are not necessarily comorbid.
- The loss of a spouse or child was more predictive of complicated grief.
- Complicated grief is more prevalent in 75-85yr olds.
- Complicated grief is a separate condition to depression and anxiety.
- Low cognitive functioning is prevalent in complicated grief.
- Complicated grief has been found to interfere with information processing.

Normal Grief

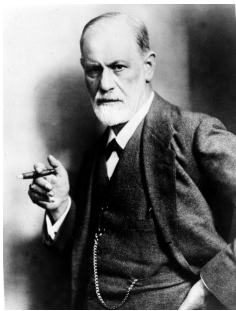
The majority of adults recover from grief within a “normal” period of time. This is about 6 months; (Wilson, 2013).

Feelings Experienced in Healthy Grief

- Sadness
- Shock
- Change in sleep patterns
- Social Withdrawal
- Lack of concentration
- Anger, anxiety, guilt

(Wilson, 2013)

Theories on grief and bereavement: Stage & Phase Models



Freud: Grief Work

Freud’s theory of grief can be described as the beginning of the modern theory on grief and mourning and the foundation of the psychological understanding of grief (Walter, 1994). Freud’s theories of confronting grief in order to allow detachment has continued to dominate theory on bereavement. Freud’s theories have faced criticism, however they do lay the foundation to future theories.

Freud (1961) psychoanalysis approach to death proposes a need to work through the loss; this involved emotional detachment from the deceased. Freud viewed grief as a solitary process that involved the mourner to withdraw from the world. This gradual process of detachment from the deceased takes place and allows the individual to release themselves from the bond shared with the deceased and to acknowledge the permanent absence of the deceased. Releasing one self from the bond involved reliving memories of the deceased so that the grief could be overcome by working through the loss. The term used for this process is “Grief Work”.

Critique

Freud’s theories were based on clinical experience with patients who were depressed. Therefore, his understanding of the grieving process may not be relevant to the general population but more specific to those already suffering from depression.

Freud suffered the loss of a child, his daughter Sophie died aged 9yrs. In his personal letters Freud expressed the value of an ongoing emotional connection with the deceased (Davies, 2004; Rando, 1995). This contradicts his belief that an emotional connection with the deceased that remains ongoing is pathological.

Lindemann (1944).

Lindemann (1944) expanded Freud's Grief Work. He highlights that by confronting the reality of the loss results in a healthy resolution. This involved the severing of emotional bonds so that new relationships can be forged and the adaptation to a new environment without the deceased. Lindemann also identified other measurable factors for normal and pathological grief. These included a change in social functioning, the duration of grief and the intensity of the grief.

Lindemann's theory of grief has five phases...

Somatic disturbance | Preoccupation with the image of the deceased | Guilt
Feelings of hostility | Difficulty with everyday routines

Critique

- Lindemann's theory is based on clinical experience and focused on patients who experienced bereavement as a result of disaster.
- Examination of Grief Work has failed to support the approach and has suggested it may be harmful to some bereaved individuals (Bonanno & Kaltman, 1999).
- "Grief Work" processes may only be suited to the bereaved who are suffering with severe grief (Bonanno, 2004). The benefits of "Grief Work" is more evident with chronic grief (Neimeyer, 2000)
- Grief specific therapies tend to be ineffective (Kato & Mann, 1999) and in some cases individuals have been more harmful compared to non treatment controls, concluding that the intervention is ineffective for individuals experiencing normal grief (Neimeyer, 2000).

Kübler-Ross (1969)

Kübler-Ross (1969) theory of grief defined 5 stages:

Denial | Anger | Bargaining | Depression | Acceptance

This model of grief progresses in a linear fashion, each stage is completed before the individual can move onto the next. This model of grieving has also met with some criticism. Stage and phase models are limited as they follow a set pattern. The reality of grief is that the stages often overlap; they can also occur in a non-sequential pattern (Buglas, 2010). Corr (1993) argues that grief and bereavement is a complex process and the five stages of Kübler-Ross' (1969) theory resembles defence mechanisms. The theory is also criticised for being too rigid and linear as well as being too passive.

Bowlby (1973)

The emphasis of Bowlby's theory of attachment is on the development of human bonds in early life, in order to explain the reactions to bereavement in adulthood, Bowlby relied on the individuals' experiences during childhood. Bowlby's grief theory explains that grief evolves through a sequence of four flexible phases that overlap. They are:

Shock | Yearning and Protest | Despair | Recovery

Bowlby's attachment theory differs from Grief Work in that the individuals experience is responsive when the strong affectionate bonds are disrupted (Stroebe, Hanson, Stroebe & Schut, 2001), an example of this is trying to regain the feeling of closeness; this closeness can not be regained after death. This then leads to feelings of despair.

Parks (1998)

Like Bowlby (1973) this theory on grief is similar in that Parks (1998) identifies 4 phases in the bereavement process. They are:

Shock or Numbness | Yearning and Pining | Disorganisation and Despair | Recovery

The phases of this model are not necessarily linear. Reminders and triggers of the loss can result in these phases being experienced several times. Grief is a process. Parks (1996) suggests grief is a succession of phases rather than symptoms that fade away.

Criticisms of Stage & Phase Models

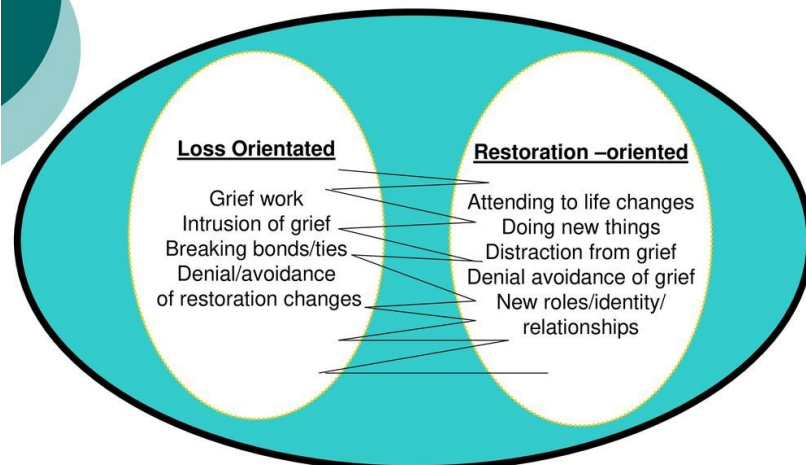
Stage or phase models tend to focus on the dynamic process of coping with grief where the bereaved actively navigates their grief. However, experiencing grief in a passive way is more representative of grieving individuals (Stroebe et al., (2001). These models attempt to find patterns. Human behaviour, however, is more complex.

The stage or phase models may help some individuals who seek comfort from the knowledge that their experiences of grief and their feelings are also shared with others and not only apply to themselves. Calling attention to a pattern of "normal" grief does not take into account the uniqueness of an individuals' grieving process (Buglass, 2010). Stroebe, Stroebe & Hannson (1993) argue that these models are too prescriptive and do not allow for variance. Furthermore, these models may not be appropriate in other cultures as they are theories developed within western culture.

Stroebe & Shut (1999)

The Dual Process Model (Stroebe & Shut, 1999) integrates existing ideas and introduces new concepts. The bereaved individual in this model has to cope with the lifestyle changes that occur after death as well as the experience of death. There are two processes in this model, loss orientated factors and restoration orientated factors. The image shows these two processes.

A Dual Process Model of Coping with Bereavement
Strobe & Schut (1999)

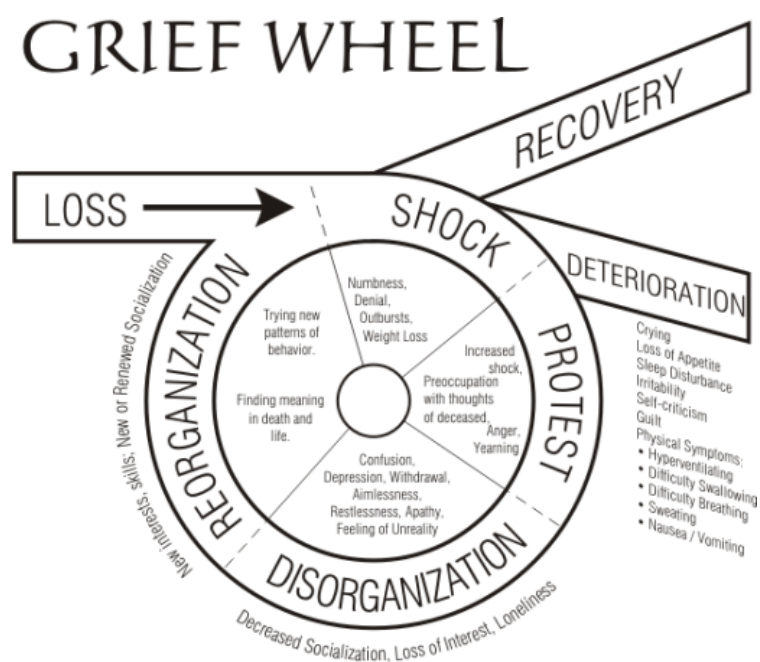


Loss orientated factors are specific to experiencing death and includes death work, while restoration orientated factors relate to lifestyle changes. This model of grief is more sensitive to cultural differences and has more flexibility than the stage and phase models. It suggests in order to move through the grieving process individuals need to move between the two factors addressing different issues, i.e, emotional then practical and vice versa. Both processes are needed and this movement between

the two allows for adjustment. Personality, gender, cultural and the circumstances of the person's death play a role in the individuals variance of adjustment. This is one advantage of this model as it accounts for the individuality of the grieving experience. Furthermore, the dual process model recognises the importance of control and expression of feelings and judgement of how an individual is coping.

A criticism of this model is that it does place a high emphasis on the ability that the individual has in being able to cope with grief. This suggests that if they are not coping the bereaved is not "normal". A further criticism of this model is the lack of scope for interpersonal relationships that may help the individual cope the death of a loved one.

The grief wheel is a useful image to explain the theories on the grieving process as it highlights how grief is not a static process.



Moving Forward:

The theories discussed in this report indicate that the grieving process is complex and can effect the elderly in different ways. Grief is a natural process following the death of a loved one. Getting the right support is important as the loss of a spouse or close family member can have a detrimental effect on an older persons well-being.

The following broacher discusses therapies that can help older adults navigate the grieving process.

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Researcher Details

Michaela Paterson
University of Wales Trinity St David Carmarthen
Email 1704051@student.uwtsd.ac.uk.

Good Grief

Improving the ways we deal with grief.

Treatments and therapies to help older adults deal with grief and bereavement.



Complicated Grief



Complicated Grief Treatment (CGT) or Grief Focused Interpersonal Psychotherapy (IPT)

Complicated grief (CG) is prevalent and debilitating among the elderly population suffering bereavement. Symptoms of

complicated grief can show an overlap with depression, anxiety and post traumatic stress syndrome (Newson et al., 2011). Shear et al (2014) study looked at the efficacy of CGT in improving complicated grief and depressive s symptoms over IPT. The aim of the study was to facilitate natural mourning and solve grief complications. CGT adopts the framework from the Duel Process Model (Stroebe & Schut,1999).

Design

- Sessions included both loss-focused and restoration-focused components.
- Participants were diagnosed with CG
- Sixteen sessions of CGT or IPT delivered over 19 weeks
- Mean age 66yrs

Results

- CGT significantly improved CG symptoms over IPT
- CGT Significant positive change in illness severity

Conclusion

Complicated grief treatment proved to be a significantly better treatment than IPT. The results support the need for health care providers to distinguish complicated grief from depression.

The findings of Shear et al., (2014) supported the finding of Shear, Frank, Houck & Reynolds (2005) who found a 51% improvement in complicated symptoms with CGT opposed to 28% improvement with IPT.

Complicated grief therapy has seen success when administered as a group therapy (CGGT) opposed to standard group therapy (treatment as usual TAU). The CGGT was based on the trial of Shear et al (2005). Significant improvements were observed with CGGT (Supiano, & Luptak, 2013). CGGT specifically targets the three elements of the Duel Process Model (Stroebe & Shutt, 1999).

Design

- Participants age 60yrs +
- CGGT & TAU delivered over 16 weeks.
- Each session lasted 120 mins.
- Both groups were similar in age, time since death and relationship to deceased.

Results

- CGGT showed significant improvement in treatment response in those with complicated grief symptoms than TAU.
- Participants demonstrated collectively and individually a progressive improvement.
- The TAU group addressed normal grief processes. And did find significant improvement.

The finding of the study suggests that CGGT interventions benefits those who perceive the death of a loved one as a personally traumatic.



Duel-Process Bereavement Group Intervention (DPBGI)

In the older population social isolation increases the risk of physical and mental health problems (Perng & Renz, 2018). Loneliness is a challenge for the bereaved, however, older adults with

social support are less effected (Utz et al., 2013). Weiss, (1973) distinguished between two types of loneliness, emotional and social emotional. Social emotional loneliness refers to social networks to which the individual no longer has a sense of belonging. Chow et al (2018) compared the Duel-Process Bereavement Group Intervention – Chinese (DPBGI-C) and the Loss-Oriented Bereavement Group Intervention-Chinese (LOBGI-C). The DPBGI-C intervention incorporates restoration-orientated, loss-orientated and oscillations while the LOBGI-C intervention comprises of the loss orientated component only.

Design

- Both incorporate weekly sessions for a duration of 8 weeks and a 4hr outing in week 8.
- Adults over the age of 60yrs & widowed within the last 2yrs.
- Primary outcomes - Grief reactions and emotional reactions.
- Secondary outcomes - Loneliness and social support.

Results

- DPBGI condition reported a greater reduction in social loneliness, emotional loneliness, depression and anxiety than the LOBGI-C condition.
- LOBGI-C condition did not report any difference in anxiety.

The findings of this study is consistent with the original DPBGI study of (Utz, Caserta & Lund, 2013). A key factor of this study is the adaptation to Chinese culture. The DPBGI adopts the theoretical framework of the Duel Process Model as does the CGT and CGGT. The significance of the DPBGI-C is it highlights that the intervention is adaptable between cultures. An example of this is in American culture financial and legal issues are of concern, this is not something that is discussed in the Chinese culture. Health is of higher importance, therefore health related topics were added. Rituals related to Chinese culture was also added.

Interventions that adapt the theoretical framework of the Duel Process Model have proven to be successfully adapted to accommodate cultural differences. Adapting successful interventions to help the older population deal with grief and bereavement is pertinent in the UK as we have a culturally diverse population. Grief and bereavement is universal and death is non-discriminatory. With an aging population it is beneficial to implement successful interventions so the bereaved are better equipped to deal with the loss of a loved one.