Geriatric Psychiatry

Bereavement in the Elderly: Clinical Considerations

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Abstract: Older adults commonly experience bereavement, which is associated with significant medical and psychiatric morbidity. Clinical evaluation of grieving older patients should be comprehensive, with a complete biopsychosocial evaluation. Although normal grief is not pathological and requires no treatment, ongoing monitoring with assessment of mood, suicidality, health and functional status is recommended. Traumatic grief and bereavement-related depression—complications of bereavement—pose challenges to treatment. It is hoped that an increased awareness of the features of normal grieving and the ability to recognize grief complications in older patients will lead to improvements in clinical care.

Résumé : Le deuil chez les aînés : considérations cliniques

Les adultes âgés font fréquemment l’expérience du deuil, qui est associé avec une importante morbidité somatique et psychiatrique. L’évaluation clinique des patients âgés endeuillés doit être détaillée et inclure une évaluation biopsychosociale complète. Bien que le deuil normal ne soit pas pathologique et ne nécessite pas de traitement, nous recommandons une surveillance continue assortie d’une évaluation de l’humeur, de la suicidabilité, de la santé et de l’état fonctionnel. Le deuil traumatique et la dépression liée au deuil — complications du deuil — défient le traitement. Il est à espérer qu’une connaissance accrue des caractéristiques du deuil normal et la capacité de reconnaître les complications du deuil chez les personnes âgées entraîneront l’amélioration des soins cliniques.

Key Words: grief, bereavement, elderly

Loss is an inevitable consequence of aging. In a recent Canadian survey of seniors, 19 per cent of individuals aged 70 years and over reported experiencing the death of a close relative during the previous six months (1). Although grieving is a normal process, adverse medical and psychiatric outcomes are common in the aftermath of bereavement (2–4). Researchers have observed higher rates of health care use, hip fractures, nutritional deficiencies and functional impairment in samples of elderly bereaved persons (5–7). Nearly all recent studies have found significant elevated mortality rates within widowed populations (8,9).

Among the bereaved, psychiatric morbidity is also prevalent. At some point during the first year of bereavement, 45 per cent to 50 per cent of widows and widowers will experience a major depression, while 15 per cent to 30 per cent will experience depression for the entire first year (10–12). Widowed older adults are also vulnerable to anxiety symptoms and disorders (13). Symptoms of anxiety and depression early in the course of bereavement predict subsequent medical and psychiatric morbidity (14,15).

And yet, insufficient research has been conducted within elderly populations; in fact, little is known about the impact of bereavement on the frail elderly, the “oldest-old” and those living in nursing homes. Bereavement research has focused almost exclusively on widowed populations, neglecting the experience of elderly grieving the loss of siblings, children and other loved ones. Research samples skewed toward “younger-old” individuals may overlook the additive detrimental effects of functional and cognitive impairment on bereavement outcome.

Also problematic in bereavement studies, adults over age 50 years have routinely been included within elderly samples—raising questions about the generalizability of data. The following sections outline clinical issues relevant to the treatment of grief in the older adult.

General Considerations

The initial assessment of a bereaved older patient requires a comprehensive approach, with evaluation of medical and psychiatric comorbidity. Somatic complaints are common in the aftermath of bereavement, but weight loss, headaches and other physical symptoms may also signify underlying pathology that requires further investigation. Obtaining a detailed medical history will help identify cardiovascular disease and other preexisting conditions associated with adverse outcomes in bereavement (16–18). Assessment of cognitive function in older bereaved patients is recommended. Frequently, the extent of the impairment becomes apparent, and previously hidden
deficits become unmasked, only after a spouse dies. A full psychiatric evaluation to determine individual and family history of depression, anxiety, suicidality, psychosis and substance abuse can highlight potential vulnerability (8,14,15,20). Obtaining a thorough personal history will uncover details about early losses, trauma and coping strategies, as well as the quality and extent of support networks. Social support has been linked with better psychiatric outcomes in bereavement (19,21). Bereaved individuals should be encouraged to strengthen relationships with friends and family and develop new social connections. This can prove challenging for older individuals faced with hearing and visual impairment, reduced mobility, cognitive decline or other factors that limit the ability to reconnect. Clinicians should also inquire about concurrent stressors. Often, grief is compounded by additional losses such as lowered income, changes in relationships and moves that, for elderly individuals, may mean institutionalization (21).

In addition to evaluating medical and psychiatric symptoms, it is important to learn about the circumstances of the death itself. Was the death anticipated or sudden? Even when deaths are anticipated, the event can be perceived as sudden and unexpected (22). Were there traumatic circumstances surrounding the death? Violent deaths, homicides and accidents, as well as suicides, are associated with significant morbidity in bereaved persons (23–26).

**Normal Grief**

Grieving is a normal process but nonetheless associated with considerable psychiatric morbidity. Bereaved individuals typically report sadness, poor appetite, reduced concentration and insomnia. Increasingly, grief is conceptualized as timeless. Time may attenuate the intensity of grief, but even years after a death, a particular event or situation can elicit powerful feelings. Celebrations, holidays and birthdays—any reminder of happier times—can trigger waves of sadness. Owing to societal expectations (real or imagined) that they “get over it” and “get on with things,” people may hesitate to reveal they are having an “anniversary reaction” (2,25,27,28).

Commonly, those who grieve describe longing and yearning for their deceased loved one. Some bereaved individuals consciously and unconsciously assume mannerisms and characteristics of their deceased loved one. Some may take up hobbies and interests of the deceased. Bereaved individuals often develop rituals to commemorate memories of their loved one. Some may choose to visit the cemetery often, while others avoid it entirely. Behaviour alone can reflect underlying difficulties with grief, but this cannot be assumed. Frequent and regular visits to a loved one’s grave can provide immense comfort to some bereaved individuals. It is not in and of itself pathological, especially if the individual is coping well in all other regards. Similarly, a bereaved individual who refuses to go to the cemetery may be doing well in all other respects.

Normal grief is not pathological and requires no treatment. Research does not substantiate the notion that the use of sedatives or hypnotics can interfere with “the work of grieving.” A recent, small, randomized double-blind placebo-controlled trial investigated benzodiazepine usage during the first six weeks of bereavement. Low-dose diazepam taken up to three times daily by individuals bereaved of a spouse or a partner in the preceding two weeks had neither beneficial nor detrimental effects on grief-related distress, as measured by the Bereavement Phenomenology Questionnaire (29). The study did not focus on elderly bereaved persons. Benzodiazepines and similar agents should be used cautiously in the elderly, in view of the potential for adverse effects, including falls, drug interactions, impaired concentration and dependence.

For older adults grieving the loss of a loved one, receiving information about local bereavement services can be immensely beneficial. Individuals may also find that it helps to join a social club or take up new activities to reduce loneliness and isolation. Some may wish to pursue volunteer work, enroll in a course or attend religious services. These are all modes of connection that facilitate reengagement after loss.

**Complicated Grief**

The bereavement literature uses the term “complicated grief” synonymously with traumatic grief to describe a posttraumatic stress disorder–like syndrome (30). Traumatic grief is characterized by prominent intrusive recollections of the deceased, disbelief over the death, yearning and searching for the deceased, together with avoidance of reminders of the deceased, guilt and bitterness (8). Feelings of numbness and detachment are commonly reported, although depressive symptoms may be absent. The Inventory of Traumatic Grief (ITG) has been devised to aid in diagnosis. Symptoms fall under the broad categories of separation distress or traumatic distress.

Traumatic grief is a syndrome that is difficult to treat (8,31). Results are equivocal regarding the benefits of antidepressants and psychotherapy. So far, research has been directed toward developing valid and reliable criteria...
for diagnosis, and a manual based on cognitive strategies is being developed (32). Table 1 outlines criteria for diagnosing traumatic grief (30). The few studies that examine the benefit of antidepressants on traumatic grief symptoms, using agents such as paroxetine and nortriptyline, have been methodologically limited and have yielded equivocal results (33).

### Bereavement-Related Depression

The boundary between grief and depression is nebulous. DSM-IV suggests considering a depression diagnosis when symptoms persist for two months after the loss. The distinction is somewhat arbitrary in that nothing precludes diagnosing a depression sooner if symptoms uncharacteristic of normal grief are present. These symptoms include excessive guilt, suicidality, feelings of worthlessness, marked psychomotor retardation, prolonged and marked functional impairment, and hallucinations. For this reason, distinguishing between grief and depression can be clinically challenging. Rather than determining whether it is grief or depression, it is perhaps more useful clinically to determine whether symptoms of grief and depression (or anxiety) coexist.

While we may understand depression in the aftermath of significant loss, it is never normal. Nevertheless, in the context of grief, it may be construed as normative. In one well-known study, only 24 per cent of bereaved spouses with a diagnosable major depression were being treated with an antidepressant (34), despite accumulating evidence linking untreated or residual depressive symptoms with chronicity (10,35).

Untreated depressive symptoms are correlated with negative health outcomes in older adults, including increased use of health care and home care, elevated mortality, greater disability and functional and cognitive impairment (36,37). Even subthreshold depressive symptoms (minor and subsyndromal depressions) have been linked with increased rates of suicide, social isolation and reduced quality of life (38). Diagnosing depression in an older adult can be clinically challenging, independent of bereavement, because the elderly tend to focus on somatic

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### Table 1 Proposed Diagnostic Criteria for Traumatic Grief

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<th>Criterion A</th>
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<td>1. Person has experienced the death of a significant other</td>
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<td>2. Response involves 3 of the 4 symptoms below experienced at least sometimes:</td>
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<tr>
<td>a) intrusive thoughts about the deceased</td>
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<td>b) yearning for the deceased</td>
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<td>c) searching for the deceased</td>
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<td>d) loneliness as result of the death</td>
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<th>Criterion B</th>
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<td>In response to the death, 4 of the 8 following symptoms experienced as mostly true:</td>
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<td>1. purposelessness or feelings of futility about the future</td>
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<td>2. subjective sense of numbness, detachment, or absence of emotional responsiveness</td>
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<td>3. difficulty acknowledging the death (disbelief)</td>
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<td>4. feeling that life is empty or meaningless</td>
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<td>5. feeling that part of oneself has died</td>
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<td>6. shattered world view (for example, lost sense of security, trust, control)</td>
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<td>7. assumes symptoms or harmful behaviours of, or related to, the deceased person</td>
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<td>8. excessive irritability, bitterness, or anger related to the death</td>
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<th>Criterion C</th>
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<td>Duration of disturbance (symptoms listed) is at least two months</td>
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<th>Criterion D</th>
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<td>The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning</td>
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*British Journal of Psychiatry (30).*
symptoms and underreport feeling sad or depressed. Medical comorbidity can confound diagnosis (39). Depression increases suicide risk in the elderly as does comorbid anxiety, psychosis, substance use and physical disability. Bereavement is also considered an important risk factor for suicide in older adults (39,40). Suicidal ideation has been noted in samples of elderly widowers in the absence of depressive symptomatology, underscoring the need for careful evaluation of suicide risk in all bereaved individuals. Antidepressant medication can be combined with psychosocial treatment strategies, such as referral to a bereavement group. There is no compelling evidence supporting the use of one antidepressant over another. The selected agent should be safe and effective for use in the elderly and chosen only after careful evaluation of each patient. Because anxiety is frequently comorbid with depression in bereavement, SSRIs, namely, citalopram and sertraline or an agent such as venlafaxine XR, would be reasonable choices for older patients (39).

Conclusion

Grief is normal but associated with considerable morbidity. Among older adults already prone to declining health, the impact of additional bereavement-related changes in health can be profound. Psychiatric morbidity is prevalent, and older adults are vulnerable to depression and anxiety in the aftermath of loss. Most research has been conducted among widowed samples, with findings generalized to other grieving populations. The nature and pattern of bereavement, however, may differ significantly across groups. Similarly, findings derived from studies that are specifically focused on younger adults may not be clinically relevant to older adult populations. Virtually nothing is known about the impact of bereavement on those with chronic illness or cognitive impairment. Normal grief requires no treatment other than a comprehensive assessment and ongoing monitoring. A syndrome of traumatic grief can be recognized and is clinically challenging to treat. Depression in the context of grief is also pathological and should be treated in older patients to minimize risk of further morbidity.

References


