

TOPICS

In Geriatric Medicine and Medical Direction – Volume 33 Issue 1 – October 2011
A Peer Reviewed Journal of the Minnesota Medical Directors Association

Bereavement and Complicated Grief in the Geriatric Population

By Steve Olson

Bereavement is the normal feeling of loss after the death of a loved one. Following the death of a spouse, individuals can experience depression, anxiety, substance abuse, suicide and suicidal ideation, as well as complicated grief. Often, the death of a spouse comes at a time when the survivor may already be dealing with ongoing age related physical, mental, and psychosocial changes. There are approximately 12 million widowed individuals in the United States and by age 65, over half of all women and over 10% of all men have been widowed at least once. The percent widowed increases to 81.3% of women and 40.5% of men by the age of 85 (1).

Complicated Grief

Complicated or traumatic grief is distinct from normal grief, as the person cannot accept the death and instead experiences disbelief and preoccupation with the deceased and often experiences yearning and searching for the individual, as well as distressing memories. Complicated grief can impair the mental and physical health and have a significant impact on the quality of life of those affected. In the Rotterdam Study, 5741 older adults were evaluated with an Inventory of Complicated Grief scale showing that the prevalence of grieving was 18.9% within the general population and 25.4% of the grieving population subset were complicated grievers, with the remaining 74.6% experiencing normal grief (2). These findings have been later confirmed by other studies. In a study performed by Simon et al. (3), one quarter of the individuals who were grieving did not have a DSM 4 axis 1 disorder and 16% of them had no lifetime disorder, suggesting that

complicated or traumatic grief was a separate disorder from depression secondary to a recent loss as described in the DSM 4. Previous studies performed by Prigerson et al. also suggested that complicated grief was distinct from bereavement related depression (4).

Cognitive Functioning

Do normal bereavement, complicated grief, depression, stress and anxiety affect cognitive functioning? Is there a difference between depression associated with bereavement and depression associated with other life events, i.e., can cognitive dysfunction simply be explained by depression, or is something else going on? In a study performed by Ward et al. (5), two groups of 25 participants aged 65 to 80 who were matched on the basis of age, gender, education and estimated premorbid IQ, were recruited. The bereaved group consisted of individuals who had lost a spouse in the last 18 months. The 19 question Inventory of Complicated Grief (ICG) was used to measure grief and identify complicated grief. Depression, anxiety and stress were measured using the Depression, Anxiety, Stress Scales (DASS). The Multidimensional Support Scale (MDSS) was used to measure availability of adequate social support. The MMSE was used to screen for dementia and to evaluate orientation, memory, attention, calculation, language production and comprehension. Memory was also tested by the Rey Auditory Verbal Learning Test (RAVLT) and attention was tested by counting with distraction through the Test of Everyday Attention (TEA).

In the study, bereaved individuals performed more poorly than non-bereaved on measures of attention, information processing, and verbal fluency, but not on tests of memory. The bereaved group however reported experiencing greater levels of depression, stress, and anxiety. When controlled for depression, stress, and anxiety, the differences disappeared with the exception of attentional switching which was not related to mood, suggesting that the ability to switch attention between tasks may be impacted by the death of a spouse. Given this, the cognitive changes of bereavement are largely from stress or depression and not the underlying loss.

Diagnosing Complicated Grief

The next issue is identification of grieving individuals. “The Inventory of Complicated Grief”, produced by Prigerson et al., (6) is a scale consists of 19 questions and individuals answering the questionnaire would rate the frequency of experiencing the condition or feeling described in each question (0 for never and up to 4 for always). A score of 25 or greater indicated that the person was experiencing complicated grief. The study was shown to be reliable and both internally consistent as well as consistent over time. The ICG has since been revised down to 15 questions after removing the 4 lowest yield questions and is now the ICG-R. As per the definition of bereavement in the DSM 4, the ICG-R is not done before 6 months post spousal death.

A study was performed in 2011 in an attempt to create a screening tool to evaluate individuals at risk for complicated grief much sooner than the 6 months indicated for the ICG-R, given the severity of symptoms experienced by those eventually identified as having complicated or prolonged grief and to get those individuals treatment sooner (7). At the 8 week mark, this study used the “Beck’s Depression Inventory” (BDI), which asks 21 questions, rating the intensity for each question (0-3). The study then performed the ICG-R at 6 months to test the Positive Predictive Value for complicated grief of Beck’s Depression Inventory. The study found that those scoring in the highest risk category detected complicated grief with a sensitivity of 85.2% and had a PPV of 73% in predicting complicated grief, while the 2nd highest risk had a PPV of 40% suggesting that the cutoff value of the scale be those

only in the highest risk group.

Family Support

Family support has also been shown to be a predictor in developing complicated grief. An article from the Canadian Medical Association Journal (8) evaluated family support and its role in complicated grief. Families were divided into 3 groups “well-functioning”, “intermediate”, and “dysfunctional”. Family members who fell into the dysfunctional and intermediate groups were more likely to experience complicated grief as well as depression, substance abuse and suicidal thoughts.

Treatment

After identifying an individual experiencing complicated or prolonged grief, the next step is treatment. A review was done by Hensley (9), which evaluated antidepressant medications given to treat grief. This review compared those treated with tricyclic antidepressants (TCAs) vs. selective serotonin reuptake inhibitors (SSRIs) vs. placebo. TCA’s and SSRI’s reduced BDI scores by 68% and ICG scored dropped 18%. Given the favorable side effect profile of SSRI’s) and higher overdose risk of TCA’s, SSRI’s appear to be the first line medication as they are with depression.

In a randomized controlled clinical trial performed by Shear et al. (10), Interpersonal Psychotherapy (IPT) was compared to Complicated Grief Therapy (CGT). In IPT, the first phase, the relationship between symptoms and grief and other interpersonal problems is discussed. There is a middle phase where grief is addressed, and other problems as indicated. The third phase helps patients arrive at a more realistic assessment of the relationship with the deceased. In CGT, there are 3 phases as well. In the first phase, the therapist provides information about normal and complicated grief and describes a model for adaptive coping. The first phase includes a focus on personal life goals which is absent in IPT. In the middle phase, therapist and patient address both coping and goals in tandem. The third phase is similar to IPT in that both are focused on review of progress and plans for the future. Both IPT and CGT improved complicated grief scores with IPT showing a 28% response rate and CGT showing a 51% response rate. The number needed to treat with CGT was 4.3.

Conclusion

The death of a spouse is a major event in the lives of many individuals in the geriatric population. These people are also more likely to have other physical and mental conditions which can make their lives even more difficult. Complicated grief is experienced by a significant proportion of those grieving the death of a spouse. It is important to screen individuals, possibly with the Beck's Depression Inventory or other validated screening tool, who have experienced the recent death of a loved one and to evaluate their social support systems. People who are shown to be in the high risk group for complicated grief will likely benefit from a trial of an SSRI, and potentially from starting Complicated Grief Therapy later, should they be experiencing complicated grief beyond 6 months as indicated by the ICG-R when normal grieving should have subsided.

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About the Author

Steve Olson, MD is a Family Medicine Resident at Hennepin County Medical Center in Minneapolis. He worked as a nursing assistant for 12 years prior to medical school, including 5 years in nursing homes. The first 2 years of medical school he attended the University of Minnesota, Duluth, years 3-4 at the University of Minnesota, Minneapolis. He can be contacted at: olso3868@umn.edu.

President's Column

By John Mielke, MD

“So Dr. Mielke, how would you define leadership?” a nurse asked during a recent educational session. I was speechless, began to sweat, and felt the tension growing in the audience. “A very good question, Larry,” I said, as I tried to distill years of reading, thinking, and observing leadership into a short sentence or two.

“Leadership is ultimately relational,” was my answer. Leadership is relating to the people we serve in effective ways: role modeling, teaching, developing systems, creating and holding a vision, and always encouraging those around us in their efforts. This relational aspect is especially true in the medical care of the elderly because it is ultimately a relational activity. If we as leaders don't make our work relational, the front-line bedside workers will fail to see their role as relational. Seeing patient care as relational, dignity-instilled, and person-hood affirming is the essential element of real quality in nursing homes. Our leadership orientation infuses that relational ethic into our organizations.

The MMDA board has had a highly relational tone these past years for me. I truly enjoy meeting with these wonderful colleagues every other month. We share a meal, carry on the business of MMDA, and share medical and personal stories. Consider joining us as a board member. I'm excited to have Christine Duncan assume the presidency this month, and George Schoephoester step in line as the president elect. A real vote of thanks to Dwight Townes for his consistent and long tenure as our Topics editor. And Bob Sonntag has again agreed to be our treasurer for the coming year. Thank these folks for their commitment to our organization at the fall conference. (I hope you're attending!)

Rosemary Lobeck is our skilled and patient executive director. Without her ability to “herd cats” we would be in serious trouble. Our decision to retain her services a few years back was a very wise move. Thanks, Rosemary, for your dedication to our organization. You have made it much better than it might have been.

A final thanks and acknowledgement to our mentor, Jim Pattee. Jim, your leadership is alive and well. The organization you helped start and grow is alive and well. We know why we exist: to provide exceptional care to our elders and disabled residents through strong, effective medical leadership. Thanks, Jim.



Minnesota Medical Directors Association

**P. O. Box 24475
Minneapolis, MN 55424
Phone: 952-929-9398
Fax: 952-929-4363**

Website:
www.minnesotageriatrics.org
Executive Director: Rosemary Lobeck
Editor: C. Dwight Townes, M.D.
E-mail: rlobeck@mnmeddir.org

Topics in Geriatric Medicine and Medical Direction is produced and Published bimonthly by the Minnesota Medical Directors Association.

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Save the Date:
MMDA Fall Conference:
October 27-28, 2011
Marriott Minnetonka Hotel, Minnetonka

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Transitions in Geriatrics Conference

Topics Include:

- Preconference Eliminating Antipsychotics use for Patients with Dementia and Behavioral Problems
- Medical Student Training in Long Term Care
- Attending Engagement Around Psychiatric Medication Reduction
- Transitioning to Geriatric Services
- Red Flags and Band Aids
- Improving Transitions in Resident Care
- Practical Ways to be a Better Medical Director and Attending MD
- Positive Pressure Ventilation – New Modalities and Indications
- Financial Elder Abuse
- Endocrinology Updates for Geriatrics Practice

Questions Contact: Rosemary at rlobeck@mnmeddir.org or (952) 929-9398.