Grief and depression in later life

Most of us will have to face the death of a person close to us, especially as we age. The process of adjusting to that loss is not a form of mental disorder in itself but factors can predispose to the development of abnormal grief. Grief was thought to be a staged psychological process, but this theory has now been challenged. The bereaved are at higher risk of developing physical health problems or even of dying themselves and they are more likely to suffer from clinical depression. The recognition of depression in older people is important as it is treatable with medication as well as a range of psychological therapies.

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Most of us will experience the death of a loved one. This is usually followed by a normal grieving process. More intensive mourning may be found in those trying to cope with the death of a child or young person, those who had a poor relationship with the deceased, or those who had mental health problems or difficulties with grieving in the past. Support and counselling early on may be critical for those most at risk of intense mourning. There is an increased risk of death for the bereaved themselves during the immediate aftermath of a death.[1] Depression is the most common mental health problem associated with grief, but it often goes undiagnosed in elderly people.[2] Grief is a normal emotional reaction to the death of a loved one. Its manifestations are readily recognisable (Box 1) and consists of our internal feelings about the loss of a loved one. Mourning describes the actions we carry out to deal with that loss, such as attending the funeral and taking steps to preserve the memory of the deceased.

Box 1: Signs of grief

- Sadness, low mood, sorrow, and regret
- Sobbing, sighing, crying out
- Shock, disbelief
- Irritability, anger
- Guilt
- Loss of pleasure and interest in usually enjoyed activities
- Passive desire to be with the deceased
- Intense focus on what has been lost with the death
- Sense of deceased being present (eg, seeing the face of the deceased in crowds)
- Impaired sleep
- Fatigue

The process of grief and mourning has been conceptualised in a number of ways.[3] The idea that grief is a form of psychological work necessary for the individual to come to terms with their loss is derived from psychoanalytical literature. The grief-work theory has been challenged by observations that those who do not show distress following bereavement do not necessarily experience problems subsequently.[4]

Recently, staged theories of mourning—whereby the bereaved person goes through recognisable and fixed stages in grieving, such as denial and anger—have been held to be overly rigid. A range of new ideas about the grieving process have been developed with the aim of stimulating new research into grief and grieving.[3] Also, the traditional stages do not necessarily feature in the grieving processes of all cultures.

Some theories now emphasise that bereavement presents a cognitive challenge to the bereaved person, which must be processed and assimilated. Others have suggested that the purpose of mourning and grief may not be the need to detach from the deceased, but rather the need to the integrate and evaluate memories of the

deceased into the life of the bereaved person. Another theory of grieving is that it involves a dual process, in which the bereaved person oscillates between pining for the deceased and turning away from the loss of the loved one, to plan for the future-loss orientation and restoration orientation respectively. Loss orientation involves the behaviours and emotions by which the bereaved person attempts to cope with the loss, while restoration orientation involves the process of changes and development which occurs in the life of the bereaved in finding a way forward. Both phases are thought to be appropriate responses, but individuals may fail to move on psychologically and become stuck in either phase. This theory explains why some find stopping grieving hard, but others seem to be able to avoid engaging in the whole process altogether.[5] Adults who described anxious and ambivalent relationships in children tend to have more protracted grief while those who, as children, learned to avoid attachment have difficulty expressing both affection and grief.

Grief reactions are not confined to loss by death. Divorce, redundancy, major financial stringency and failure to achieve important life goals (eg, university entry or career progression), or any loss perceived as significant for the individual may also trigger such a reaction. Sometimes, the grieving process precedes the loss or death, so-called anticipatory grief. This is, of course, common in the close relatives of people who are terminally ill. Cultural beliefs can affect both the mourning process and how relatives prepare for an anticipated death.[6] For example, commemorating the anniversary of the death is often a feature of the mourning rituals of certain cultures (such as yahrzeit in Judaism) and may re-ignite the grieving process.

Factors for more intensive grieving

According to the literature, 7 factors predispose an individual to developing difficulties in the grieving process[7] (Box 2). Yet when these factors were studied in a group of 74 mourners, only 3 were found to be predictive of more intensive mourning: the death of a child or young person; having a poor relationship with the deceased; and the presence of previous mental health problems, prior losses, or the experience of previous unresolved grief.[7] As this study was carried out within a mainly white, US Christian population, it is not known whether these data relate to more intensive grieving in other cultures.

Box 2: Factors reported in literature to predispose to difficulties in mourning

- An unexpected death, violent or traumatic death
- Death following lengthy illness with associated stress in carer
- Death of a child or young person
- Mourner's perception that the death was avoidable
- Poor relationship with the deceased
- The grieving person has suffered: mental health problems, prior losses, or previous unresolved grief

Preventing difficulties

Effective and open communication between the patient, their family, and healthcare professionals seems to be helpful in preventing later problems with grieving.[8] Detection of problems in the grieving process early in the mourning period helps to minimise psychological and physical morbidity associated with abnormal bereavement. Counselling, information, social supports, contact with self-help groups and others in similar situations, or practical help (eg, assisting with the funeral plans) may be helpful for mourners and may prevent the development of depression.

The effect on physical health

In a detailed review on the impact of bereavement on mental and physical health,[9] Stroebe and colleagues note that research on life events has recently focused on the effect of single events, such as bereavement, rather than cumulative stressors. This new focus is an attempt to bring a new degree of clarity to this type of research in which data are often difficult to interpret due to the interplay of several factors.

Published studies of mortality in the bereaved mainly report on spousal bereavement in the US and Europe.[9] In general, they show that there is an increased risk of death during early stages of grief, with widowers at higher risk than widows. The risk of death from alcohol related diseases, especially in widowers, and death from violence or trauma—including suicide, for which there is a much greater risk in the first week of bereavement—is particularly increased. These important findings imply

that support services should be engaged for vulnerable people immediately following a death. In view of these data, it might be expected that the recently bereaved are more likely to seek medical help after the death of their loved one than before it. But, results from a study of older bereaved women who displayed high intensity grief reactions in the 4 months after a death suggests that this is not the case—the amount of times the women visited their doctor did not increase.[10]

Effect on mental health

A study involving 92 people who experienced the death of their partner found that the majority ultimately recover from their loss.[11] Participants were drawn from an original sample of 1,532 married people, aged 65 or older, who were recruited to a survey on life patterns of older couples. One assessment took place prior to the death and three took place afterwards.

The low mood found in the bereaved is generally viewed as normal by relatives and friends and, indeed, by the bereaved themselves. Other symptoms that are often found in depression may also present in those who are grieving, such as impaired appetite, weight loss, or disturbed sleep. The onset of the bereavement reaction may be postponed, but a diagnosis of a depressive episode should be considered—according to the American psychiatric diagnostic system (DSM IV)[12]—if these types of symptoms persist for more than two months after the loss.

Signs such as guilt, a morbid preoccupation with death, feelings of worthlessness, marked psychomotor retardation, or prolonged functional impairment and hallucinations (other than those related to the deceased person) are not generally seen in normal bereavement. Where these are present, pathological depression, in terms of DSM IV, is more probable.

Classification issues

In UK clinical settings, depression is classified using the ICD 10[13] diagnostic system (DSM IV[12] is more commonly used in a research environment). ICD 10 is less useful in older people than it is younger age groups because the presentation of depression is often different in this patient population. Older people, presenting with a first episode of depression, are less likely to have a positive family history of this disorder or symptoms of guilt and agitation. They are, however, more likely to have impaired day-to-day functioning and cognition.[14]

Because of these differences in presenting symptoms, and because most of the depression scales used are more appropriate for younger depressed people, there is a risk of failing to recognise depression in older people. This includes depressive illnesses that follow bereavement.

The Geriatric Depression Rating Scale[15] has 92% sensitivity and 82% specificity in older people when evaluated against diagnostic criteria, both in primary-

Box 3: The Geriatric Depression Rating Scale

Choose the best answer for how you have felt over the past week: (Yes / No)

1. Are you basically satisfied with your life?
2. Have you dropped many of your activities and interests?
3. Do you feel that your life is empty?
4. Do you often get bored?
5. Are you in good spirits most of the time?
6. Are you afraid that something bad is going to happen to you?
7. Do you feel happy most of the time?
8. Do you often feel helpless?
9. Do you prefer to stay at home, rather than going out and doing new things?
10. Do you feel you have more problems with memory than most?
11. Do you think it is wonderful to be alive now
12. Do you feel pretty worthless the way you are now?
13. Do you feel full of energy?
14. Do you feel that your situation is hopeless?
15. Do you think that most people are better off than you are?

Score
0–4 = Normal (depending on age, education, and complaints)
5–8 = Mild
8–11 = Moderate
12–15 = Severe

and in hospital-care settings. This screening tool is recommended by the Royal College of Physicians, the British Geriatrics Society and the Royal College of General Practitioners.[16,17] It takes 5 to 7 minutes to complete, and the 15-item short version is particularly suitable for use in patients who have short attention spans because of physical illness or mild-to-moderate dementia (Box 3).

Making an accurate diagnosis of depression in the older patient is very important, not only because of the need to treat the symptoms and minimise the associated distress to the patient and their family, but also because of the need to prevent suicide. The suicide rate in elderly people is three times that in younger adults.[18] Furthermore, suicide in elderly patients is most commonly associated with depression.[19]

Clinical depression after bereavement is usually diagnosed, according to ICD 10, as an adjustment disorder. This is when the symptoms are more severe or have a greater effect on functioning than might usually be expected during the typical grieving process. However, judging which symptoms are "more severe" or "having a greater effect" than expected is difficult. Using the ICD 10 scale, an adjustment disorder occurs when the individual manifests symptoms or behavioural disturbance that is consistent with a clinical depression evident within a month of the bereavement—this differs from the DSM IV scale, which (as mentioned) classifies symptoms as clinical depression if they persist for more than two months. That the two scales differ emphasises the point that psychiatric classification systems enhance the reliability of diagnosis but in reality have little to say about the validity of their diagnostic concepts. This is because we have an incomplete knowledge of the aetiology of most psychiatric disorders and are unable to confirm their existence by any biological measure. Nevertheless, both scales are based on expert consensus following detailed examination of the literature. The ICD 10 rubric states that normal bereavement reactions are not to be recorded as pathological entities, but instead by the so-called Z code. The DSM IV uses V codes for normal grieving (V62.82). When depression becomes pathological in a grieving person, the appropriate DSM IV diagnosis is that of a major depressive episode (Box 4). Chronic, mild-to-moderately severe post-bereavement depression may fulfil diagnostic criteria for the diagnostic entity known as dysthymia in either the ICD 10 or DSM IV classification systems.

Depression is not the only psychiatric illness that may complicate the grieving process. Sudden traumatic deaths in accidents, civil disaster, or war may induce post-traumatic stress disorder. Additionally, any pre-existing psychiatric disorder may be exacerbated, or a new episode triggered, by the stress of dealing with bereavement.

Risk factors for depression in later life

Older people are particularly prone to depression if they suffer from cardiovascular or cerebrovascular disease, chronic disability, are socially isolated and deprived, or bereaved.[20] Cognitive impairment,[21] sleep disturbance, a past history of depression, and female gender are also important vulnerability factors.[22]

Box 4: Criteria for major depressive episode

Major Depressive Episode (DSM IV)

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure

1. Depressed mood most of the day, nearly every day, reported subjectively or objectively
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (subjective or objective report)
3. Significant weight loss when not dieting or weight gain (eg, a change of more than 5% of body weight in a month), or decrease, or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness, or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (subjective or objective account)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide

B: The symptoms do not meet criteria for a Mixed Episode

C: The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D: The symptoms are not due to the direct physiological effects of a substance (eg, a drug of abuse, a medication), or a general medical condition (eg, hypothyroidism)

E: The symptoms are not better accounted for by bereavement—ie, after the loss of a loved one, the symptoms persist for long than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Treatment options

Antidepressants are effective in older people who are depressed and also in depressive symptoms associated with dementia, but depression in later life is often untreated.[23] The selective-serorotin re-uptake inhibitors (SSRIs) group of antidepressants are effective in this age group, have fewer interactions than other types of antidepressants (this applies especially to citalopram and sertraline), and have few significant side-effects.[24] Elderly patients may take longer to respond to treatment than younger people. Few studies of electroconvulsive therapy that only look at older people exist, but those that are available largely support its use in cases where depression is more severe and unresponsive to pharmacotherapy.[25]

Treatment resistance in depressed elderly people is more common in those with poor social support and in those who have suffered losses and prolonged grief.[26] Comorbid physical illness, especially cerebrovascular disease, is also associated with treatment resistance. Venlafaxine, lithium augmentation, or antidepressant combination therapies may be beneficial for patients who have not responded to first-line treatments.

Counselling, focusing on support and problem solving, as well as cognitive behavioural therapy are also effective in older depressed, bereaved patients. NICE recommends that a full range of psychotherapies should be available for this group of patients.[27]

Conclusion

Grief is a normal response to the loss of a loved one, but it does carry risks of serious illness or even death for the bereaved person. Although most people cope with their grief with the support of relatives, some will need additional support and counselling. The first week after a death appears to be a critical time due to the high incidence of suicide in this period. Only when the grief is abnormally prolonged, or causes marked impairment in functioning, should a psychiatric diagnosis be considered, the commonest diagnosis being a form of depression.

Conflict of interest:

Dr Martin Livingston has acted as an advisor to Janssen-Cilag Ltd, AstraZeneca, Lundbeck Ltd, and Servier Labortories Ltd. Dr Hilary Livingston has no such affiliations

References

1. Martikainen P, Valkonen T. Mortality after the death of a spouse: rates and causes of death in a large Finnish cohort. *Am J Pub Health* 1996; **86**: 1087–93
2. Bruce ML, McAvoy GJ, Raue PJ, et al. Major depression in elderly home health care patients. *Am J Psychiatry* 2002; **159**: 1367–74
3. Dillenburger K, Keenan M. Bereavement: A D.I.S.C. Analysis. *Behaviour and Social Issues* 2005; **14**: 92–112
4. Stroebe M, Stroebe W. Does "grief work" work? *J Cons Clin Psychol* 1991; **59**: 479–82
5. Parkes C M. Grief: Lessons from the Past, Visions for the Future. *Death Stud* 2002; **26**: 367–85
6. O'Gorman SM. Death and dying in contemporary society: an evaluation of current attitudes and the rituals associated with death and dying and their relevance to recent understandings of health and healing. *J Adv Nurs* 1998; **27**: 1127–35
7. Gamino LA, Sewell KW, Easterling LW. Scott and White Grief Study: An Empirical Test of Predictors of Intensified Mourning. *Death Stud* 1998; **22**: 333–55
8. Glaser BA. The social loss of dying patients. *Gerontologist* 1966; **6**: 77–80
9. Stroebe M, Schut H, Stroebe W. Health outcomes of bereavement. *Lancet* 2007; **370**: 1960–73
10. Thomson LW, Breckenridge JN, Gallagher D, Peterson JA. Effects of bereavement on self-perceptions of physical health in elderly widows and widowers. *J Gerontol* 1984; **39**: 309–14
11. Boerner K, Wortman CB, Bonnano GA. Resilient or at risk? A 4-year study of older adults who initially showed high or low distress following conjugal loss. *J Gerontol* 2005; **60**: 67–73
12. APA. Diagnostic and Statistical Manual of Mental Disorders (4th edition, text revision) 2000. American Psychiatric Association, Washington DC
13. World Health Organisation. The ICD-10 Classification of Mental and Behavioural Disorders. Clinical descriptions and diagnostic guidelines. WHO, Geneva 1992
14. Alexopoulos GS, Meyers BS, Young RC, et al Vascular depression hypothesis. *Arch Gen Psychiatry* 1997; **54**: 915–22
15. Yesavage JA, Brink TL, Rose TL, Lum O. Development and validation of a geriatric depression screening scale: a preliminary report. *J Psychiatr Res* 1983; **17**: 37–49
16. Royal College of Physicians and British Geriatrics Society. Standardised assessment scales for elderly people. Report of the Joint Workshops of the research unit of the Royal College of Physicians and the British Geriatrics Society. London; RCP; 1992
17. Williams E, Wallace P. Heath checks for people aged 75 and over. Br J Gen Pract (Occasional paper no 59) London RCGP, 1992
18. Pritchard C. Changes in elderly suicides in USA and the developing world 1974-87:Comparison with current homicide. *Int J Geriatr Psychiatry* 1992; **7**:125–34
19. Harwood D, Hawton K, Hope T, Jacoby R. Psychiatric disorder and personality factors associated with suicide in older people: a descriptive and case control study. *Int J Geriatr Psychiatry* 2001; **16**: 155–65
20. Kennedy GJ, Kelman HR, Thomas C, et al. Hierarchy of characteristics associated with depressive symptoms in an urban elderly sample. *Am J Psychiatry* 1989; **146**: 220–25
21. Djernes KJ Prevalence and predictors of depression in populations of elderly: a review. *Acta Psychiatrica Scandinavica* 2006; **113**: 372–87
22. Cole M, Dendukuri N. Risk factors for depression among elderly community subjects: a systematic review and meta analysis. *American Journal of psychiatry* 2003; **160**: 1147–56
23. Livingston G, Hawkins A, Graham N, et al. The Gospel Oak study; prevalence rates of dementia, depression and activity limitation among elderly residents in inner London. *Psychol Med* 1990; **20**: 137–46
24. Wilson K, Mottram P, Sivaranthan A, Nightingale A. Antidepressants versus placebo for the depressed elderly. The Cochrane Database of Systematic Reviews 2001, Issue 1. Art. No. :CD000561. DOI: 10.1002/14651858.CD000561
25. Mulsant BH, Rosen J, Thorton JE, Zubenko GS. A prospective naturalistic study of electroconvulsive therapy in late-life depression. *Journal of J Geriatr Psychiatry Neurol* 1991; **4**: 3–13
26. Reynolds CF. Treatment of depression in special populations. *J Clin Psychiatry* 1992; **53** (suppl): 45–53
27. National Collaboration for Mental Health. Depression: Management of Depression in Primary and Secondary care. Clinical Guideline 23. http://www.nice.org.uk/Guidance/CG23 Accessed 10 September 2009