Mental Health Grief and Loss

Defining Generic Key Terms and Concepts

- **Depression in Later Life:** Depression in later life is much like that of younger adults, but there are some differences. First, some depressed older adults deny feeling sad, reporting instead a loss of interest or pleasure in life. Second, rates of completed suicide are higher among older adults, particularly Caucasian men over the age of 74. Women attempt suicide more then men across the life span, but men are more likely to complete the suicide, often because they use more lethal means (i.e., guns vs. pills). Third, older adults often have more medical illnesses than younger adults do. Depression is prevalent among the medically ill elderly and rates of depression increase among those with more severe illnesses. Late life illnesses and the medications used to treat them may also cause problems with energy, attention, and concentration, appetite and sleep. Depression may be overlooked if symptoms are attributed to medical problems or side effects of medication. Older adults with vascular disease or cardiovascular symptoms often experience what is sometimes called *vascular depression*. Individuals with this depressive syndrome often experience relatively little guilt or sadness but have poor motivation or initiative, move very slowly, and do not recognize that what they are experiencing is related to a mental disorder.

- **Dysthymia:** is a chronic, less severe form of depression. People with dysthymia experience depressed moods most of the time for at least two years, causing significant distress or impairment in daily functioning. Some older adults have dysthymia their whole lives, while for others it begins in later life. Dysthymia also includes changes in appetite and sleep, low energy, low self esteem, difficulty concentrating or making decisions, and feeling hopeless. This is NOT a normal part of aging.

- **Anxiety Disorders:** Anxiety is a normal response to stressful situations but becomes a problem when it prevents an individual from engaging in normal activity or diminishes their ability to enjoy activities. Among adults over 65 years of age, 5.5% experience anxiety disorders and the rate goes up to approximately 11.7% among nursing home residents. Forms of anxiety disorder include:

  Panic Attacks and Panic Disorder: Panic attacks are limited periods (usually several minutes) of intense fear that come on unexpectedly. These are accompanied by multiple symptoms, such as heart palpitations, sweating shortness of breath, nausea, chest pain, dizziness, shakiness, or fear of losing control, going crazy, or dying. Some people's attacks are triggered by specific situations while others have no apparent

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trigger. Panic attacks may be part of another anxiety disorder. If an individual experiences recurring, unexpected attacks in the absence of another anxiety disorder, they may have a panic disorder.

Generalized Anxiety Disorder: GAD is commonly seen in clinical practice with older adults. People with GAD experience excessive worry or anxiety about multiple things, and it impairs their daily functioning creating difficulty in controlling their worry. They experience at least three of the following symptoms: restlessness, problems concentrating, irritability, muscle tension, sleep problems, or premature fatigue. Sometimes the symptoms are directly due to a medical condition such as thyroid, cardiovascular, respiratory, metabolic, or neurological disorders.

Phobias: Phobias are extreme fears of specific situations or objects. The most common phobia is agoraphobia, which is the fear of being in places that it is not easy to escape, which makes it less likely that people will venture from their homes. Another phobia is social phobia, which is extreme fear of social or performance situations. Other phobias are of animals, flying, needles or specific situations**.**

Obsessive Compulsive Disorder: People with obsessive-compulsive disorder (OCD) have recurrent obsessions or compulsions that are severe enough to impair their daily functioning. Obsessions are persistent thoughts, ideas or images that are anxiety provoking and, at least initially, absurd to the individual experiencing them. Common examples of obsessions are contamination (e.g. germs), doubts (e.g. questioning whether one left the door open or the stove on), or the need to have something in a specific order. Compulsions are repeated behaviours (e.g. hand washing, cleaning, checking locks), that are intended to reduce anxiety. One compulsion that may be a problem in later life is hoarding (e.g. saving newspapers, clothes or other objects).

Post Traumatic Stress Disorder: PTSD may develop after exposure to an extraordinarily stressful event, such as being threatened with death or personal harm, or witnessing the death or severe injury of someone else. PTSD involves recurrent nightmares, feelings of reliving the event, or intense distress when reminded of the event. People with PTSD often feel distant from others, have difficulty experiencing emotions, are very irritable, have trouble sleeping or concentrating, or are hyperaware of their surroundings (fearing the event might sneak up on them again. Determining the prevalence of PTSD among older adults is difficult although estimates range from 3 all the way to 56 percent, depending on the group studied, with the highest rate being for former prisoners of war. Note: Most studies have been done with war veterans, Holocaust survivors, and disaster victims and do not include other types of trauma survivors.

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- **Normal Grief:** Researchers, theorists, and clinicians have puzzled over what constitutes normal grief for decades. Some people recover and move on right after their loss; others grieve intensely for a short period of time then move on, while others experience profound grief for years. With such variability between individual reactions to loss, determining a normal disruption of daily functioning, its extent and its length of time, becomes a very difficult task. Review of the research on grief in the general population suggests that 50 – 80 percent of people experience moderate disruption of cognitive, emotional, physical, or interpersonal functioning for the first few months after the loss of a loved one, returning to normal functioning within one year (Bonnano & Kaltman, 2001). This common pattern of disruption in functioning during grief includes:
    - Disorganization of thinking
    - Sadness, feeling empty
    - Health problems
    - Problems in social and occupational functioning
    - Some positive experiences, including thoughts about the deceased

- **5 Stages in Elizabeth Kubler-Ross's Grief Model:**

Denial: Denial can be an adaptive response that buffers unexpected shocking news. Reacting with disbelief helps to prepare for impending loss. Denial can be detrimental if maintained for too long and working with people who refuse to accept the reality of a situation can be very frustrating. However, it is futile, insensitive and, most often, counterproductive to force people to deal with something before they are ready to do so. This is especially true after the loss of a loved one.

Anger: Anger may be directed at the disease, at doctors for failing to prevent the illness or death, or at the deceased for having the disease and dying. Anger may be directed at oneself for not doing more before the onset of the disease, or for remaining healthy. Experience of loss can make people feel very out of control. Anger may be a way to exercise control over a situation. If someone or something is to blame, that implies that something could have been done differently and that future situations can be controlled.

Bargaining: When the angry response doesn't work to change the situation, Kubler-Ross suggests that people try to bargain, like a child might after a temper tantrum doesn't work. People may plead with God or powerful others to return to them that which they have lost, promising to do more or be a better person in return.

Depression: Some symptoms of depression may be expected after getting news about a life-limiting illness or the loss of a loved one. It is important to note, however, that clinical depression is not part of normal grief. If symptoms of depression persist

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beyond two months, interfering with an individuals' ability to function, the person should be referred to a mental health professional.

Acceptance: Acceptance of an illness, disability, or death can feel like giving up, so many people avoid it as long as possible. Acceptance can invoke a great deal of fear of living with a disability or without a deceased loved one, as well as apprehension about building a new life in that world. Acceptance can also bring a sense of peace. Fighting an uphill or futile battle is exhausting. Once a person is able to stop the fight, they can focus energy on moving forward.

NOTE: Years after her original publication about these stages, we now know that most people do not progress linearly through any set stages.

- **Task Model of Grieving**
  This model looks at the bereaved individual as having a number of tasks to complete in the grieving process. This is different from the stage model in that people may be working on all of the tasks at the same time, but the effort associated with them may increase or decrease in importance over the course of the grief. In contrast to Kubler-Ross's stage model, the task model may be more empowering to some. Believing that there are tasks that they can actively work on to manage their grief may be comforting. At the same time, it may not be the case that checking each of these tasks off a list will relieve all suffering. Experts have developed multiple task models, each of which has a slightly different focus.

Additional Thought-Provoking Questions.

1. Treatments for depression include three basic types of intervention: psychotherapy, antidepressant medication, and – for severe depression – electroconvulsive therapy (ECT).

2. Estimates of alcohol and drug abuse among older adults range from 13 percent to 17 percent and fewer than half of these people are referred for treatment.

3. Grief is the emotional response to a loss.

During the course, as a CPCA, you should be listening for the answers to the following:

- Tips for working with seniors and their families 'who are presently grieving'

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- The effects and stages a family may go through after a loss

- What are some of the things you can do as a CPCA if working with a family member who has just lost a senior parent?

Review Questions

1. When, after grieving, people feel as though they have returned to a normal state of functioning only to experience a sudden flash of seemingly unbearable sadness, this is termed a:

   A. SLUG reaction
   B. SLIP reaction
   C. STUG reaction

2. The most common anxiety disorder in older adults is:

   A. Phobias
   B. Generalized anxiety disorder
   C. Obsessive-compulsive disorder
   D. Panic disorder

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Notes

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Answer Guide to Review Questions:

Mental Health, Grief and Loss:

1. c
2. b

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