Our Mission: Helping to prepare Iowa’s health practitioners to care for our growing population of elders. E-NEWS is one of our methods of teaching through technology.

Each month, E-NEWS delivers abstracts from current multidisciplinary healthcare journal articles related to a specific geriatric topic. This month’s E-NEWS focuses on GRIEF AND BEREAVEMENT.

GRIEF AND BEREAVEMENT

In this issue of the E-NEWS, you will find abstracts for:

- A study that assesses bereavement service utilization and preferences among spouses of former hospice patients.
- An article that seeks to identify physiological correlates of bereavement and the impact of bereavement interventions.
- An article that describes a symposium discussion about grief in persons with dementia.
- A study that addresses grief among family members of nursing home residents with advanced dementia.
- A study that examines a clinical tool to identify bereaved people at risk of complicated grief.
- An article that reviews diagnostic and clinical considerations in prolonged grief disorder.
- An article that discusses late-life bereavement and complicated grief.
- An article that describes grief.
- A study that investigates what makes grief difficult.
- A study that explores the relationship between grief, depressive symptoms, and physical health among recently bereaved spouses.

BACKGROUND: Bereavement services are an important part of comprehensive end-of-life care with potential to ameliorate physical, psychological, and spiritual distress. We studied bereaved spouses of hospice patients to examine bereavement service utilization, barriers, and preferences regarding content, structure, and delivery of potential bereavement services. We also examined the impact of depressive symptoms and social network.

METHODS: Retrospective cohort study of bereaved spousal caregivers of patients of three hospices in Tampa Bay, Florida. Descriptive and univariate analyses assessed demographics, depressive symptoms, social network, service utilization, barriers, and preferences.

RESULTS: Nearly half utilized at least one type of specialized professional bereavement intervention to aid in coping with their loss. The most frequently used services were provided by clergy members and physicians. Primarily attitudinal in nature, barriers included the finding that more than one third felt available services did not fit their needs or interests. Individual and spiritually-based services were highly endorsed, as were services designed to provide tools to reframe the loss and cope with accompanying changes and emotions.

Lower social network was associated with higher content preferences for services consistent primarily with restoration-oriented coping.

CONCLUSION: Clinicians and service providers may facilitate coping by routinely screening for depressive symptoms and social network and tailoring interventions to those identified as experiencing elevated distress or lacking social resources. Attitudinal barriers and preferences suggest that even in the service-rich environment of hospice some modification of bereavement services might reach more bereaved spouses. Future studies might address whether preferences lead individuals to services of the greatest benefit.


The death of a loved one is recognized as one of life's greatest stresses, with reports of increased mortality and morbidity for the surviving spouse or parent, especially in the early months of bereavement. The aim of this paper is to review the evidence to date to identify physiological changes in the early bereaved period, and evaluate the impact of bereavement interventions on such physiological responses, where they exist.

Research to date suggests that bereavement is associated with neuroendocrine activation (cortisol response), altered sleep (electroencephalography changes), immune imbalance (reduced T-lymphocyte proliferation), inflammatory cell mobilization (neutrophils), and prothrombotic response (platelet activation and increased vWF-ag) as well as hemodynamic changes (heart rate and blood pressure), especially in the early months following loss. Additional evidence suggests that bereavement interventions have the potential to be of value in instances where sleep disturbance becomes a prolonged feature of complicated grief, but have limited efficacy in maintaining immune function in the normal course of bereavement.


This article describes a symposium about the clinical challenges of providing care to persons with dementia and their families. The plenary session addressed the bereavement process in the general older adult population, neurocognitive processes that alter the grief process in persons with dementia, and therapeutic approaches to support grieving persons in different stages of dementia. Participants from diverse health care disciplines met in small groups to identify (1) current responses to persons with dementia and their families who experience a loss; (2) barriers to providing effective responses; and (3) possible interventions to improve care. Two general types of interventions emerged: practical/agency support and spiritual/affective engagement.
OBJECTIVES: To describe preloss and postloss grief symptoms among family members of nursing home (NH) residents with advanced dementia, and to identify predictors of greater postloss grief symptoms.

DESIGN: Prospective cohort study. SETTING: 22 NHs in the greater Boston area. PARTICIPANTS: 123 family members of NH residents who died with advanced dementia. MEASUREMENTS: Preloss grief was measured at baseline, and postloss grief was measured 2 and 7 months postloss using the Prolonged Grief Disorder Scale. Independent variables included resident and family member sociodemographic characteristics, resident comfort, acute illness, acute care prior to death, family member depression, and family member understanding of dementia and of resident's prognosis. RESULTS: Levels of preloss and postloss grief were relatively stable from baseline to 7 months postloss. Feelings of separation and yearning were the most prominent grief symptoms. After multivariable adjustment, greater preloss grief and the family member having lived with the resident prior to NH admission were the only factors independently associated with greater postloss grief 7 months after resident death. CONCLUSIONS: The pattern of grieving for some family members of NH residents with advanced dementia is prolonged and begins before resident death. Identification of family members at risk for postloss grief during the preloss period may help guide interventions aimed at lessening postloss grief.


BACKGROUND: Bereavement is a condition which most people experience several times during their lives. A small but noteworthy proportion of bereaved individuals experience a syndrome of prolonged psychological distress in relation to bereavement. The aim of the study was to develop a clinical tool to identify bereaved individuals who had a prognosis of complicated grief and to propose a model for a screening tool to identify those at risk of complicated grief applicable among bereaved patients in general practice and palliative care.

METHODS: We examined the responses of 276 newly bereaved individuals to a variety of standardized and ad hoc questionnaire items eight weeks post loss. Inventory of Complicated Grief (ICG-R) was used as a gold standard of distress at six months after bereavement. Receiver operating characteristic (ROC) curves analysis was performed for all scales and items regarding ICG-R score. Sensitivity, specificity and area under curve (AUC) were calculated for scales and items with the most promising ROC curve analyses. RESULTS: Beck's Depression Inventory (BDI) was the scale with the highest AUC (0.83) and adding a single item question ('Even while my relative was dying, I felt a sense of purpose in my life') gave a sensitivity of 80% and specificity of 75%. The positive/negative predictive values for this combination of questions were 70% and 85%, respectively. With this screening tool bereaved people could be categorized into three groups where group 1 had 7%, group 2 had 23% and group 3 had 64% propensity of suffering from complicated grief six months post loss. CONCLUSIONS: This study shows that the BDI in combination with a single item question may be used for clinical screening for risk of developing complicated grief after six months. The feasibility and clinical implications of the screening tool has to be tested in a clinical setting.


This review focuses on the similarities and differences between prolonged grief disorder (PGD) and post-traumatic stress disorder (PTSD). It highlights how a PTSD-related understanding aids the investigation and clinical management of PGD. Grief has long been understood as a natural response to bereavement, as serious psychological and physiological stress has been regarded as a potential outcome of extreme or traumatic stress. PTSD was first included in DSM-III in 1980. In the mid-1980s, the first systematic investigation began into whether there is an extreme or pathological form of mourning. Meanwhile, there is much research literature on complicated, traumatic, or prolonged grief. This literature is reviewed in this article, with the following questions: Is it possible to distinguish normal from non-normal grief? Which clinical presentation does PGD have-and how does this compare with PTSD? Finally, diagnostic, preventive, and therapeutic approaches and existing tools are presented.

**OBJECTIVES:** The construct of complicated grief (CG) has garnered increased empirical attention since it has been proposed as a diagnostic category for the upcoming Diagnostic and Statistical Manual of Mental Disorders-V. The aim of this article is to critically examine construct validity in light of a proposed conceptual framework, with special emphasis on understanding late-life bereavement. **METHOD:** This is a review article that critically examined current bereavement and grief models. We explored discriminant and convergent validity between CG and uncomplicated grief (UG) and other psychopathological constructs in terms of symptom intensity, symptom trajectories, bereavement outcomes, and treatment response. **RESULTS:** The findings from this review show mixed support for differentiating CG from other outcomes of bereavement for the following reasons: (1) a clear boundary between CG and UG has not been adequately supported, (2) symptoms of CG and bereavement-related depression and anxiety overlap, although there is some evidence of incremental validity in that CG symptoms predict global functioning above and beyond symptoms of depression, and (3) the treatment literature demonstrated that general grief interventions and treatment targeted for improving depression are ineffective at treating symptoms of CG, whereas interventions specially tailored to treating CG have been moderately effective. The findings also emphasize the importance of considering pre-bereavement circumstances, such as preexisting depression, in the conceptualization of broader bereavement outcome. **CONCLUSION:** There were mixed findings supporting the construct validation of CG. A comprehensive framework that emphasizes pre-bereavement circumstances was proposed in order to better predict various grief trajectories and outcomes of late-life loss.


Acute grief is emotionally intense, cognitively preoccupying, and disruptive, but grief is not an illness; major depression and anxiety disorders are. Grief and mourning have a purpose. They provide an intense, focused opportunity to re-engage emotion and to engage in a learning process that is aimed at reconfiguring life without the deceased—both the internal life of the mind, and ongoing life in the world. A bereaved person needs to figure out how to find meaning, purpose, joy, and satisfaction in life without someone who has previously been central to these feelings. This reconfiguration is a very natural process that tends to occur in fits and starts as bereaved people move forward and deal with everyday life. Nevertheless, a knowledgeable, empathic and supportive clinician can foster good adjustment. Successful mourning is, however, not a given. For some people, the mourning process is derailed and acute grief is inordinately painful and prolonged. For others, the stress of bereavement triggers the onset or worsening of symptoms of MDD, an anxiety disorder or another psychiatric or medical condition, suicidality or negative health behaviors. Clinicians need to be alert to all of these problematic responses to loss. In the wake of bereavement, we need to both facilitate effective mourning and diagnose and treat co-occurring conditions.


**OBJECTIVE:** Family members who take on the role of caregiving for someone who is dying begin bereavement after being emotionally and physically taxed by the caregiving experience. The course of bereavement is influenced by a number of factors, including health problems, financial concerns, social support, and family relationships. This paper reports on findings from a secondary analysis of qualitative data from a study examining family caregiver coping in end-of-life cancer care, to describe, from the perspectives of bereaved family caregivers, their perspectives on what made their grief difficult. **METHOD:** Qualitative data from three focus groups with family caregivers (n = 19) and two focus groups with health professionals (n = 14) were subjected to interpretive thematic analysis. **RESULTS:** Our finding suggest three broad areas that make family caregivers’ grief difficult: (1) dealing with occurrences in everyday life; (2) dealing with challenges specific to the caregiving situation; and (3) dealing with the healthcare system. **SIGNIFICANCE OF RESULTS:** The findings provide an important beginning point in understanding the types of issues that seem to make grief difficult for family caregivers of cancer patients at the end of life and can help professional groups to understand what is needed by family caregivers in terms of support and delivery of services.

PURPOSE: Widowhood is among the most distressing of all life events, resulting in both mental and physical health declines. This paper explores the dynamic relationship between physical health and psychological well-being among recently bereaved spouses. DESIGN AND METHODS: Using a sample of 328 bereaved persons who participated in the "Living After Loss" study, we modeled trends in physical health, somatic symptoms, and psychological well-being over the first year and a half of widowhood. The primary focus is whether physical health at the time of widowhood modifies psychological well-being over time. RESULTS: There were considerable somatic symptoms during the earliest months of bereavement but no major health declines over the first year and half of bereavement. Those in poor health had initially higher levels of grief and depressive symptoms, but the trajectories or changes over time were similar regardless of health status. Those with poor health at the time of widowhood had significantly higher risks of complicated grief and major depression disorder. IMPLICATIONS: Bereavement requires physical and emotional adjustment, but the psychological trajectory of bereavement may be somewhat universal. Bereavement support ought to include a focus on self-care and health promotion in addition to emotional support, especially because those with poor health initially may be most susceptible to prolonged and intense clinical distress.

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Next Month's Issue:

Physician Orders for Life-Sustaining Treatment

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