Grief - a big issue for older people and the trajectory of healthy ageing

This article is the fifth of a series on frailty, prepared by Dr Chris Bollen of BMP Healthcare Consulting for the Hunter New England Central Coast Primary Health Network frailty early intervention program.

Supporting patients experiencing grief, loss… and frailty!

Older people have limited opportunities to discuss grief and loss with their GP, given the time pressured consultation environment and frequent existence of multiple comorbidities, but often GPs will hear patients say "Doc, I'm so tired…"

Fatigue is a very common complaint during both the acute and long-term phases of grief, and it - and the consequences of grief discussed in this article - adds at least one point to a patient's FRAIL Scale score.

What is grief?

Grief is a reaction to loss of any type. Common types of grief include:

- Loss of sense of purpose or identity upon or after retirement,
- Loss of partner through death or divorce,
- Loss of children by death or leaving the local region for work or marriage,
- Loss of a pet,
- Loss of friends, either through death or changes in their function or family which impacts their ability to meet and socialise meaningfully,
- Loss of independence (which often coincides with loss of driver's license),
- Loss of function, which impacts ability to mobilise, and everything associated with this - hobbies, friendships, activities, social functions and much more…
- Loss of sight and/or hearing,
- Loss of the long-term family home and a move into smaller retirement home.

Grief may also be anticipatory, after a major operation (e.g. heart disease or cancer). This occurs when previously well-functioning adults confront their mortality and experience a major change in their self-perception, and it takes place despite the positive benefits of surgery for treatment of the underlying disease.

The stages of grief

The classical stages of grief described by Elizabeth Kubler-Ross apply to older people.

Initial shock, numbness, denial and disbelief is followed by anger, bargaining ("If only I had…"), guilt and depression, then finally acceptance. These should be recognised by all clinicians.

It is helpful for clinicians to briefly describe the stages of grief, and to listen to how the patient has experienced these stages.

Further support can be provided by explaining that there is no fixed timeframe for each stage, and that progress is not always linear. In fact, “red letter dates” (such as birthdays, anniversaries and other important occasions) may trigger earlier feelings of grief again.

It is even possible to experience all these feelings in one day - such is the chaos of the human “roller coaster” emotional response to grief. This process is known as “normalising” the emotions a person is feeling.

The emotions are acute, painful and are real. Listening and being supportive is essential.

Recognising the anger stage is helpful, and reflecting how it has been impacting a person’s behaviour is an important clinical action.

Loss accumulates as people age

Grief (and its short- and long-term effects) have a major impact on older people. Any change - major or minor - can trigger a reaction of grief, regardless of the magnitude of change.

After age 65, people may experience an accumulation of losses which may or may not have been appropriately dealt with during their life. Any accumulation of loss or unresolved earlier losses - plus the acute reaction of grief to a new loss - can trigger a downhill slide.

These losses are often not discussed (apart from the obvious major loss of a partner).

The inability to articulate feelings and their impacts can impact the normal resolution of grief. It’s not helpful to tell someone - or oneself - to simply “get over it”, or “pull your socks up and move on”.

Grief impacts healthy ageing and the ability to self-manage

When people experience the various stage of grief and are angry or depressed as a result, self-care suffers.

The impacts for an older person with multiple long-term health conditions can be many and varied, and include:

- Poor sleep, which causes fatigue,
- Increased use of analgesia to address physical pain from osteoarthritis or other issues - and increased use of opioids or tricyclics increases tiredness and fatigue,
- Raised or markedly reduced blood glucose in diabetics, as meal planning and usual eating habits are challenged (which can result in fatigue),
- Reduced appetite, which is why “psychological distress” is a risk factor for undernutrition on the Mini-Nutritional Assessment scale,
- Forgetting to take medications, which may result in deterioration of the underlying health conditions (e.g. If diuretics, ACE inhibitors, or beta blockers are not taken regularly, what happens to heart failure? If puffers are not used, what happens to COPD?),

- Reduced activity due to social withdrawal (e.g. not attending exercise-based activities such as dance, gym, fitness classes and walking groups). This can result in more sitting or lying at home, triggering deconditioning and subsequent loss of muscle mass, walking speed and grip strength.
- Increased self-medicating with alcohol, smoking, opioids and/or other drugs, which can cause deterioration in mental and physical health, aggravate other long-term health conditions, trigger fatigue and result in loss of physical strength.

Grief does not need more medication!

When a patient has scored one or more on the FRAIL Scale, and admitted they are fatigued, it's essential to check with them and understand what has been happening in their life.

Underlying losses, resultant grief reactions and a depressed mood may have triggered more isolation, leading to a downward trajectory rather than a health ageing experience.

Both grief and frailty can be aided by:

- supportive counselling,
- sleep supports (e.g. reading, podcasts, relaxing music),
- aerobic and/or resistance exercise (alone or - even better - with a friend or group),
- eating good quality cheese and dark chocolate (protein!)
- releasing endorphins by crying and/or having a good laugh

A depressed mood does not always require treatment with an antidepressant, and sleep disorders should not be addressed with benzodiazepines such as oxazepam or diazepam, which can further sedate older people, as well as cause drug interactions and may also aggravate underlying health conditions, resulting in less activity and less appetite, both of which can spiral the trajectory of ageing further downwards.

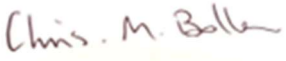
Finally, additional medication adds to the burden of polypharmacy for older people, which itself has been recognised as a risk factor for unhealthy ageing.

There are many non-drug options for managing grief and a depressed mood which should be discussed and trialled well before any medications.

Additional resources to support grief, loss and bereavement

- National Ageing Research Institute
- Aged Care Grief and Bereavement Support
- **Hunter New England HealthPathways** - Bereavement, Bereavement Support Services, Patient Mental Health Hotlines and Telephone Counselling and Adult Psychology, Social Work and Counselling Referrals
- **Central Coast HealthPathways** - Bereavement, Loss, and Grief Counselling, Adult Psychology and Counselling and Older Peoples' Mental Health Assessment

Yours sincerely,



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