BEREAVEMENT IN THE ELDERLY

Losses of one sort or another occur with increasing frequency as we get older. Friends and relatives die, and diminishing mobility makes it difficult to maintain contact with those who remain, jobs and the co-workers associated with them are lost; homes and familiar neighbourhoods are left behind; sight, hearing, and other physical functions diminish.

We can hardly be surprised if grief and its concomitant, loneliness, are common problems in old age. Remarkably, many elderly persons do seem to maintain reasonably contented existences despite these major changes in their lives.

This article will examine the psychological reaction to bereavement associated with the death of a loved one. The conclusions that are drawn apply to other losses, as well, and contain important implications for all those concerned with the care of the elderly.

EFFECTS OF BEREAVEMENT IN THE ELDERLY

Despite the high incidence of bereavement in old age, most of the psychological research into bereavement has focused on younger age groups. One reason for this was the claim by several investigators that the elderly suffer less from grief than their younger counterparts and that the risk to mental health is correspondingly reduced.[1,2] Good evidence exists, however, that much of the high incidence of depression and of suicide in old age is attributable to bereavement, and there is no justification for ignoring the problem.[3,4]

Clearly, it is important for us to discover why some older individuals can cope well with bereavement but others may develop mental illness. An understanding of the pathological determinants may then suggest ways in which this problem can be prevented or cured.

Examination of the research evidence indicates that although the elderly certainly do grieve, the form that their grief takes often differs from the pattern of grieving typical of younger persons.[5] Extreme outbursts of despair and rage seem to be less common in old age, and even sudden bereavement seems less devastating in its overall consequences in the elderly than in younger widows.[6] In one study,[1] British widows more than 65 years of age were found to have consulted their general practitioners less often for psychological symptoms and to have received fewer

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prescriptions of tranquilisers and sedatives during the first 18 months after bereavement, as compared with a group of younger widows registered with the same health-service general practitioners (note: in Britain, the health-service general practitioner is the first line of help for all illnesses). Nevertheless, these elderly widows were more likely than the others to have consulted their general practitioners with complaints of an aching back and joints, as well as with a variety of somatic problems. This suggests that elderly individuals are more vulnerable than younger persons to the physical effects of bereavement and that preexisting chronic illness, such as osteoarthritis, may be aggravated by the anxiety, tension, and lack of distraction that follows conjugal bereavement.

COPING WITH BEREAVEMENT

Bereavement presents us with a number of tasks.[7] These can be categorised as tasks of acceptance, grieving, revising assumptions about the world, and learning new roles and purposes. Each of these tasks can be helped or hindered by the special circumstances of old age.

Those with memory defects often fail to remember what they do not want to remember. Older persons whose cognition is mildly impaired may surprise their friends by forgetting that their partner is dead. Confrontation with the facts may produce extreme distress or outright denial.

Some older individuals of strong religious faith find little cause for grief. The conviction that the partner is in another world, to be joined eventually by the bereaved, and that the partner at the same time is always near at hand and watching over the bereaved makes it unnecessary to accept death as a real loss at all.

In many societies, the expression of grief is both a duty to the dead and a part of the rituals of mourning, but in northern European and American culture this is not always the case. Those who were brought up during and between the world wars were subjected to considerable social pressure to maintain a "stiff upper lip" in the face of loss. Grief was seen as a weakness, and it was feared that failure to maintain rigid self-control would lead to a "breakdown". This generation remains wary of the tendency of young people today to openly express their emotions, yet evidence from both clinical work and research suggests that the repression or avoidance of grief only postpones it and may cause a delayed or distorted reaction.

Grief is a process of relearning about the world, of discovering what chains of thought, what plans, what habits are now obsolete. Like other tasks, it requires the active participation of the learner. Bereaved individuals must spend long hours thinking and talking about the implications of their loss. Each set of assumptions about the world must be examined. At first, it may seem as if every turn of thought ends up in a blind alley. Only by active exploration do the bereaved discover which assumptions must be revised.

This exploration of the internal world is so painful and frustrating that some try to avoid it. "You can't teach an old dog new tricks," they say, and try to act as if nothing has changed. Elderly persons more than others may refuse to acknowledge the implications of their bereavement.

A distinction between "young old age" and "old old age" has often been made, the important difference being that the "young old" have a life to look forward to but the "old old" do not.

In Anglo-American culture, people lack not only sanction for mourning but also sanction for ending mourning. Older persons, who are less inclined to defy convention than younger individuals, seem to need the security that social expectations can impose. Lacking clear guidelines as to what is "right", they may go to extraordinary lengths to demonstrate their fidelity and love by endlessly mourning for the dead. This is more likely to occur if they want to make reparation to the dead person for some real or imagined wrong.

Another factor that can prolong the course of mourning is undue dependence on the deceased. Lacking the confidence to give up the protected role of mourner, the bereaved may be tempted to idealise love felt for the deceased as if this justified remaining crippled by grief.[8]

Of course, the adoption of new roles and responsibilities presupposes that new roles and responsibilities are in fact available. To the elderly bereaved, this must often seem very doubtful. In a society in which old persons are expected to retire from work and from parenting, in which children and grandchildren move away and the physical limitations of advancing years may make it hard to avoid common dangers, it is easy to understand why the elderly may feel obsolescent. What can the bereaved do when most of their significant roles involved a partner who is no longer there? It must be very tempting to remain shut up at home, doors shut against the dangers of a world that suddenly seems alien.

Withdrawal is a normal part of grieving, and in younger persons it can be regarded as a temporary phase that will soon pass. In older individuals, however, withdrawal may continue. Cumming and Henry[9] have proposed that this is a normal consequence of aging, although Chellam,[10] found a significant correlation between withdrawal and anticipation of one's own death. It seems that those who do not anticipate a future for themselves in this world are more likely to withdraw and to remain withdrawn than others who still see themselves as having a life to lead. In Chellam's study, however, those who remained withdrawn were no more likely to be depressed than others. This observation sheds doubt on the suggestion that withdrawal is a symptom of depression and that we should treat it by persuading the elderly to come out of their shells and involve themselves in the lives of others.

HELPING THE ELDERLY BEREAVED

A distinction between "young old age" and "old old age" has often been made, the important difference being that the "young old" have a life to look forward to but the "old old" do not. Of course, this is not necessarily a feature of age at all; the same could be said of any person with a terminal illness. A young man, close to death, recently told me of a dream that vividly illustrated his wish to die. In it he saw himself floating outside his body, but his family, who sat around his bed, kept pulling him back by means of strings attached to each of his limbs. With his permission, I was able to call the family together and tell them of the dream. His mother found it difficult to accept the obvious message it contained, but the other family members were supportive, and, after she had raged for a while and cried, the patient's mother agreed that it was time for them to let him go. The young man died peacefully a few days later.

This story illustrates one of the major issues we face when we set out to help the elderly bereaved. When should we encourage them to face the tasks of grieving in the hope that they will painfully fight their way through to a new and worthwhile chapter of life, and when should we go along with their wish to give up on this world?

In each case, the most important deciding factor is likely to be the quality of life that will result from our actions. Some forgetful old persons live out their lives in blissful ignorance of the fact that their partner has died; some succeed in avoiding reminders of their lost spouse, and it would be an act of cruelty to confront them with an album of photographs; some take great pride in looking after an old house and garden because "this is the way she likes it," and for some the belief that "my husband hears and sees everything I do" is a continuing source of comfort and satisfaction. Clearly, we have no right to interfere with ways of coping that are helping these individuals get through a chapter of their lives that might otherwise be miserable.

But what of those who are already miserable, whose ways of coping with bereavement are only prolonging their misery, and who may make others equally miserable? Here it is necessary to help them to undertake those tasks of grieving which have been avoided. To do this, we must establish a relationship of empathy and trust that will enable the bereaved to feel secure enough to share their feelings. When grief is repressed, drugs should be avoided, because they only serve to reinforce avoidance and confirm the bereaved's fears of being sick.

Talking about what has happened and its implications is the best way of discovering what assumptions are obsolete and must be abandoned. It may be necessary to gently point out the consequences of the loss that are being ignored and roles that are now unfilled.

We should temper confrontation with mercy. The bereaved do not have to grieve all the time. They may need encouragement to take a break, to visit friends, even to have a drink or a minor tranquiliser when exhausted by grief. This may help to build up the strength that is needed to return to the work of grieving. At the same time, the bereaved should be warned of the dangers of undue dependence on alcohol or other drugs.

Finally, the bereaved may need to be assured that their duty to the dead is done and that they need not suffer grief forever. It may be difficult for them to find the courage to emerge from the protected world of mourning, and their first few steps may be very small and cautious. This is the moment when praise should be unstinted, and it must be recognised that, to one who has come to rely too much on another person, something as simple as going out to dinner with a friend may be an act of heroism. Step by step, the chronic griever can begin to let go of the need to mourn.

The distinction between grief and mental illness is not clear, and there is little point in agonising whether or not a particular person is to be regarded as mentally ill. The important issue is whether the person needs help and, if so, what kind of help. Suicidal thoughts should be taken seriously, and we should never be afraid to ask, "Has it been so bad that you have wanted to kill yourself?" When the answer is "Yes," it is important to alert the family and to obtain psychiatric help. The psychiatrist may prescribe antidepressant or tranquilising drugs (according to the predominant clinical picture); in either case, care should be taken to ensure that the patient does not have access to potentially fatal quantities.

Another indication that extra help is needed is failure to respond. Each grief has a trajectory, and it is usually possible to see that change, although it may be slow, is occurring. Although the bereaved may say, "It doesn't stop," change in weight, increased activity, and the gradual return of a capacity to laugh provide reassurance that recovery is taking place. When it is not, or if circumstances seem to be getting worse, it may become necessary to consider

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other sources of help. Organisations for the elderly or the bereaved can do much to help the withdrawn widow or widower to begin a new life. Short-term psychotherapy may be needed when grief is debilitating, and it is sometimes necessary to explore earlier unresolved losses in a person's life in order to unravel the tang'ed consequences of a recent loss. Drugs may be needed if withdrawal or fear are so pronounced that the individual cannot begin the work of grieving.

Overall, the end result of caring is likely to be good. Whether we are helping the elderly grieve for the loss of a spouse, the loss of a home, a part of their body, or a particular job, we find ourselves involved in a process of growth and change that tends toward acceptance of renewal.

I recently met an old man whom I had previously seen during the course of making a television documentary, "The Life That's Left." At that time, two years after his wife's death, this man had been depressed and negativistic, refusing offers of help and without hope for the future, yet now he appeared suntanned and smiling, slightly plumper, and, he informed me, engaging in a wide range of hobbies and other activities. Eight years had passed, and he estimated that it had taken him five to get back on course. I reminded him that in the film he had asked for euthanasia. "What do you think about that now?" I asked him. "It would have been such a waste," he replied.

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IBCA: A POLICY STATEMENT

The Institute of Burial and Cremation Administ ation has put forward proposals for a common policy of its members to requests for burial or cremation of embryo babies following abortion and miscarriage. Its report was summa ised in 'Funeral Director' November, 1985.

A report on the phone-in from Broadcasting Support Services. Reprinted with permission.

The Shadow of Suicide was made by Mike MacCormack and shown on Monday, 20th January, opening the Open Space season on BBC 2. Broadcasting Support Services provided a helpline, funded by Gulbenkian Foundation.

The film opened with a brief statement—there are some 5,000 suicides and 100,000 suicide attempts per year in the UK—more by men than women—more older people than young—usually preceded by a period of severe depression. But this programme was not about suicide but its impact on the people left behind.

There were no more statistics, no experts. Three families, who had each lost a child by suicide, talked about it. The pa ents of Tom, who hanged himself at school a year ago aged 17. The mother and sister of Mandy, an engineering student, who jumped to her death 2½ years ago when she was 22. The parents of Frances, a nurse, who killed herself 9 years ago, also in her early twenties.

As well as their grief, the difficulty of believing it had really happened, the questioning why, the uselessness "Our love didn't make a blind bit of difference", they talked about other people's reactions "When you say she took her life people think she was a no gooder—but she was a daughter anyone would have wanted". "I feel other people are afraid of me."

BBC TV Presentation mentioned the helpline before the film and at the end said "If you have lost someone through suicide and would like to talk about it and find out about local support groups this helpline number is open for the next three hours. The number is 01-992 5522. If you don't get through the first time please keep trying."

The helpline was staffed by 4 members of Compassionate Friends (the self help group for bereaved parents), 3 members of Cruse (the national organisation for the widowed and their children), and 10 Samaritans.

We felt that those bereaved by suicide would want to make contact with each other, and wished there was such a group we could put them in touch with. Compassionate Friends do link up parents who have lost their children in similar circumstances. But for those who have lost someone other than a child by suicide there is no comparable service, though callers could ask their local Cruse branch to put them in touch with others if possible. Phone answerers were able to offer callers local contacts of Compassionate Friends, Cruse, Samaritans, Organisation for Parents Under Stress and Family Network Helplines, from directories compiled by BSS for the occasion. (As well as calls from people bereaved by suicide we expected other calls about suicide, and calls about other bereavements.)

The Response

Immediately the announcement ended all the phone answerers were hunched over their phones, listening intently, murmuring their acceptance of what they heard. With occasional breaks after particularly difficult calls, they continued like this all evening. This was certainly the quietest, most intensely hardworking helpline we have been involved with. There were few abortive calls—5 silent calls were recorded. 327 people told their experience during the evening; the 16 lines were all busy for the first 2 hours. 30 people phoned the next day when a Samaritan was here to help them.

Of the total of 357 calls 258 people (72%) had lost someone through suicide. Of the other calls, 51 were from those who had attempted suicide or felt suicidal, or from people concerned about others' attempted or possible suicide. The remaining 48 were made up of 15 from people who had been bereaved, but not through suicide, 10 from people who were distressed but not suicidal, 14 from professionals and volunteers wanting to help, and 9 people phoning to comment or contact the programme.

As with any helpline after a programme about emotional crisis, particularly one that breaks a social taboo, phone answerers had to gain callers' trust that they had really heard and understood them and therefore that the local support offered was also to be trusted. And they had to do this as quickly as possible so that as many callers as possible could be helped. By acknowledging many of the feelings involved the programme had already built up trust and callers came straight to the point. Many simply said how and when they had been bereaved, that they felt the grief, bewilderment, uselessness expressed in the programme, and asked for information on local support. Some were trying to be brave and needed to hear that it was alright to cry, to feel guilt and anger. Others needed a lot of time and care before they could trust the phone answerers to accept their suicidal despair, fear that they would re-enact a suicide, hatred, or guilt over feeling relief at a suicide. The average time of a call was 8 minutes, the longest was 1¼ hours.

As we expected many callers wished there was an organisation specifically for those bereaved by suicide, but all except a handful who were already in touch with the organisations, accepted the information we offered on sources of support. Many callers thanked the producer and BBC. "I was amazed it was put on, it was marvellous", "I'll be able to cope better now", "It was nice—upsetting—very worthwhile" and asked for the programme to be shown again. A few drew attention to aspects of suicide not covered by this programme, which they hoped might be looked at in future—including the causes of suicide and the rejection experienced by those who have attempted suicide.

Of the 258 people who had lost someone by suicide, 96 had lost a partner or ex-partner, 59 a child, 29 a parent, 26 a brother or sister, and 34 another relative, friend or client. 14 people had lost more than one person. The most recent loss was a week ago, the most distant 30 years. As usual for helplines on personal problems, more women (281, 79%) phoned than men (76, 21%) and this bias is reflected to different degrees in each group of callers. Among those who had lost someone by suicide, more mothers phoned than fathers, more daughters than sons, more sisters than brothers. Among those who had lost a partner or ex-partner, 10 times as many women phoned as men, which may also reflect the different patterns of suicide among men and women. Of the suicides callers talked about, 206 were by men and 51 by women, twice the bias in national rates. Callers had lost more sons than daughters, more brothers than sisters. But there were more phone calls about the loss of a mother than the loss of a father.

It is difficult to acknowledge the despair of suicide, let alone respond to the anguish of so many so close to it, as The Shadow of Suicide producer and phone answerers did. Many people are very grateful to them, and to the families who shared their grief as a source of strength for others.

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