Grief Reactions in the Elderly Following Death of a Spouse: The Role of Crisis Intervention and Nursing

by JAMES FELL

Duvall lists that a developmental task of aging is to adjust to loss of one's spouse. The average couple can expect seven to eight years together after retirement at age 65. During this time the pair can become extremely interdependent with their entire sphere of being revolving around the existence of the marriage partner. Lidz points out that most married elderly believe it is too late to again achieve a sense of completion that has been lost over several decades, so the couple hope to die together. However, the typical case has the widow surviving about eight years after the death of the husband; but in any case the situation is set for major psychological problems as a result of the loss of a significant relationship.

Grief reactions in the elderly fall on a continuum from abnormal to normal. Thus, the grief reactions and interventions will be unique to each individual. Normal grief reactions are those that are successfully resolved by the individual himself without lasting impairment. In the geriatric client, this concept may be found unworkable by nurses. Gramlich stated that typical grief is uncommon in the old since most will tend to exhibit behavior the present writer has included under abnormal grief.

The classic work of Engel described three stages in successful grieving. The first stage is shock and disbelief. The survivor is stunned as the psychological control mechanisms try to overcome the hurt and unbearable stress. This stage can last minutes to days. The second stage, developing awareness, begins when the bereaved has gotten over the hump of shock and begins to see the stark reality. Engel notes normal responses such as an empty feeling, crying, and anger. A sudden attack on the doctor, nurse, or relative can be considered normal at this time, as can self-condemnation. The third stage is the actual grief work or restitution. Funeral customs help to emphasize the reality of the loss but create a climate where friends and relatives share grief and spiritual aid. The average normal grief work period is one year. Engel states that in resolving the loss, the survivor has to deal with the painful void created by the lost love object. The mourner will reminisce about the deceased and idealize with the bad times shoved into the subconscious and only the good remembered. Upon completion of this idealization the survivor is free to tackle reality again. Engel concludes a sign of successful grieving is when the survivor can comfortably and realistically remember the good and bad of the deceased.

In the aging client, grief can be a very hazardous situation. Although most elderly have constant feedback as to the spouse's physical decline, the correct employment of adaptive mechanisms at this time of extreme stress spells the difference between mastery of a new situation and failure. A flurry of sympathy at funeral time can be therapeutic, but few relatives realize the grieving person still needs support after the services are over. The old can be prone not to receive this aid so that a normal grief reaction changes to an abnormal one.

Several classes of abnormal grief have been postulated. Lindemann stated a delayed grief reaction occurs when the survivor has denied the reality of the spouse's death at the time of the funeral. Much later grief work

Photograph by WILL. PATTON, El Segundo, California.
starts but is inappropriately linked to some reminder of the earlier loss such as in one old widow who started grieving years after her husband’s death on the date of a major anniversary. Distorted grief reactions include several types of pathology. Extreme identification with the deceased may exist to the point of expressing the same physical symptoms of the dead spouse. Other types of distorted grief reactions are the development of psychotic, schizophrenic, or depression states. One elderly widow visited by the author had isolated herself for years and had developed an elaborate system of delusions of “men bothering her.” These disappeared after only a few weeks of reminiscing with the public health nurse about the good times she experienced with her husband. Distorted grief is evidenced in the loss of the client’s skills in socialization resulting in shunning of friends and social withdrawal.

Inhibited grief exists when the spouse grieves in a passive manner for an extended time. Chronic grief is continued mourning stalled in one stage. Munro states chronic grief is particularly self-defeating since it can alienate significant others. An offshoot of chronic grief is a somatic grief reaction where suppression of the grief work is vented in physical symptomatology. This effect could be intensified in the old who have fewer physical and psychosocial resources to lend support. Prados, Stern, and Williams partially support this hypothesis in their work with bereaved aged by finding a relative “preponderance of somatic illness” in their widow subjects.

Where a chronically ill spouse has been nursed by the bereaved, a common situation in the aged, abnormal grief reactions can be observed. The caregiver is under constant stress so the reaction with the death of the spouse may be relief instead of mourning. One woman cared for her husband through multiple strokes. With each subsequent hospitalization grief work started anew, only to be destroyed when the spouse returned home. At his death the widow grieved and shortly and rapidly renewed old social patterns. Unfortunately our culture believes in grieving after death and this may foster guilt in the survivor for inadequate grief work, or for her past wishing that the chronically ill spouse would die and be “out of his misery.”

Grief in the old can be seen as a crisis since it is a time-limited, turning point in their life. At the death of a spouse crisis is provoked when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilization of customary methods of problem solving. A period of disorganization ensues...during which many different abortive attempts at solution are made. Eventually some kind of adaptation is achieved...

Crisis resolution forces the bereaved to make some type of bearable decision regarding his grief although he may function at a level lower than that which existed pre-crisis. This is seen in the aged bereaved who find it easiest to socially withdraw following the loss. Jacobson et al state this sad time can be a danger, but also an opportunity to increase self-actualization and growth depending on how the bereaved handles this crisis. Thus, crisis intervention is the therapeutic approach to guide the client to at least the level of functioning of pre-crisis and optimally to a higher state. An objective is to reestablish homeostasis that the disorganization and stress of crisis destroyed. A further goal is to teach coping skills so that future crises can be better managed by the individual himself.

There are two approaches in the utilization of crisis theory. The generic method focuses on the particular hazard or population as a class. Intervention under this approach is directed toward the general group of elderly bereaved. Most clients in this class will display similar pathology so therapy can in each case follow the same lines and be more easily taught to paraprofessionals. The second school of crisis theory uses the individual approach stressing individual psychodynamics. Health professionals only utilize this method because skilled therapies need to be formulated for that client’s specific problem, personality, and resources.

The favorable aspects of the previously stated approaches can be utilized in a team approach by nurses, physicians, outreach workers, and social workers to the treatment of elderly grief reactions specific to a particular community. In housing complexes for the old, services can be organized around Caplan’s preventive psychiatry concept:
professional knowledge which may be utilized to plan and carry out programs for reducing the incidence of mental disorders in a community (primary prevention), the duration of a significant number of those disorders which do occur (secondary prevention) and the impairment which may result from those disorders (tertiary prevention).

The generic approach is most applicable to primary prevention, and the individual approach to secondary prevention. Tertiary prevention utilizes a combination of the two methods.

Primary prevention is aimed at the population of aged residents in the community to decrease the incidence of new cases of abnormal grief. Programs utilize supportive environmental and team resources to help residents cope with the crisis of bereavement before they convert to a pathological state of abnormal grief. In the elderly community the crisis team will not wait for death of a spouse to occur before it intervenes. Wilson found the best time for a public health nurse to visit the home was before the client lost the spouse. The nurse can attempt to foster pre-death grief work for the resident who sits beside the ill person by allowing the client to verbalize anxieties and frustrations regarding the terminally ill spouse. The couple and nurse can discuss the impending death together so the uncomfortable climate of the home is cleared. Ross states it is an extreme demand for one family member to nurse a dying relative 24 hours a day. Yet this is what often happens with the aged, especially if the children are living hundreds of miles away. A home health aide can come into the residence and sit with the ill spouse since Ross believes the caregiver is entitled to some time out to recuperate from care of the dying.

Early detection and treatment are the methods of secondary prevention of abnormal grief. Since intervention seeks to terminate continuation of disability it is ranked as a method of prevention. As the crisis team is established in the community, the first level of intervention will regard the already chronic cases. The team will have to find these cases by door to door case finding and by family and neighbor referral. Once an effective program for these stricken persons is underway, the team can focus on organization of primary and later tertiary prevention programs.

Secondary prevention relies on a variety of treatment techniques that are specific to the individual. Some clients may have developed such severe grief reactions, such as schizophrenic symptoms, that the only course is referral to a hospital. Otherwise care can be home based following the steps of assessment, planning, intervention, and resolution listed by Aguilera and Messick.

An accurate assessment of the client and problem is necessary before further intervention proceeds. The nurse can ask questions as: What does the death of the spouse mean to the client? How will the death affect the client’s future? Does the client see the loss in a realistic or distorted manner? Does the client have support from peers and relatives? How has the client coped with grief in the past? How is he coping this time and is it working? How is the client accustomed to releasing stress and anxiety? Is the client suicidal? Assessment includes a short history and in the elderly the history must include a mental status exam. A physical exam will detect chronic disease that can further demoralize to the patient.

Planning serves to guide all team members on the same course of action. Plans may have to be modified as new data is collected or as the client recovers.

An initial goal of intervention is to help the client gain insight into the cause-effect relationship of the crisis and stress. The client must be encouraged to express his feelings, to verbalize his tension and anxiety. Ross places great emphasis on this catharsis. Since the public health nurse is close to the actual situation, she may be present soon after death. The nurse must prepare herself in advance and have her own feelings worked out so that she can facilitate the expression of emotions of the bereaved. Society tends to reward the person who controls his emotions and the widower especially may need much support to ventilate. The physician may prescribe temporary psychotropic medication for symptomatic relief. However, drugs may dull the emotional impact in the old to the extent that grief work is retarded. Intervention may also involve religious support. Many housing estates for the aged have phone numbers of concerned clergy who are willing to visit on short notice. Later intervention involves the nurse helping the client further develop his kinship and community resources to foster resolution of grief work. Means need to be found to supply the gratification the spouse provided, and an accurate assessment provides the clues of which individuals or activities can do this.

At resolution and before termination the nurse reviews the problem, plan, and solution with the client. The present level of functioning is appraised and new coping mechanisms and environmental resources are reinforced.

Tertiary prevention attempts to reduce the rate of lasting impairment due to grief. The crisis team seeks to prevent recurrence of mental disorders corrected in secondary prevention. Hopefully, the client has learned new coping skills so if a new crisis tests him, he will successfully resolve it. If confronted by a reminder of the bereavement, the client will not exhibit recurrent grief. The community crisis team seeks to help the individual
reestablish social relationships such as club activities. Groups can be formed to deal with new problems of aging such as coping without a spouse.

One such program for young widows described by Silverman\textsuperscript{10} utilizes other widows for therapy. This program could be set up in a housing complex for the old using volunteer widows and widowers to reach the recently bereaved. Silverman found that clients, who interacted with others who felt the same loss, stated that these lay people were more helpful than professionals. The clients surveyed in this study believed professionals and friends pushed them to recover or date again. Other widows allowed the client's grief to run its full course and merely offered support. Tertiary prevention can serve to reduce the incidence of impairment following grief by continued friendly visiting of the client by the outreach worker. Beyond providing socialization, these visits could avert new crisis situations by counseling referral as circumstances arose. There is the bonus of further case finding by satisfied patient recommendation. For widowers especially, homemaker services could instruct in preparing meals, shopping, laundry, and cleaning the home.

Crisis intervention provides prompt treatment for an immediate problem\textsuperscript{14} by the nurse who is familiar with the community and the type of families that inhabit it. The elderly feel more secure contacting a nurse working within the housing estate or community instead of the mass of red tape and sharp words likely to be encountered in seeking help via an inservice institution. By focusing on a more specific population at risk such as the aged, the nurse can feel more influential with a theory that stresses predictable behavioral responses and interventions.\textsuperscript{31}

Crisis intervention stresses a scientific approach to problem solving and therapy with specific, yet flexible, guidelines to identify and handle elderly grief. Because man is an inherently social creature, crisis theory seeks to change his behavior so he fits into society at large. Grief reactions draw man out of normal circles of socialization. Effective crisis intervention seeks to work through grief to inject man back into normal life circles with effective social skills once more. The bulk of therapy time is spent in directive, educative communication of new coping mechanisms and enhancement of the use of environmental resources. Crisis intervention subtracts the old ineffective patterns of coping and adds new behaviors.

By using a home-based approach the climate of trust and low stress necessary for client-therapist problem solving is generated sooner. Dependence of the client is not fostered. The bereaved must remain independent to facilitate re-entry into society for all but the extremely abnormal grief reactions should be handled in the home environment instead of the womb of a hospital.

References