

## Loss and Grief Can Lead To 'Bereavement Overload'

BY MITCHEL L. ZOLER  
Philadelphia Bureau

PHILADELPHIA — Loss is inevitable for the elderly, and with loss comes grief.

Losses are not just the deaths of loved ones, friends, and acquaintances. The elderly also experience loss and grief with their diminished ability to do things. It can cause them to lose a sense of purpose.

There is also the loss of their homes, possessions, health, and vocations, not to mention their independence, Vicki L. Schmall, Ph.D., and Patrick Arbore, Ed.D., said at a conference sponsored by the American Society on Aging.

"Anything lost in which a person has invested their emotions, attention, time, energy, or dreams" leads to grief and mourning, said Dr. Schmall, president and gerontology specialist at Aging Concerns in West Linn, Ore.

"The psychologic context of loss is different for the elderly compared with younger people," said Dr. Arbore, director of the Center for Elderly Suicide Prevention at the Institute on Aging in San Francisco. In younger people, losses tend to be sudden and unexpected. For the elderly, losses are not unexpected and are perceived as inherent to living a long life, but the accumulation of loss can lead to "bereavement overload," he said.

Grief is a natural and expected reaction to any loss, not just another person's

death. It is the process of experiencing the psychological, behavioral, social, and physical reactions to loss.

A key issue for physicians and other health care providers who care for the elderly is whether people move forward with their grief or get stuck and become depressed. "Grief is an emotional pain that needs to be acknowledged and experienced," Dr. Arbore said.

In general, after the loss of a loved one, symptoms of depression usually last for up to 2 months, but it's hard to put a timetable on grief. Periods of sadness should not be diagnosed as depression unless they are unusually prolonged, severe, or cause clinically significant impairment.

Normal reactions that occur after the loss of a loved one include denial, confusion, lack of concentration, fatigue, forgetfulness, irritability and anger, sadness and anguish, anxiety, and horror.

Health care workers should not make the mistake of giving patients agents that sedate the pain of grieving, said Dr. Schmall. This prevents people from talking about their loss, an important part of grieving.

A person needs an outlet for their pain by grieving. They need to work through their grief and pain, Dr. Schmall said. The best ways to help someone who is grieving is to listen, be empathic, acknowledge the loss, and help the patient experience the event at his or her own pace. ■

## Ask Elderly Patients About Religious, Spiritual Beliefs

BY MITCHEL L. ZOLER  
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PHILADELPHIA — Religious and spiritual beliefs often play an important role in the lives of the elderly and should be taken into account by health care workers who care for geriatric patients.

Physicians and others who care for the elderly should take a spiritual history of their patients following the FICA model: faith, importance, community, and addressing spiritual needs, Kathleen L. Egan, Ph.D., said at a conference sponsored by the American Society on Aging.

This means asking patients if they have a faith, how important it is to them, whether they belong to a faith community, and whether they have a spiritual need that requires action, said Dr. Egan, director of geriatrics education at the Institute on Aging at the University of Pennsylvania.

The physician or other care provider should also ask elderly patients if their religious and spiritual beliefs provide them comfort or stress, if their beliefs might influence or conflict with their medical care, and if other members of their religious community are supportive. But the caregiver should not proselytize, insist on taking a spiritual history if the patient does

not wish to give one, argue with the patient, or give spiritual counseling. If the patient asks to pray with the caregiver, it should only be done if the caregiver is comfortable with the request.

The caregiver who is responsible for making a spiritual assessment will vary depending on the setting. It could be done by a physician, nurse, social worker, or whoever else has the opportunity.

Patients aged 75 or older come from a generation that, in general, grew up in religious households. The elderly are, proportionately, the most actively religious segment of the United States population, Dr. Egan said. Recent results from national polls showed that among people in this age group 95% believe in God or a higher power, 80% belong to a religious organization, 75% say that religious spirituality is very important to them, and about 55% attend religious services at least weekly.

Patients who are religious or spiritual will often view their medical conditions in a religious context. They may be resigned to their current condition as something that is only controlled by divine influences. A medical caregiver should acknowledge these sentiments with respect; they should not judge patients but care for them, Dr. Egan said. ■

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Reference: 1. Kessler RC, Adler L, Barkley R, et al. The prevalence and correlates of adult ADHD in the United States: results from the National Comorbidity Survey Replication. *Am J Psychiatry*. 2006;163:716-723.

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