 HOW COGNITIVE BEHAVIOUR THERAPY CAN ALLEVIATE OLDER PEOPLE’S GRIEF

Jim Gibson discusses the challenges that affect people who are bereaved in later life, and how they can be helped to adapt to their new situation.

Abstract

Experiencing the death of a loved one is generally considered to be part of growing old and this ‘understandability’ factor is reflected in society’s response to such loss. This attitude has resulted in inertia in terms of the provision of structured psychotherapeutic input to acknowledge and deal with the thoughts, behaviour, emotions and physical difficulties that the bereaved older adult may experience.

This article describes the specific needs that the bereaved older adult has and how cognitive behaviour therapy (CBT) can be an effective way of managing bereavement-related problems.

This article also discusses: definitions, grief and the older adult, CBT, CBT and the older adult, a CBT model of grief, and includes a brief case study.

Keywords

Bereavement, cognitive behaviour therapy, grief

MANY PEOPLE consider the bereavement an older person experiences following a death to be one of the many normal losses encountered in later life (Garrett 1991). Malkinson and Ellis (2000), however, argue that for the survivor, loss through death of a significant person is a negative external event that marks the end of a relationship and the beginning of a painful process of grief with its psychophysiological reactions. Often, not much thought is given to the specific needs of older people in these circumstances.

Bowling and Cartwright (1982) suggest that the difficulties encountered by older widowed people, who make up one third of the population over 65, will often be similar to those faced by other older people. However, most will also be confronted by additional problems and decisions, such as learning to live alone, or uprooting themselves from their home to live with relatives or in residential care. For older people, the loss of a spouse, relative, friend or even a pet comes on top of social and physical health losses (Alty 1995).

Definition

Although the terms bereavement, grief and mourning are often used interchangeably, their definitions are distinct. According to Costello (1995):

- Bereavement is the fact of loss and it often results in grief.
- Grief is the feeling of being robbed of someone/something valuable.
- Mourning is the social expression of grief. It is a culturally defined duty and, to a large extent, independent of the individual’s affective state.

Malkinson and Ellis (2000) see grief as a process with components and outcomes, and view it as a normal response to loss through death. The cognitive perspective elaborates on the bereaved person’s constructions of the death, over which he or she had no control. The loss shatters previously existing assumptions about the self, others and the world. Experiencing such an event is also likely to increase a person’s tendency to become irrational, especially during the acute phase of the grieving process (Malkinson and Ellis 2000). Grief and mourning...
appear to be natural responses to bereavement. While some people may have the internal strength to adjust to such life events, for others, grief may intensify to a point where the individual is unable to cope with the loss.

When considering grief and the older adult it is important to be aware of the older adult's generational beliefs (Laidlaw et al 2004). In the author’s clinical experience, older adults generally perceive that such experiences and the resultant symptoms are simply to be expected and endured. The predominant culture in the UK does not encourage people to grieve openly, and crying and other ways of expressing strong emotions can be seen as a sign of weakness, particularly in the older population (Gibson 2009).

Worden (1993) identifies several features of grief in relation to older adults (Box 1).

**Loss of a spouse**
Worden (1993) and Garrett (1991) point out that, for older people, the death of a loved one can be a protracted experience with the spouse suffering a range of problems, including increasing frailty, loss of mobility, incontinence and mental health changes. The death of an older spouse often means the loss of one half of a previously coping partnership. In the early stages of grief the bereaved person will be aware of what they have lost. However, the awareness of who they have lost – a lover, gardener, cleaner, driver, cook, social partner and so on – can take some time to be realised.

In such cases, the death can leave the survivor vulnerable, both functionally and emotionally. In marriages or partnerships of 50 years or longer, the couple can often function more as a pair rather than as two individuals. While it could be argued that there is a similarity between bereavement and other losses encountered by the older adult, Laidlaw and Knight (2008) suggest that the finality of death sets grief work apart. While it is possible to regain some, if not all, functioning via physical rehabilitation or cognitive work, death is a loss that must be accepted.

Well-intentioned relatives and friends often advise the bereaved person to 'give it time'. This is in keeping with the concept of ‘phases of grief’ (Rando 1984, Lendrum and Syme 1992) and the understanding that the older person will resolve his or her grief through the passing of time. However, while Worden (1993) does not disagree with the concept of phases, he suggests that such a concept can imply passivity – something that the bereaved person passes through. Worden’s concept of tasks of grief, on the other hand, is more consistent with the concept of grief ‘work’, in that it implies that the bereaved person is required to take action. In other words, time alone will not resolve grief – it is what the person does in that time that influences the outcome.

Whatever model of grief the therapist employs there are core considerations that have to be addressed. Malkinson (2007) suggests that specific grief therapy must focus on:

- The relationship with the deceased.
- The pain and yearning elicited by the loss.
- Preoccupation with the deceased.
- Who the deceased represented for the bereaved.

**Therapy**
According to Turnbull (2011) cognitive behaviour therapy (CBT) is about helping the patient to change dysfunctional thinking, behaviour and emotional patterns (Box 2). CBT addresses the way in which the patient thinks and behaves in response to situations by developing more flexible ways to think and respond in the future. CBT helps patients learn how to identify problem situations and themes, emotional disturbances and unhelpful behaviours, and replace them with healthier responses (Turnbull 2011).

Hepple (2004) suggests that CBT is the form of psychotherapy most commonly used with older people. In controlled studies it has been shown to be effective in treating depression and anxiety, and problematic behaviours in the context of dementia. CBT is structured and time-limited.
(Hawton et al. 2004), with the client and therapist working together to identify and understand problems in terms of the relationship between our thoughts, feelings and behaviour. There is a reliance on both to develop a shared view of the individual’s problem. This shared view leads to the identification of goals and strategies designed to overcome the problem.

Much of the treatment focuses on the present, rather than the past, and there is an assumption that the main goal of therapy is to help clients bring about desired changes in their lives. Gibson (2010) says CBT for depression and anxiety is based on this collaboration, with an emphasis on guided discovery, which can result in increased insight and the acquisition of alternative strategies.

**Adjustments**

This approach appears reasonable when applied to people with purely functional disorders, such as depression and anxiety. However, therapists working with older adults may be called on to work with bereaved people who also have a co-existing form of dementia. This can cause difficulties such as disorientation to time and place, and problems with registering and recalling information, calculation, attention span, reading and writing, which can inhibit CBT efficacy. Adjustments may be necessary to the existing framework of CBT practice. Homework, including reading CBT information, relaxation, thought-recording sheets and activity schedules, should be kept simple. Audiotapes of the sessions can also be beneficial for reviewing the information outside of the session, and shorter more frequent sessions can be arranged, for example, 30-minute sessions twice weekly (Gibson 2010).

To benefit from CBT the person needs to take responsibility for any change. However, this can be problematic for people from an older generation who may perceive the therapist to be ‘the expert’ whose job it is to provide the answers to their distress. Gibson (2010) suggests that, in reality, the person is also bringing his or her own ‘expertise’ to therapy. Difficulties in collaborating are highlighted by Charlesworth and Greenfield (2004) who suggest that barriers experienced when working with older people can include:

- Achieving active involvement with clients who expect to be passive recipients of care.
- Working to a cognitive model with clients who hold a ‘non-cognitive’ theory of cause or maintenance of their presenting problems.
- Making complex conceptualisations understandable and meaningful for clients with reduced cognitive capacity.

Depression can also be triggered by grief or when someone experiences feelings of grief that may have been blocked, sometimes for years (Gilbert 2001). As people engage with grief, various fears about feelings can surface. For example, a person may fear being overwhelmed and ‘knocked out of action’ by the power of their feelings. They may be ashamed of the feelings and by spontaneous crying, for example, or they may start to feel guilty for not having done more for the person who has died (Gilbert 2001).

**Depression and grief**

There is considerable overlap in the symptomology of depression and grief. Both result in negative thoughts, a reduction in pleasurable activities, problems in eating and sleeping, and feelings of hopelessness, guilt and anger. Similarly there is an overlap in the symptomology of anxiety and grief, including thoughts of not being able to cope without the deceased, perceived threats in terms of engaging in existing/new activities and roles, a reduction in sleeping and eating, and general feelings of vulnerability. It is, therefore, understandable that bereaved people can find themselves locked in a vicious psychological circle (Figure 1).

CBT can play a vital role in the resolution of grief (Gibson 2009). The dilemma is whether to approach the problem as one of depression or anxiety. Kavanagh (1990) says behavioural interventions for grief have relied on exposure and habituation to grief cues as the primary strategy. However, such an approach does not adequately confront the challenges that are posed by bereavement.

Malkinson (2007) suggests that grief is a cognitive, emotional, behavioural and physiological experience in which cognitions have an important

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**Figure 1** Psychological cycle

![Psychological cycle diagram](image_url)
Case study

John, 70, is a retired miner who has two sons. He was referred to the author by his GP for cognitive behaviour therapy (CBT). His wife Margaret, who he had been married to for 50 years, had died of a heart attack six months previously. Throughout their marriage they had adopted traditional roles common to their generation.

John presented with three over-arching emotional problems: sadness, anxiety and guilt. He was saddened by the loss of Margaret, but he found it difficult to express his sadness because he believed this would be a sign of weakness on his part. He was anxious about how he was going to cope with the practicalities of life without his wife. John had never done any of the shopping for groceries, used a washing machine or cooked any main meals. There was guilt as well, in that John felt that it would be wrong for him to engage in any social activity that could result in pleasure for him.

Using the Hospital Anxiety Depression Scale (HADS) (Sigmund and Snaith 1983) John’s initial mood ratings were 15 for anxiety and 15 for depression. Both these scores indicate significant levels of anxiety and depression.

We began by adopting a behavioural approach. John’s family had rallied round him and were doing the tasks that Margaret had previously undertaken. However, while such interventions were well meant, they did not give John a chance to grow. So, over a period of time, using graded exposure, John developed his household skills. Originally, John had avoided the domestic work, but he now viewed them as challenges. He was advised that in the early stages, such activities could result in a sense of achievement rather than pleasure: a sense of mastery and pleasure would come later.

The key to success with such activities is to employ them on a regular and consistent basis. Having set activities to perform also has the added benefit of distracting the person from negative cognitions. Such distraction can be viewed, not as avoidance, but as ‘cognitive respite’. Kavanagh (1990) suggests that sometimes re-involvement in activities can cause the person to begin to confront their grief, rather than distract them from it, and this seems to be what happened with John. Apart from the anxiety of having to develop the skills to manage such tasks, John was also avoiding them. Taking on and mastering the tasks would signal an acceptance of the reality of Margaret’s death – something that, in the early stages, he did not want to confront.

A more cognitive approach was adopted to work on John’s feelings of guilt. He thought it would be disrespectful to his wife’s memory to socialise and he was also concerned about what others would think of him if he did so. This created a vicious psychological circle: a significant reduction in pleasurable activities was being maintained by cognitions that were based on a negative belief that John had created, rather than factual information. Our objective was to examine and dispute the authenticity of John’s thoughts. This was achieved by acknowledging the effect of such cognitions and generating evidence to dispute and challenge them. When ‘the evidence’ was gathered it was reviewed using cognitive distancing techniques, such as ‘the court of law’. This method encourages John to imagine what a judge and jury’s verdict would be after having heard the evidence. An additional cognitive distancing technique is to ask: ‘What would you say to a friend in a similar situation?’ According to Lam (1997), focusing on the client’s own ‘territory’ is often fruitless. Distancing him from his subjective territory is an alternative and better strategy that can provide a lens through which an objective and alternative view can be achieved.

Over ten sessions of CBT, John’s HADS scores decreased to within normal limits: his anxiety score was 7 and his depression score was 8. His activity increased as he reinstated previously pleasurable events. Initially John was apprehensive about going out and enjoying himself socially and indeed he did not experience the level of pleasure he once had. However, we had discussed potential outcomes with him in therapy so this was not a surprise him. If potential difficulties are not explored before starting therapy, the result could be that the person maintains the vicious circle and a spiral into depression.

John accepted the challenge to introduce new activities. A simple example of this was starting to go for his groceries at the local shops. This was achieved gradually. To begin with he would go when the shops were less busy, building up to going anytime he needed to buy something. Overall, John’s sadness remained, but it became part of his life, rather than all encompassing. Other, more adaptive cognitions and behaviours are now in place.

Kavanagh (1990) says that many people cope with bereavement by themselves, and for those, intervention may be counterproductive. But he accepts that a cognitive behaviour intervention, following the models for depression or anxiety, can assist vulnerable individuals to obtain a more rapid or complete adjustment (Kavanagh 1990). The case study (see panel) shows how CBT interventions can assist the older adult to manage grief.
Evidence
Currier et al (2010) reviewed evidence of the efficacy of CBT interventions for bereaved persons between the ages of 37 and 55 and the extent to which these therapies alleviated distress compared with non-CBT approaches and no treatment control groups. They found that CBT-based interventions were more effective than other commonly practised therapies’ follow-up and their relative efficacy did not vary across the different bereavement-related symptoms.

Compared with no-treatment control groups, CBT-based interventions were beneficial immediately after intervention but did not yield statistically significant overall effects at follow-up. Findings of the review provide preliminary evidence for the helpfulness of CBT-based interventions with bereaved people (Currier et al 2010).

Generally, CBT, in relation to post-traumatic stress disorder (PTSD), will follow exposure-based interventions, including imaginal and real-life (in vivo) exposure. Currier’s studies would appear to follow this pattern with some alterations. If we accept that there are similarities between grief and PTSD, including avoidance of anxiety-provoking situations, then it would be reasonable to adopt exposure-based interventions, as in the case study.

Such an approach appears to be supported by Turnbull (2011) who suggests that CBT treatments for PTSD generally include strategies such as exposure, relaxation and cognitive restructuring. However, Malkinson and Ellis (2000) acknowledge the traumatic aspect of loss, but suggest that the level of trauma can be determined by suddenness and unexpectedness of the death. The more sudden and unexpected the death, the more traumatic it tends to be; its impact is greater, and it is likely to affect the bereaved person’s ability and willingness to come to terms with the loss (Malkinson and Ellis 2000).

Challenges
For the therapist, working with someone who is grieving is a special encounter involving pain and sorrow, emotions that Malkinson (2007) suggests evoke many thoughts and feelings related to issues of life and death, and the client’s special needs. For the client, Worden (1993) says that mourning can end, and people can regain an interest in life, feel more hopeful, experience gratification again and adapt to new roles. Kavanagh (1990) and Gibson (2009) advocate focusing on bereavement as a challenge, and on the adaptive capabilities that most people have to meet it. CBT-based interventions have been shown to out perform non-CBT interventions, both immediately following intervention and at later follow-up assessments (Currier et al 2010).

References