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Case Report

From Loss to Loneliness: The Effects of Prolonged Grief in Elderly

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Abstracts

Introduction: COVID-19 high death tolls have brought about many bereavements all over the world. In this brief report, we aim to describe the effects of traumatic end-of-life experiences causing prolonged grief and loneliness as mediators for psychiatric disorders in the elderly. **Case:** The patient was a 60-year-old woman with chronic sleep disturbance since her only daughter suddenly passed away after several days of being isolated in the hospital during the COVID-19 pandemic and being hastily buried with the COVID-19 protocols. The patient yearned for her daughter but at the same time also avoided all memories of her daughter. She felt anxious most of the day which escalated to panic attacks requiring visits to the emergency room. Various examinations were carried out with normal results, except for blood pressure. She was diagnosed with prolonged grief, generalized anxiety, post-traumatic stress disorder, and hypertension. Treatments included SSRI, benzodiazepine, antihypertensive medicine, and psychotherapy. Improvements were significant within 9 months of therapy. **Discussion:** Traumatic end-of-life events may precipitate prolonged grief and loneliness. Bereavement is the most common cause of loneliness in the elderly. Untreated prolonged grief and loneliness generate a loss of sense of self and purpose and are associated with low-grade peripheral inflammation and poor health. The combination of pharmacotherapy and psychotherapy is the most effective treatment which improves the patient's outcome significantly. **Conclusion:** Traumatic end-of-life experiences are associated with prolonged grief disorder, loneliness, and poor physical and mental health outcomes, hence the right holistic approach is necessary to improve patient outcomes.

Keywords: Prolonged Grief, Loneliness, COVID-19, Anxiety, Post-Traumatic Stress Disorder, Elderly

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INTRODUCTION

The coronavirus disease (COVID-19) has become a public health emergency and global pandemic since 2019. It has claimed almost 7 million lives worldwide [1]. Death rates from other life-threatening illnesses also proportionally increased, partly attributed to limited access to health services and postponed treatment during the pandemic. Unsurprisingly, the pandemic high death tolls have brought about many bereavement that profoundly affected survivors, families, and friends [2, 3]. Moreover, the traumatic end-of-life experiences, isolation, disruption of social and economic support, and being unable to visit or say goodbye to loved ones have been associated with dysfunctional or prolonged grief, more intense loneliness, and other psychiatric disorders, especially in the elderly population [4, 5]. The perceived lack of funeral ritual, profound sadness, and anxiety regarding the future and pandemic situation, loneliness, and sleeping problems were some of the extents of day-to-day effects of loss during the pandemic [6].

The elderly are at greater risk of grieving due to multiple losses of their loved ones. [7], with the most devastating is the loss of a child [8]. Grief is the emotional response to a loss. For some, it is difficult to adjust to bereavement over time, moreover in the elderly, their grieving persists daily for years as prolonged grief [9]. Prolonged grief is associated with poor physical and mental health outcomes. Loneliness which has risen during the pandemic is another significant factor in grieving [2]. In this report, we aim to describe the effects of COVID-19 traumatic end-of-life experiences causing prolonged grief and loneliness as mediators for psychiatric disorders in the elderly.

CASE

The patient was a 60-year-old woman who came to the psychiatric clinic with a referral from a cardiologist. She came with the chief complaint of difficulty sleeping from 1.5 years ago, which was the peak of the COVID-19 pandemic when her only daughter suddenly passed away after being isolated for several days at the hospital due to untreated complications of diabetes. Without a chance to say her last goodbye, her daughter was hastily buried with COVID-19 protocols. Since then, the patient remained in anguish, miserable, and anxious.

The patient had a hard time accepting her daughter's death. She was very close to her daughter who always accompanied and helped her daily to take care of her bedridden husband and the house. Her daughter was a hard worker but had economic crises during the pandemic. She regretted how her daughter's life ended so tragically, leaving 2 children to live on their own. She unconsciously reexperienced her childhood memory, when at the age of 8, she left her parents in a small village to live with her uncle in a big remote city. Due to several practical reasons, her mother never visited her, eliciting lonely feelings underneath ever since.

The patient tried hard to avoid the memory of her daughter by doing extra activities from morning to evening. She always sought noisy places surrounded by people and avoided solitude, but in the night, she became increasingly restless and fearful.

What disturbed her most was her anxiety. She worried much about her orphaned grandchildren's future. Her anxiety persisted throughout the day as if something bad was always ready to happen. She described her feeling as if her life was on the edge of something dangerous. Her mind often felt full and restless. Her chest sometimes felt heavy, followed by difficulty breathing as if she was choked, and then could barely move her limbs.

Those symptoms got worse to the point that she twice visited the emergency room (ER) with the presumption of having heart attacks. Various examinations were carried out. She had hypertension stage II but had been well-treated with antihypertensive medicines. The following tests included physical examination, routine blood test, cardiac

markers, chest X-ray, and cardiac catheterization, were within normal limits. She was also treated for a suspected gastroesophageal reflux disease (GERD) but to no avail. Her symptoms persisted over time.

The cardiologist then referred the patient to see a psychiatrist. After thorough examinations, the patient was diagnosed with generalized anxiety disorder, post-traumatic stress disorder, and prolonged grief disorder. Hamilton Anxiety Rating Scale (HAM-A) scored 31 (severe anxiety) and the Inventory of Complicated Grief (ICG) scored 46 (cut-off point is 25). She was treated with sertraline 25 mg once daily, clobazam 5 mg twice daily, and continued her antihypertensive medicines. She was taught to practice relaxation and sleep hygiene. Complicated Grief Treatment (CGT), integrated with dynamic and existential psychotherapy (logotherapy), was conducted on a weekly and then monthly basis. In the third month, she became symptom-free, HAM-A score decreased to 7 (minimal anxiety) and ICG score decreased to 14, since then clobazam was no longer prescribed. She continued taking sertraline for the following 6 months before it was finally tapered off. The cardiologist also reported that the patient needed fewer medicines to control her blood pressure.

DISCUSSION

Prolonged Grief, Loneliness, and Related Health Outcomes

The patient lost her daughter all a sudden during the pandemic, more than a year ago, without a proper farewell. She had been grieving ever since. COVID-19 restrictions made many families mourn without a body and could not hold proper funerals, making it challenging to achieve emotional closure. It is reasonable that people find it difficult to adaptively overcome the loss, hence they develop pathological reactions and pain, as in dysfunctional grief [2].

Dysfunctional or complicated or prolonged grief results from transition failure from acute grief to integrated grief, so that acute grief is prolonged beyond 6 months. It is characterized by separation distress (repetitive pangs of painful emotions, intense longing, and preoccupation of the deceased) and traumatic distress (denial and anger, intrusive thoughts, and pronounced avoidance of the painful loss) that be the major focus, along with inevitable anxiety, frustration, and sadness. Maladaptive behaviors include over-involvement in activities associated with the deceased but at the same time also excessive avoidance of anything that reminds them about the deceased. The person having prolonged grief often feel estranged from other people, including the ones that they used to be close [10].

Based on DSM-5, prolonged grief disorder (PGD) exists following the death of someone close minimal 12 months earlier (Criterion A), a person suffers preoccupation or intense yearning (Criterion B), plus a minimum 3 of 8 symptoms of identity disruption, disbelief, avoidance, emotional pain, difficulties moving on, numbness, a sense that life is meaningless, and loneliness (Criterion C) for more than one month, which cause significant distress or disability (Criterion D), exceed contextual and cultural norms (Criterion E), and are not better explained by another mental disorder (Criterion F) [11, 12]. PGD is distinguished from depression or post-traumatic stress disorder. The International Classification of Diseases, eleventh edition (ICD-11) defines PGD as pervasive and persistent grief characterized by persistent yearning or preoccupation of the deceased leading to intense emotional pain [13]. PGD can be further identified with the Inventory of Complicated Grief (ICG). ICG score ≥ 30 at least 6 months after the death indicates a PGD [21, 22].

Grieving a child's death is one of the most challenging life events with many consequences [14, 15]. For the patient herself and also for the left children. Grief is the natural response to a loss. It will last until the bereaved can create meaning and a new routine of their life without the deceased [10].

Some contemporary experts agree that the stages of grief, are numbness, yearning, disorganization, and reorganization, as stated by Bowlby. Other experts believe there is never a clear finish line, and that grief will be followed by adaptation instead of recovery. Most people cope well with grief, but the study showed that 10-15% of people after a natural cause of death and 50% of people after unnatural losses are unable to cope well and in need of psychiatric intervention [16, 17]. The prevalence of prolonged grief is about 6-18% of those experiencing bereavement. Individual response to grieving is affected by coping style, flexibility, how the death happened, attachment style and relation with the deceased, and social support [18].

The death of the patient's only daughter left an unfinished business. Freud suggested that in pathological grief, there is also an unconscious conflict between the bereaved and the deceased. The daughter's death was traumatic for the patient, moreover, the patient had experienced loss of maternal nurturance earlier due to living apart from her mother during childhood even though it was her own decision. Individuals with a history of losing a significant person in early relationships or having multiple losses, a history of anxiety or mood disorders, and whose health or social support or concurrent stresses overwhelm their ability to cope, seem to be at risk for having prolonged grief [10]. The patient's close relationship with her daughter might be seen as an undoing project for the choice of leaving her parents in her childhood.

Bowlby explained four pathological responses to grief, including unconscious persistent yearning to recover the lost object, unconscious persistent anger toward others and the self, eagerness in caring for another bereaved person (projective identification) and denying of the loss [19]. Bereavement may also be viewed as an attachment loss, and the bereaved's response to grief and loss will be different according to the bereaved's attachment style. People with anxious attachment styles can be highly expressive but fail to cope and maintain coherent memories of the deceased [18].

Melanie Klein posited that the patient experienced a loss of external and internal relationship with the deceased child which caused annihilation anxiety so that the patient was no longer able to restore a sense of well-being within herself, as if something valuable had been taken away from her. She suffered from unbearable anxiety so she unconsciously chose to deny her dependence on the deceased child, leading to manic activities. Meanwhile, according to Winnicott, the patient had difficulty calming herself down because she failed to maintain within herself the inner representation of her deceased child. This separation anxiety could further result in the patient's ego disintegration [21, 22].

The patient reacted to her traumatic end-of-life event with intense psychological pain, failure to accept, and feelings of loneliness. She was preoccupied with it while she tried to avoid her thoughts and feelings, so she became emotionally and functionally impaired. Her impairment also elicits an internal trigger that constantly reminds her of the things she wanted to avoid, as well as external triggers, all of which cause her to feel more powerless and lonely, becoming a vicious cycle [18]. Researches show that avoidance reactions of the bereaved person will give contradictory results, such as a decline in activities, or in another case, overactivity as a manic defense experienced by the patient. Preserving emotional link to the deceased, while struggling to continue life, and building future expectations gave rise to emotional tension and distress [15].

It is harder for the elderly to cope with a change in everyday challenges, to recover, and to find meaning and hope for the future. The coping process for the patient was even more complicated due to her disabled spouse and her histrionic trait. Furthermore, the elderly bereavement differ from the younger,

especially related to somatic illness [7, 15, 20].

Bereavement is highly related to increased morbidity. The patient's twice panic attacks requiring visits to the ER were all unconsciously preceded by stressors of perceived loss. During therapy, she was guided to recognize the triggers for her panic attacks, then found out that the fear of leaving her family when she was far from home, was the recurrent triggering topic. She was afraid something bad might happen during the temporary separation. In her past, she once experienced childhood parental separation which elicited her loss-of-love-object anxiety, which was reactivated once again by the sudden loss of her daughter last year.

Following the patient's histrionic trait, she denied and repressed her unacceptable thoughts and feelings. When her ego defenses could no longer facilitate it, more intense anxiety arose in the form of panic attacks and also persisted the whole day as a generalized anxiety. Besides, every once in a while, the traumatic memory of her daughter's death generated intense anxiety, restlessness, and autonomic symptoms, hence the patient also had post-traumatic stress disorder.

For parents, the death of a child, as it is the real termination of their relationships with the child, generates severe anxiety and guilt about being unable to protect the child. The death of the child also challenges the predicted order of life, parents may question their basic existential presumptions [13]. The first 6 months following the child's death are the most difficult for bereaved parents regarding their physical health. Bereaved parents often reported decreased communication and feelings of isolation. Furthermore, 25% of them reported new illness or intensified chronic illness. Results of multiple studies confirmed how the grieving process is correlated to elevated risk of pathological responses and adverse health behaviors, especially cardiovascular disease, cancer, substance use (e.g., tobacco and alcohol use), anxiety and mood disorders, chronic sleep difficulties, and suicidality [2, 8, 25]. All of these result in global functioning impairment and premature mortality [26]. Various consequences following bereavement are explained in Figure 1.

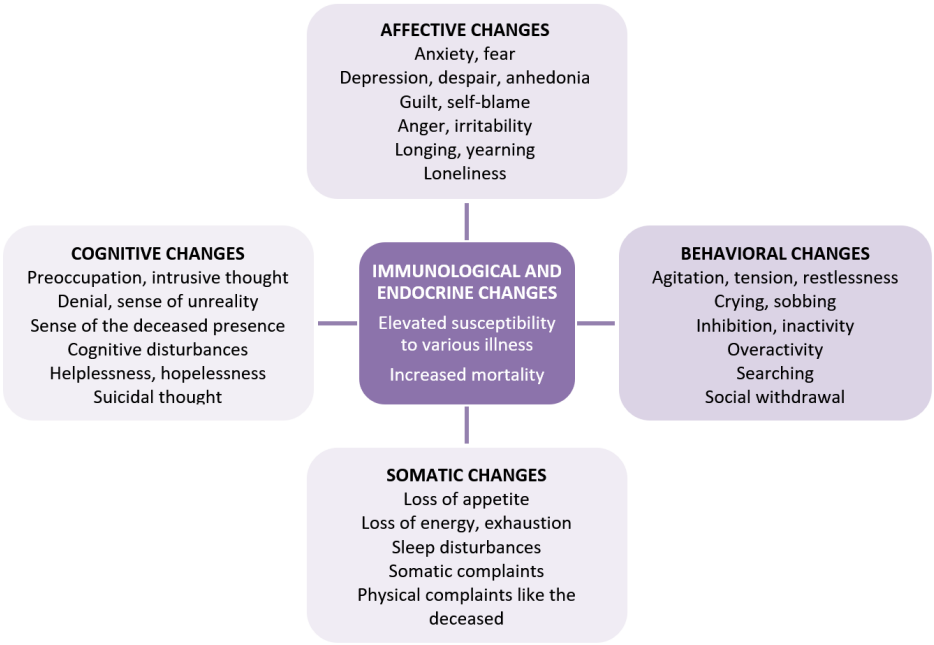

Figure 1. Various consequences of bereavement (adapted from [2])

The patient used to be emotionally close to the deceased daughter. During bereavement, she hid from her family her grief, anxiety, and sleep problems. Studies mentioned that cohesion and adaptability of the family system define the family's effective functioning to support the emotional needs of its members [15]. So, even though the patient lived with her family, she still experienced loneliness.

Loneliness is defined as an unpleasant "subjective feeling of isolation, not belonging, or lacking companionship" and lack of affection. Loneliness indicates dissatisfaction with interpersonal relationships. The elderly particularly are susceptible to loneliness due to multiple experiences of loss which may provoke and amplify loneliness [15, 27, 28]. There are two distinguished categories of loneliness: social and emotional loneliness. Social loneliness refers to the longing for social connection, while emotional loneliness refers to the longing for intimate attachment. The impact of child bereavement on various psychiatric disorders is mediated by emotional loneliness, not social loneliness. Social support does not directly alleviate emotional loneliness [28]. According to attachment theory losing a child means losing a significant attachment figure, and family support is unable to compensate for it [29]. More about factors that increase the risk of the bereaved having loneliness is mentioned in Figure 2.

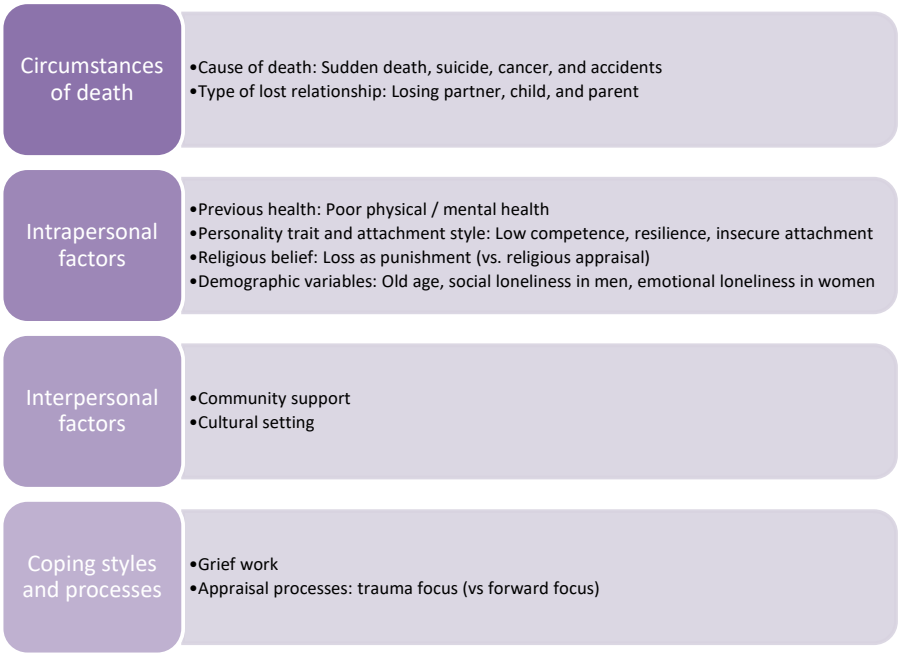

Figure 2. Risk factors of loneliness following bereavement (adapted from [29])

Loneliness accounted for 30% of the mental health consequences of PGD [25]. Clinicians should consider the role of grief and loneliness in assessment and targeting proper intervention. Loneliness is an extensive indicator of social well-being. It is expected when people lose someone closely attached to them. Bereavement is the most common cause of loneliness in the elderly, yet loneliness should be seen as a different entity from grief [30]. Several researches found loneliness as the hardest challenge to coping and it amplifies bereavements, particularly during the COVID-19 pandemic. There is considerable evidence that loneliness plays a key role in adaptation following bereavement [2, 31]. Parkes (1972) and Bowlby (1961) explained the link between grieving and loneliness. Grieving requires the person to redefine the internal model of self-representation. It is painful as it involves the period of acute loneliness when the bereaved is drawn to-

ward what is missing and searching for the deceased. This searching behavior ends in despair and frustration, painfully realizing that the missing person will not return. The bereaved will detach themselves emotionally from the deceased as they begin the grief work until their loss-related emotional intensity diminishes over a certain amount of time. Eventually the bereaved will adapt to the loss and begin their new habit. Unfortunately, for the elderly, bereavement is more than just passing through the grief stages. Grieving for the elderly can be viewed as living with loneliness [30, 31]. Intervention targeting loneliness in the grieving elderly is important, otherwise, it will result in a loss of sense of self and purpose [9], and poor health.

Loneliness has been established from longitudinal studies as one of the major risk factors for poor physical and mental health and overall well-being, including a twofold risk of Alzheimer's and another degenerative disease in the elderly [31]. Research has associated loneliness with the rapid decline in cognitive functions, including semantic memory, visuospatial ability, and perceptual speed [28]. Chronic stress related to loneliness may elicit low-grade peripheral inflammation which is linked to premature aging, cancer, and various inflammatory diseases, such as diabetes, autoimmune disorders, and cardiovascular disease, including hypertension. Loneliness has also been proven as a risk factor for later-life hypertension [34]. The research mentioned both emotional and social loneliness correlate to elevated total peripheral resistance which leads to hypertension [32, 33].

Treatment

Pharmacotherapy for the patient included sertraline, clobazam, and antihypertensive medicines. Sertraline, a serotonin selective reuptake inhibitor (SSRI) with σ1 receptor binding as augmenting anxiolytic action, is the first-line drug to treat the patient's generalized anxiety. Clobazam is a benzodiazepine class medication that works as an anti-anxiety, especially when the patient experiences a panic attack [23].

Complicated grief treatment (CGT), a model of psychotherapy, showed a high efficacy in treating PGD. CGT combines a cognitive behavioral approach with interpersonal therapy and motivational interviewing. The treatment consists of structured exercise which focus on repeatedly revisiting the time of death as well as progressive reengagement of avoided activites or situation. CGT consists of several sessions with the main structure: (1) establishing therapeutic alliances, stabilizing, ensuring safety, exploring, and motivating the patients to redefine their current roles, and also motivating patients not to avoid; (2) exposing the patients to the real problems and carrying out cognitive restructuring; (3) assisting the patient integration and transformation by exploring their hopes and future goals; (4) guiding the patient to establish routine rituals dedicated to the deceased [21, 22].

Dynamic and existential psychotherapy also reveal high efficacy in treating PGD [21, 22]. The patient was guided to recognize her unconscious childhood loss of maternal nurturance and her sudden abrupt "undoing/redemption project" which intensified her current loss. The patient had a close relationship with her only daughter to unconsciously make up for her own mother's lack of closeness with her. The daughter was the self-projection of the patient, while the patient was the projection of her mother which was repaired according to her longing. This sense of redemption compounded the sense of loss when her daughter died. The patient felt that the redemption project had not finished yet and was abruptly cut off. The fact that the patient felt sorry for her two granddaughters who had lost their mother confirmed the existence of the undoing/redemption project. The patient saw herself in her two granddaughters who lost their mother like she once did before, even worse than her own losing experience. During therapy, logotherapy and

spiritual approaches were also integrated into the sessions, as the patient was guided to find meaning in events that happened in her life and to realize that she had never been alone in her worldly struggles. Psychotherapy combined with pharmacotherapy is the most effective treatment for PGD, comorbid anxiety, and somatic illness [2, 10].

Interventions targeting loneliness are equally necessary to optimize the treatments for PGD, especially in the elderly. Interventions for loneliness can be provided in various forms, such as individual therapy, group therapy, in family therapy, and also in group retreats. The main types of interventions for loneliness are providing social support, establishing social skills, recognizing maladaptive social behaviors, and developing chances for social interaction [28]. In this case, we used the family approach to intervene in the patient's loneliness, while also guiding her to gradually open up to her family about her long-time bottled-up feelings. The patient also showed good progress in terms of returning to her daily job as a merchant and socializing with her customers who indeed supported her.

RESULTS

Once the bereavement process reaches the resolution phase, the bereaved person will be able to experience post-traumatic growth. It proposes that positive personal growth is possible, despite having traumatic events, as the person struggles to cope with the trauma. A therapist's comprehension of how a person experiences post-traumatic growth is essential in guiding holistic support. Potential facilitators of post-traumatic growth are meaning-making, ongoing bonds to the deceased, personal traits, and family social support. Post-traumatic growth happens in five domains, including an improved perception of self, having better relationships, gaining insight into new possibilities ahead, having a better appreciation of life, and also a deeper existential understanding [24].

With the right pharmacotherapy and psychotherapy, all of the patient's symptoms were significantly improved. HAM-A and ICG scores were remarkably decreased in the third month. The patient's need for antihypertensive medicine also decreased. Careful assessment and holistic intervention to assess and treat prolonged grief, loneliness, and other comorbidities, including generalized anxiety, post-traumatic stress disorder, and hypertension, are essential to provide better outcomes for the patient.

CONCLUSION

The COVID-19 pandemic's high death tolls have brought about many bereavements all over the world. Grief is a natural response to a loss and will subside when the bereaved can create meaning and new routines without the deceased. However, traumatic end-of-life experiences, particularly in the elderly who grieve over a child's death during the pandemic, have been associated with prolonged grief, loneliness, and poor health outcomes. Bereavement is the most common cause of loneliness in the elderly, yet loneliness should be seen as a different entity from grief. For the elderly, grieving can be seen as living with loneliness. Loneliness itself amplifies bereavement and is an extensive indicator of social well-being.

Untreated prolonged grief and loneliness generate a loss of sense of self and purpose and are associated with poor health. Chronic stress related to prolonged grief and loneliness may result in anxiety and mood disorders, cognitive disturbances, sleep difficulties, substance use, suicidality, and also low-grade peripheral inflammation which is linked to premature aging, cancer, and various inflammatory diseases, such as diabetes, autoimmune disorders, cardiovascular disease, resulting in global functioning impairment and premature mortality. Careful assessment and the holistic approach targeting loneliness in the grieving elderly are important. Psychotherapy combined with pharmacotherapy is the most effective treatment for PGD and psychiatric comorbidities

which will significantly improve the patient's general outcome. Hence, we suggest that the holistic treatments implemented in this case can be used more profoundly in similar cases. Further research regarding the treatment's efficacy will be beneficial.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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