Bereavement in Older Adults

14

Mercedes Fernández Cabana,
Alejandro García-Caballero, and Raimundo Mateos

Abstract

In this chapter, bereavement is defined as the response to the loss of a loved one, and the normal and pathological manifestations of that response are explained, as well as its expected progression, making reference to the mourning model as a process, proposed by Worden. The peculiarities of bereavement in old age are addressed, as well as the risk factors for the development of a complicated grief and the differential characteristics between a normal grief response and an episode of major depression or a psychotic disorder. Intervention guidelines are offered for the management of grief in the context of primary care and criteria that indicate the convenience of referral to specialised care and/or non-governmental resources, emphasising the importance of promoting instrumental and emotional support from the family and social environment of the mourners. The chapter also includes two clinical cases that illustrate the practical intervention with elderly people in grief.

Key Points

- Bereavement is defined as the response to the loss of a loved one.
- The normal response to bereavement is manifested by perceptual, cognitive and behavioural alterations, along with physical feelings and sensations related to the loss [1].
- In older adults, adjusting to life after a significant loss, such as the loss of a spouse, may be hindered by factors such as the existence of multiple losses, increased personal awareness of their own death and the interdependence that usually exists in the case of long-term partners [1].
- As the bereavement progresses, the intensity and frequency of the psychological distress should lessen [2].

M. Fernández Cabana
Servicio de Salud Mental, Hospital Virxe da Xunqueira. Cee, A Coruña, Spain

A. García-Caballero
Department of Psychiatry, School of Medicine, University of Santiago de Compostela (USC), Santiago de Compostela, Spain

Department of Psychiatry, EOXI Ourense, Ourense, Spain

South Galician Health Research Institute (IISGS), Ourense, Spain

R. Mateos (✉)
Department of Psychiatry, School of Medicine, University of Santiago de Compostela (USC), Santiago de Compostela, Spain

Psychogeriatric Unit, CHUS University Hospital, Santiago de Compostela, Spain
e-mail: raimundo.mateos@usc.es

C. A. de Mendonça Lima, G. Ivbijaro (eds.), *Primary Care Mental Health in Older People*,
https://doi.org/10.1007/978-3-030-10814-4_14

- Risk factors for the onset of complicated bereavement include a previous history of psychiatric disorders, a lack of perceived social support and cases in which the circumstances of the death are particularly distressing.
- The presence of frank psychotic symptomatology, depression or insuppressible suicidal thoughts is an indicator that the case should be referred to the mental health services.

14.1 Concepts and Expressions of Bereavement

Bereavement entails the series of psychological and psychosocial processes following the loss of someone with whom the person had a psychosocial connection [3]. In most cases, bereavement following the loss of a loved one is associated with an increased risk of suffering different psychological and physical disorders [4], which may result in an increased number of primary care visits. It is necessary to draw a distinction between those manifestations that are normal and expected and those that are not in order to offer appropriate and non-pathological support.

Feelings of loneliness, sadness, anger or impotence are common, along with sensations of yearning and anxiety (which may be manifested physically) with complaints of shortness of breath, chest tightness, anergy, etc. Responses of disbelief and shock may also emerge (particularly in the case of sudden deaths), as well as confusion and concern regarding the deceased and/or the circumstances of the death. There are often different perceptual alterations (which are generally temporary) such as feelings of presence and brief visual or audible hallucinations during which the mourner seems to perceive the deceased person.

On a behavioural level, sleep and eating disorders, distraction and a tendency towards isolation are frequent after the loss, with sobbing, whimpering and behaviours of searching for the deceased. Certain people try to avoid stimuli that remind them of the loss, while others constantly seek such stimuli, keeping the belongings of the deceased.

The aforementioned manifestations are normal [1] and must not be pathologised by those close to the mourner.

Although individual variability is the norm, certain researchers have attempted to classify this response into states [5] or stages [6–8], as can be observed at the Table 14.1:

On occasion, such attempts have been criticised, as it is thought that they transmit a vision of bereavement as a succession of stages through which people progress with certain passivity, while researchers such as Worden [1, 9] prefer to refer to bereavement as a process, which entails several different tasks in order to reach a satisfactory resolution. The first task to which he refers in his model is to *accept the reality of the loss*, in other words, the intellectual and emotional acceptance that the person has died and will not come back. This acceptance may take time, and behaviour such as keeping all of the belongings of the deceased for months or visiting psychics to "contact" the person indicate that this task is still unresolved.

The second task proposed by Worden [1] is to *process the pain of the grief*. This refers to the fact that, in general, it is necessary to recognise the suffering caused by the loss and work through the experience without denying its importance or

Table 14.1 Some proposals for classifying *the phases* of the grieving response

Author	States or stages of bereavement			
Kübler-Ross [5]	Denial	Anger/bargaining	Depression	Acceptance
Parkes [6]	Numbness	Yearning	Despair	Reorganisation
Bowlby [7]	Numbing	Yearning and searching	Despair	Reorganisation
Sanders [8]	Shock	Awareness of loss	Withdrawal	Healing/renewal

taking refuge in avoidance behaviours, such as sudden trips or the use of alcohol or drugs.

The third task proposed is *to adjust to a world without the deceased*. This may entail external adjustments (such as learning new skills or taking on roles that were once performed by the deceased), internal adjustments (confronting the effects of the death of a loved one on the mourner's own self-esteem, self-efficacy and on their definition of themselves) and spiritual adjustments, i.e. the way they see the world and their beliefs and values until that time. Those who find this task difficult will appear helpless and will not develop the new skills that they need, or they may isolate themselves so as not to confront the requirements of their environment.

Finally, the fourth task is to *find an enduring connection with the deceased in the midst of embarking on a new life*, in other words, finding ways to think about and remember the person that do not result in excessive emotional activation and that make it possible to engage with other people or activities and continue to experience life. However, in some cases people feel that their life ended with the death of their loved one and they are unable to relate to others or appreciate what life can still offer them.

The author [1] stresses that these tasks do not follow a strict order and that they do not have to be resolved sequentially, but rather they can be addressed simultaneously and at different times throughout the grieving process.

14.1.1 Bereavement in Later Life

At present, the population is progressively ageing, especially in developed countries. With age, there is an increased possibility of suffering multiple losses (and, therefore, multiple griefs) not only of loved ones but also in terms of status, physical and cognitive problems and, in some cases, awareness of the need to depend on others.

Over the years, people have increased awareness of their own vulnerability and mortality, and the death of their partner may precipitate their need to move house or enter an institution. Furthermore, remaining in the house shared with their partner for so many years may lead to an intense sensation of loneliness, especially if the relationship was harmonious [1].

In later life, marriage has been associated with better mental health, possibly because it provides social support and increased self-esteem [10]. Thus, the loss of a partner after a long-term relationship entails the need for significant adjustments, both for men, who may need support to assume "feminised" tasks and to continue to feel a bond to their loved ones [10], and for women, who may require instrumental assistance or assistance of another kind [11].

Being widowed in later life has been linked to an increased risk of mortality related to heart problems [12] (this risk is greater in men [13]). The loss of a loved one may lead to worsening health in general, with symptoms such as weight loss and decreased functional capacity [14].

The loss of a partner is also associated with the onset of depressive symptoms, especially in the months following the death of the partner. A prior diagnosis of depression or anxiety disorders is a risk factor for complicated bereavement in older adults [14, 15]. It is also necessary to rule out psychotic disorders or dementia.

Deaths of friends and family also represent a progressive decrease of a person's social network, in other words, less possibility to receive support. Furthermore, cultural prejudice regarding old age may mean that older adults are neglected and do not receive accurate information in the event of the death of a loved one, with ideas such as "they do not understand", "they do not feel as much" or "better not to tell them".

However, research demonstrates that many older adults are able to work through grief in a satisfactory manner [16], especially those who have effective social support [17] and who are able to use positive coping strategies [18, 19].

It can be considered that the bereavement has been overcome when the person is able to remember the deceased with composure, without feeling overwhelmed by the memory, and is able to pay attention to the positive experiences shared [20].

14.2 Criteria for Detecting Abnormal Responses to Bereavement

There are certain risk factors that can hinder the grieving process. They are related to the relationship maintained with the deceased, the situation and characteristics of the patient and the cause and circumstances of the death.

The kind of connection that was held with the deceased is a factor that must be taken into account [21]. In this respect, when there was an ambivalent or excessively dependent relationship with the deceased, working through the bereavement may be more difficult. This is also the case when there is a certain uncertainty surrounding the death (when it is the result of an accident in a faraway place, deaths in which it is not possible to recover the body, etc.) or in the event of multiple losses. A previous history of difficulties to work through other situations of grief, a background of depressive episodes and certain personality characteristics related to an inability to tolerate emotional distress, as well as a tendency to respond with withdrawal or avoidance behaviour, are also personal risk factors.

With regards to the cause of death, death by suicide tends to be especially difficult for those left behind, as it is not usually interpreted as the final consequence of severe emotional suffering or mental illness but rather as a "choice" that could have been avoided, and mourners often think that *they should have done something to prevent the death* [22]. Therefore, feelings of guilt, suicidal thoughts, shame and stigma may emerge, given the social rejection that this cause of death provokes in the majority of cultures. There may also be a tendency to hide the cause of death [23], which reduces the possibility of receiving appropriate social support.

Sudden deaths, as a result of accidents, violence from others or physical problems (heart attacks, strokes, etc.), are usually more difficult to work through, as they entail more intense sensations of disbelief and unfairness, guilt and the need to blame others (e.g. medical staff) [1]. There may be unresolved issues after the sudden death of a loved one, and when this happens at an unexpected moment of the life cycle, it may jeopardise the grieving process.

The *Diagnostic and Statistical Manual of Mental Disorders* (fifth ed.; APA, 2013) has included "Persistent complex bereavement disorder" under the *conditions for further study* chapter, for cases in which there is an intense and sustained reaction to bereavement [24].

This diagnostic category would include common manifestations of grief, such as intense sorrow and emotional distress, yearning for the deceased and concern for the deceased or the circumstances of the death. Response to this distress would include symptoms such as difficulty accepting the death, with a sensation of numbness or disbelief regarding the loss, or bitterness or anger, and difficulties remembering the deceased in a positive manner, self-blame and excessive avoidance of stimuli associated with the loss.

Another of the proposed criteria would be social and/or identity alteration, with symptoms such as a desire to die to join the deceased, difficulty trusting other people, with disregard and a sensation of loneliness, difficulty keeping up with interests or making plans, a loss of the reason for living and a reduced feeling of individual identity.

Diagnosis will only be made in cases in which the grief is disproportionate or inconsistent with existing cultural or religious norms and when it results in clinically significant distress or impairment in social, occupational or other important areas, at least 12 months (in adults) after the death. Persistent complex bereavement disorder is associated with the onset of unhealthy behaviours such as the use of alcohol or tobacco, resulting in a lower quality of life and an increased risk of suffering medical conditions.

The manual [24] estimates that prevalence of persistent complex bereavement disorder is approximately 2.4–4.8%. It is more frequent in women, and there is a higher risk in cases of greater dependency on the deceased and when the deceased is a child. Other researchers estimate a prevalence of 10–25% of complicated bereavement among grieving older adults [25].

The DSM-5 also includes the specification "with traumatic bereavement" in cases of grief due

to murder or suicide, in which distressing and persistent concerns may emerge regarding the traumatic nature of the death and the final moments of the deceased, their suffering and injuries or the malicious or intentional nature of the death.

Older adults who have lost a loved one (especially in the case of a long-term partner) may suffer high levels of depressive symptoms [26], and this response can be found in both men and women [27]. A distinction should be made between a depressive episode and bereavement (and the possible presence of both must be taken into account). Table 14.2 (modified from DSM-5 [24], 2013) shows the difference between the two.

Finally, perceptual alterations consisting of audible or visual illusions or hallucinations should be temporary and be followed by the criticism of the mourner. Such characteristics differentiate them from those that may appear in a psychotic disorder.

14.3 Possible Interventions and Recommendations for Specific Primary Care Management

Primary care services represent a privileged environment in which to care for people who are grieving and to offer them the monitoring that they need. In developed countries there are an increasing number of requests for professional support to cope with grief and other psychological difficulties. In the past, this role was carried out by the community, the family or religious institutions, but as a result of the progressive secularisation of society, along with the scattering of the family and the progressive isolation of individuals, family doctors now receive many of these requests for help.

On occasion, long-term contact with patients in a primary care setting means that doctors have prior knowledge of the background of the mourner and information regarding the social support available to them [28, 29].

In the case of recurrent visits with physical complaints, it is important to explore if there has been a recent change in the person's life such as the loss of someone important. Such losses may be communicated directly by the patient or the patient's family and must not be ignored but rather addressed to the extent that the situation allows. Below we will describe some possible interventions:

- Dedicate a few minutes to investigate how the death occurred and the specific circumstances, enabling the mourner to express emotions. Avoid replying with clichés or trying to prematurely soothe the person.
- Ask how the person is and reassure them about expected symptoms of bereavement. Explain

Table 14.2 Criteria of normal grief response and major depressive episode

	Normal response to bereavement	Major depressive episode
Predominant affect	Emptiness and loss	Sadness, inability to experience happiness or pleasure
Mood	Dysphoria that gradually decreases in intensity and that appears in waves faced with certain stimuli	Persistent depressed mood that is not associated with specific thoughts or worries
Range of emotions	The pain may be accompanied by moments of humour and positive emotions	Intense unhappiness with less variability
Thoughts	Worry linked to thoughts and memories of the deceased	Self-criticism, pessimistic rumination
Self-esteem	Preserved	Feelings of worthlessness and self-hate are frequent
Thoughts of death	Typically passive, at times related to the idea of "joining" the deceased	There may be active suicidal thoughts, related to the feeling of worthlessness, indignity or inability to cope with the distress

to patients and their families that the grieving process is long and usually has ups and downs, especially on specific dates (such as celebrations and anniversaries of the death) and also 3–6 months after the death, when external support tends to decline.

- In the case of intense distress, openly explore as to whether there are possible suicidal thoughts, for example, by asking if the patient has considered the idea that it is not worth living. If the answer is yes, explore how structured the idea is and if they have thought how they would do it (the greater the level of intent and planning, the greater the risk).
- The use of psychiatric medications for acute bereavement is not recommended, except in cases of major depression or other mental disorders. Despite this, the prescription of such medications has increased in recent years [30]. The use of anxiolytics is contemplated for the first weeks after the death, to facilitate coping with the presence of intense anxiety or insomnia. They could be taken under the supervision of a carer, to prevent the mourner from taking potentially lethal doses.
- Explore the circumstances of the older adult, if they live alone and their perception of the availability of family support or a social network. Pay particular attention to older adults who have lost their partners and who feel that they have no valid social support.
- Ask if they are able to maintain their self-care (hygiene, diet, medications in the event of illness, etc.), and respectfully enquire if they are resorting to drugs or alcohol to cope with the distress that they feel and if the loss has also resulted in a significant decline in their economic resources.
- Encourage the instrumental and emotional support of family members and that of their social environment.
- If consulted on the matter, encourage the older adult to see the deceased to say goodbye and express their pain, which will facilitate acceptance of the death [31]. Advise against taking important decisions during the acute grieving period.

14.3.1 Referral Criteria

In order to decide whether it is necessary to refer the patient to specialised treatment, it is advisable to abide by clinical criteria and take the person's previous history into account, as well as cultural norms for the expression of distress.

The decision should also be based on the criteria of the actual patient, placing importance on their subjective interpretation of the death and their self-perception as to whether they are able to cope.

It will be useful to assess the contact held with nursing staff and the social services in cases in which there are self-care and economic difficulties.

General criteria to be taken into account for referral include the excessive duration of the distress (over 1 year according to certain authors), impaired health or self-care difficulties, the onset of frank psychotic symptomatology, insuppressible suicidal thoughts or clinical depression [32, 33].

14.4 Clinical Cases

Below we will examine two clinical cases in order to illustrate the different responses to the loss of a loved one.

14.4.1 Case 1

Healthcare Context: Interdisciplinary team at a community psychogeriatric unit (PGU). The patient is referred from his community mental health unit after assessment.

Mr. García is 83 years old, he is a widower and he is accompanied by his daughter. Level of Studies: Primary. He emigrated to Venezuela when he was 17, where he worked as a builder, married and had a daughter. He returned to his home country with his family when he was 63. He lives with his daughter, son-in-law and 19-year-old grandson.

According to his daughter, he looked after his wife, who had Parkinson's disease, for many

years. When she died, 18 months ago, the patient suffered a significant physical and psychological depression. He was sad, restless and could not sleep. He started to suffer several falls (he was taking benzodiazepines).

Six months ago his daughter became alarmed after an extremely serious incident involving a pair of scissors, and she took him to the emergency department where they prescribed 50 mg/day of sertraline and 25 mg/day of quetiapine, and they referred him to the mental health unit. There he was diagnosed with a depressive adjustment disorder with behavioural disorders and mild cognitive impairment, and he was referred to the psychogeriatric unit for follow-up.

His daughter states that his mood has improved in recent months, but his memory is greatly impaired. One day he lost his keys in a park (they were later handed back to him), and on occasion he has lost money, so she withdraws his pension money from the bank for him.

The patient says that he is losing his memory and he finds it difficult to remember the name of people that he knows but that he is not too concerned about this because he knows that it is due to his age. Speaking in a fluent, coherent and orderly manner, he provides an alternative account to that of his daughter regarding the incident with the scissors. He says that he has been finding it very hard since the death of his wife with whom he had lived happily for over 60 years. He says that he was cutting up some cartons when his daughter challenged him and this angered him, but it was a misunderstanding, and it never occurred to him to attack her. He also appears upset because his family does not trust him (his daughter goes to the bank to withdraw money for him).

The patient gets up at 9:00, he visits a coffee shop on a regular basis, he gathers with other older adults in the park and he attends a memory workshop. He watches the television for 2 h. He drinks one glass of wine at a bar and half a glass with his main meal (1/4 of a litre per day). He has never been an excessive drinker or smoker.

With regards to his history of mental illness, he visited a general practitioner when he was around 40, at a time when he was stressed at work and barely slept. The daughter confirms that he was prescribed Valium for a time and that he had subsequently took it again on occasions, but she has never seen him so depressed for large periods of time. When he was 50, he tried to return to Spain, but he found it very difficult and returned to Venezuela.

Mental Status Examination: His appearance is excellent, he is clean and he is willing to collaborate. Affective contact is good. There is no evidence of psychotic symptomatology. He is euthymic and there are hardly any symptoms of anxiety. He now eats and sleeps well. MMSE = 24/30 points, which for his age and low level of studies is considered as high performance in our environment.

Prior Personality: Mister García describes himself as a "methodical and responsible" person.

Based on his recent positive evolution, his psychopharmacological treatment is continued, and he is advised to increase his social relations.

At a revision held 9 months later, he is cheerful and he states "I'm alone, because my wife has died, but I have my daughter... we might fight at times but we're happy (he laughs at his joke)... although I am losing my memory".

His daughter confirms his positive evolution and plays down his memory losses, which are now minor.

Final Diagnosis: Complicated bereavement with a moderate depressive episode and a psychomotor agitation crisis. It is assessed that the grieving process is progressing in a satisfactory manner, thus reversing cognitive impairment (although there are still subjective complaints).

Follow-up Plan: His pharmacological treatment is continued, and he is still advised to increase his social interaction. A follow-up appointment is scheduled after a year, and he can call if necessary. A written report is submitted to his primary care physician.

Discussion: Case 1

This case is an example of complicated bereavement in a person with a good prior level of mental balance. The good relationship with the deceased and the high level of family and social support were factors in his positive prognosis. The cogni-

tive impairment which is frequently associated with depression has not progressed, so the onset of dementia has been ruled out, despite the emphasis placed on this matter initially by the patient and his daughter. Despite the positive evolution of the case, it should be followed up conjointly by the primary care centre and on the specialised mental health level, in this case, the community psychogeriatric unit [34].

14.4.2 Case 2

Healthcare Context: A medium-sized nursing home, with an in-house medical and nursing service. The psychogeriatric unit collaborates through a referral and liaison programme, with monthly visits from the psychologist and psychiatrist. The case has been addressed in conjunction with both professionals and in direct collaboration with the residential centre's doctor, social worker and nurse.

Mr. Martínez is 88 years old and he was widowed 6 months ago.

Level of Studies: Primary. He worked on fishing boats.

He is referred to our PGU by the doctor at the nursing home because one night he got out of bed saying that he wanted to jump out of the window.

The first interview is performed by the psychologist. At first, the patient denies any psychotic symptomatology, and he complains of foot pain because his shoe bothers him. When asked about his deceased wife, he says that he misses her, despite the fact that it was quite difficult for him when she was ill. He says that he dreams a lot and he admits that he is sad and has a "fear of living". He is worried about everything. He says that he is waiting to be transferred to another home that is closer to where his niece lives, who they raised as a daughter. He says that he does not care about dying and, if he had the strength, he would take his own life.

The psychiatrist visits him the following week. He states that he has head pain and is depressed, "I feel hopeless... I remember my wife and sometimes it feels like I can see her and that she is with me". He accepts that "for her it was better to die, she was in a lot of pain, she wanted to die".

He has delusional ideas of bankruptcy: "I'm worried about my bank book, and if they're going to trick me, when I signed I realised that it was like I was signing my death sentence, I signed so many times... there are six thousand euros... I became obsessed with the idea... I don't know if it's true or not... I think about it a lot... yesterday I went to the bank to complain but I don't know what I said..."

He has persistent suicidal thoughts: "...I thought about jumping off somewhere, I don't belong here".

Good cognitive status according to his level of studies: MMSE = 21/30. He has been taking a benzodiazepine to sleep for several years.

He is diagnosed with complicated bereavement with major depression, with suicidal thoughts and delusional ideas of wrong being done to him. He is prescribed 75 mg/day of venlafaxine.

After 6 weeks a clear improvement is observed and he is calmer.

After 4 months he is well, calm and coherent. He refers to the possible transfer to another home with less anxiety, "I'm not as bothered now". He eagerly recounts how yesterday "I ate a cake and I smoked a cigar, I thought it would harm me, but it didn't".

After 6 months he is admitted to hospital with lower gastrointestinal bleeding due to diverticulosis. He suffered an episode of delirium while he was in the hospital, and in his discharge report, a diagnosis of dementia was made.

A short time after his discharge from hospital, at the home he is serene and euthymic. His cognitive status is similar to the last time (MMSE = 21/30). It is verified that he does not have dementia, and as the hospital reduced the pharmacopoeia, eliminating the antidepressant, it is decided that no psychiatric drugs will be prescribed.

Two months later, he suddenly expresses a fear that his bank books will be altered, "I become obsessed with strange things like this". "I always felt hopeless about everything in life". Although he appears euthymic, the recurrence of delusional ideas renders it advisable for him to resume tak-

ing 75 mg/day of venlafaxine. Based on his positive evolution and after several months, the venlafaxine was reduced to 37.5 mg/day.

At his 18-month follow-up, he was euthymic. He was advised to go for walks outside of the centre, accompanied by a volunteer. After 30 months he was stable. The patient died 4 years after becoming widowed.

Discussion: Case 2

In this case we have a person with complicated bereavement and a major depressive episode, with suicidal thoughts and delusional ideas of wrong being done to him. His depressive personality was a predisposing factor, and the fact that he had certain family support was a factor in his positive prognosis.

He demonstrated a positive and quick response to pharmacological treatment and psychotherapeutic support. The positive evolution of the case highlights the diagnostic error made during his time at the hospital: his delirium was confused with dementia.

Mr. García was never transferred to another home, and despite this his evolution was positive. He died 4 years later (at the age of 92) without ever having developed dementia.

14.5 Conclusion

Cognitive, perceptual and behavioural alterations, along with physical feelings and sensations, are normal responses to bereavement. However, the bereavement process can be exacerbated by risk factors related to the relationship maintained with the deceased, the situation and characteristics of the patient and the cause and circumstances of the death. Support for bereaved individuals used to be provided by the family, community or religious institutions. Due to increasing secularisation of society, changing family structures and isolation of older adults, people may turn to family doctors for help. Primary care practitioners should have structures in place to be able to help directly or at least refer to appropriate services, sometimes within the non-governmental sector. This chapter has provided some case studies and very practical ways of supporting bereaved individuals.

References

1. Worden JW. Grief counseling and grief therapy. A handbook for the mental health practitioner. 4th ed. New York: Springer; 2009.
2. Payás A. Las tareas del duelo. Madrid: Paidós; 2010.
3. Tizón JL. Pérdida, pena y duelo: vivencias, investigación y asistencia. Paidós Ibérica: Barcelona; 2004.
4. Stroebe M, van Son M, Stroebe W, Kleber R, Schut H, van den Bout J. On the classification and diagnosis of pathological grief. Clin Psychol Rev. 2000;20(1):57–75.
5. Kübler-Ross E. On death and dying. New York: Macmillan; 1969.
6. Parkes CM. Bereavement: Studies of grief in adult life. New York: International Universities Press; 1972.
7. Bowlby J. Attachment and loss: Vol. 3. Loss, sadness, and depression. New York: Basic Books; 1980.
8. Sanders C. Grief: the mourning after. New York: Wiley; 1989.
9. Worden JW. Grief counseling and grief therapy. A handbook for the mental health practitioner. New York: Springer; 1982.
10. McLaren S, Gomez R, Gill P, Chesler J. Marital status and suicidal ideation among Australian older adults: the mediating role of sense of belonging. Int Psychogeriatr. 2015;27(1):145–54.
11. DiGiacomo M, Lewis J, Phillips J, Nolan M, Davidson PM. The business of death: a qualitative study of financial concerns of widowed older women. BMC Womens Health. 2015;15:36.
12. Carey IM, Shah SM, DeWilde S, Harris T, Victor CR, Cook DG. Increased risk of acute cardiovascular events after partner bereavement: a matched cohort study. JAMA. 2014;174(4):598–605.
13. Stahl ST, Arnold AM, Chen JY, Anderson S, Schulz R. Mortality after bereavement: the role of cardiovascular disease and depression. Psychosom Med. 2016;78(6):697–703.
14. Shear MK, Ghesquiere A, Glickman K. Bereavement and complicated grief. Current Psychiatry Report. 2013;15(11):406.
15. Bruinsma SM, Tiemeier HW, Verkroost-van Heemst J, van der Heide A, Rietjens JA. Risk factors for complicated grief in older adults. J Palliat Med. 2015;18(5):438–46.
16. Burns RA, Browning CJ, Kendig HL. Examining the 16-year trajectories of mental health and well-being through the transition into widowhood. Int Psychogeriatr. 2015;27(12):1979–86.
17. Powers SM, Bisconti TL, Bergeman CS. Trajectories of social support and well-being across the first two years of widowhood. Death Stud. 2014;38(6–10):499–509.

18. Ong AD, Bergeman CS, Bisconti TL, Wallace KA. Psychological resilience, positive emotions, and successful adaptation to stress in later life. J Pers Soc Psychol. 2006;91(4):730–49.
19. Ong AD, Bergeman CS, Bisconti TL. The role of daily positive emotions during conjugal bereavement. J Gerontol B Psychol Sci Soc Sci. 2004;59(4):P168–76.
20. Latiegi A. Prevención y tratamiento del duelo patológico. In: Astudillo W, Arrieta C, Mendinueta C, Vega de Seonae I, editors. La familia en la terminalidad. Bilbao: Sociedad vasca de cuidados paliativos; 1999.
21. Kho Y, Kane RT, Priddis L, Hudson J. The nature of attachment relationships and grief responses in older adults: an attachment path model of grief. PLoS One. 2015;10(10):e0133703.
22. Tal I, Mauro C, Reynolds CF, et al. Complicated grief after suicide bereavement and other causes of death. Death Stud. 2016;41(5):1–9.
23. Sveen CA, Walby FA. Suicide survivors' mental health and grief reactions: a systematic review of controlled studies. Suicide Life Threat Behav. 2008;38(1):13–29.
24. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Washington, DC: Author; 2013.
25. Nam I. Complicated Grief Treatment for older adults: The critical role of a supportive person. Psychiatry Res. 2016;244:97–102.
26. Sikorski C, Luppa M, Heser K, et al. The role of spousal loss in the development of depressive symptoms in the elderly - implications for diagnostic systems. J Affect Disord. 2014;161:97–103.
27. Lee HJ, Lee SG, Chun SY, Park EC. Sex differences in depressive effects of experiencing spousal bereavement. Geriatr Gerontol Int. 2017;17(2): 322–9.
28. Ferreiro JA, Mateos R. International commentaries: Spain. In: Chew-Graham CA, Baldwin R, Burns A, editors. Integrated management of depression in the elderly. Cambridge: Cambridge University Press; 2008. p. 171–5.
29. Cerecedo-Pérez MJ, Tovar-Bobo M, Rozadilla Arias A. Medicalization I. 'Disease labeling: all business'. Atención Primaria. 2013;45(8):434–8.
30. Shah SM, Carey IM, Harris T, DeWilde S, Victor CR, Cook DG. Initiation of psychotropic medication after partner bereavement: a matched cohort study. PLoS One. 2013;8(11):e77734.
31. Núñez MA, Carballo N, Fernández-Cabana M, Pérez MA. Cuidados Paliativos en Oncología. Algoritmo de actuación ante el duelo y manejo psicológico del paciente terminal y su familia. In: CHUOU, editor. Diagnóstico y tratamiento en medicina hospitalaria: Enfoque práctico. Libro do Peto. Ourense: Complexo Hospitalario Universitario de Ourense; 2014.
32. Richardson R, Lowenstein S, Weissberg M. Coping with the suicidal elderly: a physician's guide. Geriatrics. 1989;44(9):43–47, 51.
33. Pérez-Sales P. Trauma, guilt, grief. Towards an integrative psychotherapy. Bilbao: Desclee de Brower Ed.; 2006.
34. Mateos R. Asistencia en Psiquiatría Geriátrica. De la Teoría a la Praxis. In: Agüera L, Cervilla J, Martín M, editors. Psiquiatría Geriátrica. 2nd ed. Madrid: Masson; 2006. p. 909–45.