Geriatric Grief Reaction: Grief and Depression in the Elderly

Clare Hawkins, MD, MSC, FAAFP

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The content of my material/presentation in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated:
- Lithium, Buspirone, Levothyroxine and stimulants are all FDA approved, but not for augmenting depression therapy but are widely used to do this. Stimulants are used in hospice especially when depressed patients don’t have time to wait the three weeks for SSRI to work.

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Lead physician, Aspire Health in Texas

Dr. Hawkins splits his time between practicing family medicine in private practice in Houston, Texas, and managing a palliative care home-visiting service in Texas and Louisiana for Aspire Health. He also manages Renaissance Physicians, a large independent physician association (IPA). He is a recent past president of the Texas Academy of Family Physicians, is a member of the AAFP’s Commission on Health of the Public and Science, and is a chair of the commission’s Subcommittee on Clinical Practice Guidelines. With 30 years of experience as a family medicine educator and more than 15 years serving as faculty for the AAFP, Dr. Hawkins has presented on a variety of medical topics. In addition, he has a long-term interest in the physician-patient relationship and physician resilience.
Learning Objectives

1. Distinguish among bereavement, grief, depression, and anxiety.

2. Utilize the appropriate depression and anxiety screening tools.

3. Implement the new psychiatric collaborative care management process with the appropriate billing requirements.

Audience Engagement System

Step 1

Step 2

Step 3
1. Arthur

- 10 months ago, my wife died
- I experienced the physiology of grief.
- I felt greatly sad and yearned for her.
- I didn’t sleep well.
- When I returned to a now empty house, I became agitated.
- My weight declined owing to a newly indifferent appetite

AES Question #1

Arthur has:
A. Normal Grief Reaction
B. Complicated Grief
C. Major Depressive Disorder
D. Persistent Depressive Disorder
Arthur

- 46 years of marriage
- Difficult Anniversary Reaction
- Ongoing sadness & sense that a part of me is gone forever
- Caregiver for wife, who died of Alzheimer’s disease
- Still caring for our memories.
- Is there anything wrong with this?


2. Cynthia

- 68 yo asks for help with sleep
- 4 yrs after husband’s death
- Sleeps on couch rather than bed
- Stopped regular meals
- Ruminating on unfairness and on her loss
- Too painful to do things they used to do
- Often wishes she could die
AES Question #2

Cynthia has:
A. Normal Grief Reaction
B. Complicated Grief
C. Anxiety
D. Persistent Depressive Disorder

Epidemiology……….. Death

- 2.5 million Americans Die each year
- How many relatives, then, are dealing with the loss…
- Universal Human Experience
- “typical” grief 2-6 months, culturally variable

Friedman, 2012
Normal Grief & Bereavement

- Yearning, longing, sadness
- Thoughts and images of deceased person prominent (benign hallucination)
- Confused about social role & identity
- Disengage from usual activities
- Disbelief or shock that loved-one is gone
- Dysphoria, anxiety, depressive symptoms, and anger
- Wax and wane unpredictably
- Time Limit? Culturally determined

Grief & Loss: a normal part of life

- Losses
  - Loss of vitality, youth, pluripotential horizon
  - Loss of friends & family
  - Loss of spouse
  - Loss of independence
  - Loss of financial security including asset transfer to qualify for state services
- Psychological variability in dealing with grief
  - Denial, anger, bargaining, (depression), & acceptance

Elizabeth Kubler-Ross 1969 On Death and Dying
Edward F Rickets
Cannery Row & Log from the Sea of Cortez by John Steinbeck

“A kind of anesthesia settled on the people. There was not sorrow really, but rather unanswered questions;
– What are we going to do?
– How can we rearrange our lives?
– Everyone who knew him turned inward
– We were lost and could not find ourselves”

DSM V Depression caveat with respect to loss

• Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode.
DSM V Depression caveat with respect to loss

- Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered.
- This decision inevitably requires the exercise of **clinical judgment based on the individual’s history and the cultural norms** for the expression of distress in the contest of loss.

Time Limit

- DSM IV 2 months
- DSM V removed time exclusion
  – To allow for earlier treatment of depression during bereavement
  – To recognize the arbitrary nature of time-limit
- Still…… 2-6 m? Longer?
- Majority of bereaved parents with symptoms at 18 m
Health Risks of Grief

- Increased risk of Affective Disorder (anxiety and depression) especially if past history
- MI, Takotsubo cardiomyopathy and risk of death
- Substance abuse disorders
- Sleep disturbance, decreased cortisol, and immune suppression (and cancer risk)

Wax & Wane

- Good days and bad days
- Calendar
  - Anniversary reactions
  - Family Holidays
  - Group celebrations
- Validate feelings, and anticipate events
Waves

• Sadness is mixed with more pleasant emotions
• Reviewing times with loved one Waves of feeling
• Pangs of regret
• The grief will seem more acute during some times and more subtle during others. Most people know deeply, “this too shall pass.”

Ron Pies https://psychcentral.com/blog/how-the-dsm-5-got-grief-bereavement-right/ accessed July 22, 2018

Normal Grief Can Have Optimism

• Can maintain the hope that things will get better
• Contrast with Depression
  – Pervasive Gloom
  – Pervasive Despair
  – Pervasive Hopelessness
Self Esteem Preserved In Normal Grief

• Worthlessness is missing
• Self Doubt can be present but not pervasive
• Past History of Depression can help differentiate

• Patients may need to be reminded to treat themselves with love and kindness during this time.

7 Tips to help with Grief

1. Make Time to Grieve. Consider using an photo or symbolic object
2. It is ok not to feel like “Cheering up”
3. Exercise and Eat well
4. Try and open your eyes to the delights around you
5. Know your limits. Take a Break
6. Give Back
7. Support Group

Practice Registry
(population management of grief risk)

• Consider practice-based outreach to those having experienced recent loss to invite them for evaluation or even phone support
  – Evaluate for adherence to medications for chronic conditions
  – Evaluate for coping with loss and socialization
  – Evaluate for suicide risk
Complicated Grief  Epidemiology

- 2-3% of population
- 10-20% after death of a romantic partner
- > 20% after loss of a child
- Even higher incidence after violence, (Accident, Homicide, Suicide)
- Higher risk if having been caregiver during extended illness

Complicated Grief

- Unusually severe and prolonged, & impairs function
- Yearning, longing, emotional pain, frequent preoccupation, disbelief or inability to accept, or imagine a future without the loved one
Complicated Grief: Psychology

- Alterations in reward system
- Abnormalities in autobiographical memory
- Altered emotional regulation
- Altered neurocognitive function (fMRI)

Complicated Grief

- Sleep disturbance
- Substance abuse
- Suicidal thinking and behavior
- Neglect of one’s health
- Poor adherence to medication regimen
  - Passive wish to allow death (leave death to chance)
Complicated Grief: Family

- Often frustrated that they cannot help
- Sometimes critical or withdraw from person
- May help interpret cultural context for timeline $> 6$ m
- Can help uncover maladaptive grief responses

*Brief Grief Questionnaire*

Not at all, Somewhat, a lot. (0,1,2)

1. How much are you having trouble accepting the death of ____?
2. How much does your grief still interfere with your life?
3. How much are you having images or thoughts of ____ when s/he died or other thoughts about the death that really bother you?

[https://www.massgeneral.org/psychiatry/assets/Brief_Grief_Questionnaire.pdf](https://www.massgeneral.org/psychiatry/assets/Brief_Grief_Questionnaire.pdf) accessed August 3, 2018
Brief Grief Questionnaire
Not at all, Somewhat, a lot. (0,1,2)

4. Are there things you used to do when_____ was alive that you don’t feel comfortable doing anymore, that you avoid? Like going somewhere you went with him/her, or doing things you used to enjoy together? Or avoiding looking at pictures or talking about_____? How much are you avoiding these things?

Brief Grief Questionnaire
Not at all, Somewhat, a lot. (0,1,2)

5. How much are you feeling cut off or distant from other people since_______ died, even people you used to be close to like family or friends?
– A score of 5 or more may be suggestive of the presence of the syndrome of Complicated Grief
AES Question #3

Which response supports normal bereavement rather than complicated grief
A. Duration greater than a year
B. Significant functional impairment
C. Preserved Self Esteem and Optimism
D. Inability to accept loss of loved-one

Complicated Grief Treatment

Human beings must sometimes endure “proper sorrows of the soul,” which do not belong in the realm of disease. Neither do these sorrows require “treatment” or medication.

Thomas a Kempis 1380-1471
Complicated Grief Treatment

- Identify and resolve complications
- Facilitate adaptation to loss
- Focus on restoration of functioning (plans for future)
- Focus on the loss (finding new ways to think about the loss)
- 16 weeks including homework
- Twice as effective than supportive therapy (2 small RCT)

Supportive Psychotherapy

- Interpersonal psychotherapy
  - Less structured
  - Less focus on death
  - Less focus on facing reminders of loss
  - Not directly evoking memories or imagined conversations with the deceased person
Complicated Grief Pharmacotherapy

- SSRI a reasonable option (five open-label trials) showed improvement, and better participation in therapy
- Benzodiazepines were not shown of benefit
  - Uncertain if short-term assistance with sleep helpful or benefit exceed risk in elderly

When does Bereavement need Medication?

- Persistent and pervasive dysphoria
- Unable to laugh
- Vegetative symptoms
- Rumination affecting function
- Difficult to assess in dementia
- Suicidal
Clinical Judgment (Wisdom)

• Understanding the patient in perspective of their life experiences

Time-limits are arbitrary and can be stretched in mild cases

Major Depression
DSM V Major Depressive Episode

A. > 5 Symptoms present past 2-week period (> 1 either depressed mood or loss of interest/pleasure):
   1. Depressed mood
   2. Diminished interest or pleasure in activities
   3. Weight loss or gain, or decrease or increase in appetite
   4. Insomnia or excessive sleeping
   5. Psychomotor agitation or retardation
   6. Fatigue or loss of energy
   7. Feelings of worthlessness or inappropriate guilt
   8. Diminished ability to think or concentrate
   9. Thoughts of death / suicidal ideation

B. Significant distress / impaired functioning

DSM V Depression Continued

B. The episode is not attributable to the physiological effects of a substance or to another medical condition.
   Note: Criteria A-C represent a major depressive episode. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

C. There has never been a Manic Episode
Depression PHQ9

“Over the last 2 weeks, how often have you been bothered by the following problems?” 0, 1, 2, 3 several, over half or all days

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling, or staying asleep, or sleeping too much
4. Feeling tired or having little energy


Depression PHQ9

“Over the last 2 weeks, how often have you been bothered by the following problems?” 0, 1, 2, 3 several, over half or all days

5. Poor appetite or overeating
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
Depression PHQ9
“Over the last 2 weeks, how often have you been bothered by the following problems?” 0,1,2,3 several, over half or all days

8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual

9. Thoughts that you would be better off dead, or of hurting yourself

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
## PHQ-9 Scoring

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>

### Suicide

[Image of a person standing at the end of a dock in a misty environment.]

AdobeStock License # 92656896
• Suicide Risk Factors:
  – Previous attempt
  – Bereavement
  – Chronic Illness
  – Age
  – Rehearsal

Suicide Interventions

• Non-Suicide Contract not effective
• Admit to hospital if suicidal risk high
• Work with families to reduce access to lethal methods
• Differentiate passive suicide from active
Persistent Depressive Disorder (Dysthymia)

• A. Depressed mood for > 2 years
• B. Presence, While Depressed, Of > 2 of Following:
  – Poor appetite or overeating
  – Insomnia or hypersomnia
  – Low energy or fatigue
  – Low self-esteem
  – Poor concentration or difficulty making decisions
  – Feelings of hopelessness
• C. During 2-year period, person never without symptoms in criteria A & B for > 2 m
Adjustment Disorder with Depressed Mood

- Emotional or behavioral symptoms in response to identifiable stressor occurring within 3 months of onset of stressor
- Symptoms do not represent “Normal” bereavement (> 1 year)
- Once stressor ended, symptoms do not last > 6 months

R/o Bipolar

- Mood Disorder Questionnaire (MDQ) Specific but not sensitive
- Ask about mania even if currently depressed
- Adopt 2-3 questions which you will ask everyone
  - Have you ever not needed to sleep
  - Grandiosity
  - Involvement in pleasurable activity in spite of the consequences
Anxiety GAD 7

“Over the last 2 weeks, how often have you been bothered by the following problems?” 0, 1, 2, 3 several, over half or all days

1. Feeling nervous, anxious, or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it’s hard to sit
Anxiety  GAD 7

“Over the last 2 weeks, how often have you been bothered by the following problems?” 0,1,2,3 several, over half or all days

6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen

5-9  Mild (monitor)
10-14 Moderate (possibly clinically significant)
> 15  Severe  (Active treatment probably necessary)

Pharmacotherapy for Depression

<table>
<thead>
<tr>
<th>Medication</th>
<th>Min Dose</th>
<th>Max Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>20</td>
<td>60</td>
</tr>
<tr>
<td>Sertraline*</td>
<td>50</td>
<td>200**</td>
</tr>
<tr>
<td>Citalopram/ Escitalopram</td>
<td>20/10</td>
<td>40/20</td>
</tr>
</tbody>
</table>

*First-Line Agent
**May Go Higher?
Pharmacotherapy for Depression

<table>
<thead>
<tr>
<th>Medication</th>
<th>Min Dose mg</th>
<th>Max Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serotonin/ Norepinephrine Reuptake Inhibitor (SNRI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venlafaxine XR*/ Desvenlafaxine</td>
<td>75/50</td>
<td>225/100</td>
</tr>
<tr>
<td>Duloxetine</td>
<td>30</td>
<td>60**</td>
</tr>
<tr>
<td>Levomilnacipram</td>
<td>40</td>
<td>120</td>
</tr>
<tr>
<td>Vilazodone</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Vortioxetine</td>
<td>10</td>
<td>20</td>
</tr>
</tbody>
</table>

*First-Line Agent  **May Go Higher?

Pharmacotherapy for Depression

<table>
<thead>
<tr>
<th>Medication</th>
<th>Min Dose mg</th>
<th>Max Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trazodone*</td>
<td>50</td>
<td>400</td>
</tr>
<tr>
<td>Mirtazapine**</td>
<td>15</td>
<td>45</td>
</tr>
<tr>
<td>Bupropion XL**</td>
<td>150</td>
<td>450</td>
</tr>
</tbody>
</table>

*Too weak to be first line agent  **First-Line Agent
Pharmacotherapy of Depression in the Elderly

- Avoid Tricyclics
  - Amitriptyline, Doxepin, Nortriptyline, Desipramine
- Caution with Bupropion and seizure threshold
- Start Low, Go Slow
- Tapering when stopping to avoid “flu-like” sx
  - Weekly downgrade

Augmentation

- Atypical Antipsychotics (aripiprazole FDA approved)
- Non-FDA Approved
  - Lithium
  - Buspirone
  - Levothyroxine
  - Stimulants (Dextroamphetamine & Modafinil)
Pharmacotherapy Tips

- Start with medication with prior response
- Poor adherence related to number of doses
- Caution with time of day prescribing

The Collaborative Care Model

- Primary care physicians deliver half of all mental health services (92 percent among the elderly)
- Primary Care office schedule often prevents attention to detailed interaction

WHO & WONCA, Integrating mental health 2008
Collaborative Care Model

- Case Management & Follow – Up
- Provider Communication, (Education, Specialist Advice, Guidelines)
- Motivational Interviewing & Brief Psychotherapy
- Community Resources
- Screening & Goal Setting

Collaborative Care Outcomes

- Better follow-up, provider communication and psychological intervention
- Fewer symptoms, Improved MH-QOL
- PC Depressed Patients > 60 yo without cardiovascular disease
  - 48% dec risk of CV event (NNT = 6)

Stewart et al. 2014
Integrating Behavioral Health

- Improved outcomes
- Reduced No Show
- Patient Satisfaction
- Medication Adherence

http://psycnet.apa.org/record/2013-28686-005  accessed July 29, 2018

Levels of Behavioral Health Integration

1. Minimal collaboration, referrals only
2. Collaboration at a distance, some direct communication
3. Basic on-site collaboration
4. Close collaboration in a partly integrated system
5. Close collaboration in a fully integrated system

Develop Care Plans

• Initially close follow up
• Who will initiate treatment and who will refill?
• Facility and process for admission for high suicide risk patients
• Psychotherapy along with medications

Tips

• Billing: specific to level of behavioral health staff, credentialing and health plan
• Shared Medical Records, consent, HIPPA
• Evolution & Space
• Finding the right specialist
• Avoiding self-referral risk (minimal)
• Weighing the benefit, (efficiency, patient-satisfaction, improved outcomes)
Billing for Services

• E & M
• Time-Based
• Billing for Credentialed Providers
• ICD 11  Prolonged Grief Disorder proposed (yes ..... Sorry ICD 11)

GETTING PAID

CMS

• January 1, 2013 allowed billing time-based & E & M same day
• Clearly documenting the amount of time spent only on psychotherapy services.

https://www.aafp.org/journals/fpm/blogs/gettingpaid/entry/potential_pitfall_in_medicare_billing.html  Accessed July 31, 2018
Time

• E & M also payable same day if they are significant and separately identifiable service
• Time spent for the E&M service is separate from the time spent providing psychotherapy
• Clearly document in the patient’s medical record the time spent providing the psychotherapy service

Psychotherapy with patient and/or family member

Without E & M
• 90832: 30 minutes (16-37)
• 90834: 45 minutes (38-52)
• 90837: 60 minutes (>53)
• No longer dependent on service Location

With E & M
• +90833: 30 minutes
• +90836: 45 minutes
• +90838: 60 minutes
Document

- Time separate from E & M
- Treatment Modalities (i.e., supportive psychotherapy, CBT, Solution-Focused)
- Progress to date
- Treatment Plan

AES Question #4

The most frequent error when billing psychotherapy concurrent with E & M
A. Underestimating time spent
B. Not documenting the separate time spent counseling from total time
C. Writing too much detail
D. Specifying type of therapy
“Incident to” Billing

• Provider working under supervision of Physician, Psychologist, PA, NP
• Requires physical presence and supervision
• May choose to bill this, or to credential separately


Mental Health Treatment Limitation

• 62.5% of total fee if patient is an outpatient
• Excludes
  – Diagnosis, especially alzheimers
  – Brief OV for monitoring drug therapy, HCPCS code M0064
  – Psychological testing

Psychotherapy Notes

• “Notes recorded (in any medium) by a mental health professional which document or analyze the contents of conversation during a counseling session and that are separated from the rest of the individual’s medical record.”

Excluded from the HIPPA definition

• Medication prescription and monitoring
• Session start and stop times
• Modalities and frequencies of treatment
• Clinical test results
• Summary of
  – Diagnosis
  – Functional status
  – Treatment plan
  – Symptoms
  – Prognosis
  – Progress to date
Practice Recommendations

A. Screen for Depression with supports in place to intervene (SORT A)\(^1\)
B. Differentiate Complicated Grief from Bereavement and Depression (SORT B)\(^2\)
C. Integrate Behavioral Health into Practice (SORT B)\(^3\)

1. USPSTF
2. Shear 2015
3. Kwan & Nease 2013

Questions
Contact Information

• drclarehawkins@gmail.com

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• Kersting A et al. *Prevalence of complicated grief* in a representative population-based sample. J. Affect Disord 2011;131;339-43


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• Stewart JC  Effect of Collaborative Care for Depression on Risk of Cardiovascular Events: Data from the IMPACT Randomized Controlled Trial. Psychosom Med. 2014 Jan; 76(1): 29–37.

Web Resources

• https://www.cms-billing.com/forms/NHIC_Medicare_B_Mental_Health_billing_guide_2008.pdf  accessed July 31, 2018

• https://www.aafp.org/journals/fpm/blogs/gettingpaid/entry/potential_pitfall_in_medicare_billing.html  Accessed July 31, 2018
Web Resources: Inventories

• PHQ9
  – https://www.aafp.org/afp/2008/0715/p244.html
• GAD
• Brief Grief Questionnaire
  – https://www.massgeneral.org/psychiatry/assets/Brief_Grief_Questionnaire.pdf

Web Resources

• https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening (B)