



Case Report

Grief Processing and Alzheimer's disease: The Case of Mrs. B

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Abstract

The emotional processing of grief is necessary to move forward with one's life after a significant loss. However, emotional processing has been shown to be impaired in individuals with cognitive impairment, possibly due to degeneration of the underlying cognitive structures. Specifically in Alzheimer's disease (AD) research does suggest that the ability to interpret emotional stimuli, mostly negative, is impacted by cognitive decline, while the ability to identify positive emotions remains more accurate. There is also research to support an overall cognitive impact of suffering from complicated grief. Noteworthy, the question of grief processing in AD has yet to be explored thoroughly. In effect, does AD interfere with emotional processing in grief?

Keywords

Alzheimer's disease; AD patients; Breast cancer; Grief processing

Introduction

To understand this better, we present a case of Mrs. B, who lost her husband around 18 months ago. She was diagnosed with AD in 2015 and has experienced cognitive decline since that time. Her primary complaint, when she can express it, is aphasia (primary progressive aphasia); feeling very frustrated by her inability to express herself and relate with people as she was so fond of doing in the past. She is sad, cries, and becomes emotionally distraught periodically. The details of her husband's death are not lost, as she can clearly recall the events leading up to his death and holds anger towards him for not addressing his health problems. In fact, the emotional context of his death is impacting her ability to create new life goals and to assimilate his death into her sense of self. This case attempts to illuminate the impact of AD progression on grief processing and hopes to inform care practices in the treatment of grieving AD patients [1-3].

Mrs. B

Mrs. B is a 77 year old Caucasian female who was born and raised in Atlanta, Ga by both of her parents. She earned her high school diploma and attended some college. After her education, Mrs. B began clerical work and remained in that field throughout her career. She last worked in 2000. She married at age 18 to her husband of over 55 years and together had three children; two sons and a daughter.

She has lived in Middle Georgia for over 30 years since moving here for her husband's work. Her husband died around 18 months ago of complications related to alcoholism. Prior to his death, he drank regularly and caused Mrs. B significant emotional distress. Her children are currently involved in her care and one of her sons is living with her. Her son's health is complicated at this time, impacting the quality of her care. Primary concerns include medication adherence, physical, intellectual and social activity, symptoms of complicated grief, and diet, though her son is a chef and when he is fully functional provides a nutritious diet.

In addition to her AD diagnosis, Mrs. B was treated for breast cancer in the past 5 years and is currently in remission. She suffers from chronic back pain but tolerates it well. She is also being treated for hypothyroidism (controlled), renal issues, gastrointestinal issues, and depression. Her current medications include levothyroxine, anastrozole, sennalax, oxybutynin, bisoprolol, omeprazole, citalopram, and ibuprofen. Again, she cannot perform many IADL tasks and is managed by her son who has his own problems.

Initial assessment for cognitive issues occurred in May 2015. She earned a score of 13/30 on the Montreal Cognitive Assessment (MoCA), and exhibited universal decline on the Repeatable Battery for the Assessment of Neurological Status (RBANS), including visuospatial abilities, attention, language, and memory. On a test of executive function, she scored in the impaired range. Results on self-report assessments of mood indicated presence of depressive symptoms. Post-assessment, she and her family were given feedback regarding the importance of activity in staving off further decline and they were provided with supportive recommendations. She was invited to attend a memory group at the time and was a willing participant. She was driving at the time but has since stopped. Her insight into her situation was intact and she was aware of her decline at that time.

Mrs. B's husband died early in 2016 and his death has been difficult for her. She was again given the MoCA in April of 2016 where she scored an 8/30 and was no longer able to complete an executive functioning measure which requires sequencing and alternation between letters and numbers. Despite this, she continues to attend group regularly and participates actively. Her youngest son moved in and is her primary caregiver, though all of her children are involved. Her caregiver's health is in decline, complicating her care. Currently, insight into her circumstances is mostly intact though this varies.

Complicated Grief

Grief is a universal reaction to loss. For the purposes of this case report, grief is conceptualized as a result of the loss of an attachment figure, where the lost loved one represents an element of one's own working model [4]. Attachment systems involve elements of memory; factual information about this person which is stored and retrieved. When a person loses someone to whom they are deeply attached, there is a period of adjustment to life without that individual; a natural healing process occurs which helps incorporate the new reality into the person's existing sense of self [4]. However, some individuals do not smoothly move through this process. Complicated grief, a constellation of symptoms not yet recognized by the DSM, effects an

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estimated 2-3% of the population [5]. Making this issue more urgent to address, complicated grief is associated with impaired function, risk of health problems, and increased mortality [6].

The criteria for complicated grief, as proposed by Zisook et al. [7], includes: (A) the presence of bereavement related to loss that has been present for more than six months; (B) ongoing intense distress which involves yearning for the loved one to return, lack of acceptance, frequent disturbing thoughts or images related to the loss, and/or a persistent desire to feel close to the loved one or to join them; (C) the person suffering from distressing thoughts, dysfunctional behaviors and/or emotional responses related to the loss which fall under at least three of the following criteria: frequent troubling thoughts about the circumstances or consequences of the loss, feelings of anger or bitterness, reactivity to reminders of the loss, avoidance of reminders, isolation from those who seem unsympathetic, excessive confusion over one's purpose in life since the loss, belief in a purposelessness without the loved one, and a hopelessness regarding future joy and satisfaction. These symptoms are present for at least one month and result in clinically significant distress in multiple areas of life. We note too the recent DSM-5 which allows a person in grief to be seen as clinically depressed after a short period of time, given problems.

Addressing Complicated Grief: Working with Mrs. B

Previous interventions in complicated grief involve cognitive behavioral models and assume a cognitively intact patient [4]. The question then becomes how we attempt to treat complicated grief as practitioners in patients with a dementia. Some studies suggest that emotional processing through venting of feelings tends to make the negative emotions more salient for the patient, bringing to the forefront emotions related to the loss [8,9]. There is also support for a relationship between amygdala volume, which declines with the progression of AD, and sustaining happy emotions [10]. Intuitively, avoidance of introducing negative emotions to AD patients would be prudent.

However, research into treating CG comorbid with AD is limited. One case mentioned by Rentz et al. [9], utilized distraction and SSRI's with a patient who was having difficulty integrating the loss of her husband into her understanding. In her case, SSRI's and not reminding her of her husband's loss, as well as moving her to a community accommodating to moderate cognitive impairment, was enough to improve her quality of life and relieve both she and her family's distress.

In contrast, Mrs. B's insight seems to be mostly intact. This decision then is between helping her retrieve negative memories in order to better integrate the loss versus avoiding reminders of negative stimuli to prevent disturbing emotional reactions. Mrs. B meets criteria for complicated grief. She reports significant and frequent anger over her husband's despondence which led to his death. Additionally, she fears not being able to be happy without him and longs for him to not be deceased. She becomes tearful and distraught at times, which is very disturbing for her family. Despite her cognitive decline and significant loss, she still smiles and laughs frequently. Interactions in the Memory Group where she participates are fraught with fighting to find words and providing cues to others in the room for help to remember so that she can complete her sentence. Her strength is her primary coping mechanism, laughter.

Upon entering the group session recently, she was confused, her speech was more halted than normal, and she frequently interrupted

the group to discuss a topic she on which she was fixated. She was obviously more disturbed than normal. Therefore, she was taken aside for individual counseling and to further explore suspicions about her complicated grief symptoms. When Mrs. B was given the opportunity to vent regarding her husband and provided with a sympathetic and comforting environment, she seemed to benefit from the experience.

One vehicle to assist in the emotional grief process is the Typical Beliefs Questionnaire (TBQ). This was administered to assess for maladaptive cognitions which correlate with symptoms of complicated grief [6]. At times, Mrs. B can clearly produce words, but she requires cues. With the TBQ, she could freely state her frustrations when provided the Likert style response options. She could elaborate, with some aphasic interruptions, better than in previous group interactions. Typically, she is very frustrated by her inability to express herself, despite the fact aphasia was one of the first presenting symptoms. Therefore, this assessment may have provided her with verbal cues to express the negative feelings which are less accessible when suffering from cognitive decline and may have been useful for her in processing and identifying the negative emotions related to her husband's death.

Mrs. B was able to identify and elaborate on the feeling of sorrow related to her inability to intervene in his decline as well as her intense anger towards him for not being willing to "take care of himself." His chronic alcoholism, emotional distance, and declining health led her to feel helpless in alleviating his distress. In the session, she was able to laugh and cry appropriately and upon leaving she was in much better spirits and expressing herself more clearly. She said she was grateful for feeling listened to as she feels her friends are "tired of hearing about it".

Mrs. B's case showed clear benefit from venting about her husband's loss, and did not appear fixated on the negative component. Instead, she appreciated the opportunity to be heard and to express her feelings. What is unclear is whether this intervention will alleviate her symptoms. Further follow-up seems to suggest this. She responds with more emotional clarity about her situation as well as those of her group mates. She is above all pleasant and engaging. She shows this to her family also. She even takes criticism of her failing memory to better effect. She seems to enjoy living while still recalling her life and her loss.

In general, it may be prudent not to encourage emotional expression in individuals with AD because of the potential for flooding of emotions and focus on the negative memories. But there are reasons why this may not always be so. Research shows that older patients tend to focus more on positive memories [11,12]. Additionally, emotion regulation is not always optimal. It involves processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions. Emotion regulation deficits have been demonstrated to be a significant pathomechanism in depression (major depressive disorder (MDD)). Cognitive theories assume that cognitive biases in attention, memory, or interpreting emotion-eliciting ambiguous events underlie the difficulties in emotion regulation in depressive people. Moreover, it is proposed that deficits in cognitive control and executive functioning impact negatively the ability to cope with the mentioned cognitive biases and result in a more frequent use of maladaptive emotion regulatory strategies. Applying adaptive emotion regulation strategies predicts lower depressive symptom severity in patients with MDD. This has not been applied, however, in dementia.

Finally, in Rentz et al. [9], this was not the case. We believe that a clinical decision can be made focusing on the constancy of the affect, the ability to retain the processing experience, and desire to unburden self with pain. In Mrs. B's case she was validated, provided supportive mechanisms, and rewarded for her emotional processing efforts.

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