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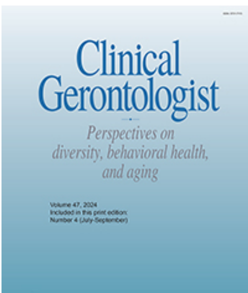

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Primary Care Consultations for Grief in Older People – a Missed Opportunity for Mental Health Support

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ABSTRACT

Objectives: Bereaved older adults often experience health complications, yet receive limited support in primary care settings. This research explored general practice staff's exposure to older patients' grief and identified barriers/enablers to bereavement support.
Methods: We examined 15 in-depth interviews with general practitioners and practice nurses across Australia. Data were analyzed thematically and via poetic narrative analysis, an innovative arts-based method to meaningfully translate participant's lived experience and emotions.
Results: Exposure to older people's grief and bereavement informed primary care staff assumptions about older people's grief, their ability to identify signs of grief, their understanding of how culture, gender, and grief intersected, and how grief could be managed in general practice (e.g. mobilizing nurses to provide support). Barriers/enablers to bereavement support included: Communication, access to support, time to discuss concerns, and knowledge/awareness of grief complications.
Conclusions: Older adults require access to tailored support that addresses their experiences of repeated exposure to grief and loss. Primary care is a key conduit to specialist services but to make such referrals more training is needed on ageism and stigmas surrounding mental health. Arts-based methods can open a dialogue about grief and destigmatize help-seeking among older adults.
Clinical implications: Clear documentation of grief in patients' medical records; Destigmatizing mental health support among older patients; and Training primary care staff on grief, age-, culture- and gender-specific needs, and available resources can overcome some of the identified barriers to bereavement support. Primary care providers can use consultations with older patients to enquire about potential recent bereavements and mental health support needs, going beyond the mere assessments of physical symptoms. Timely assessment and documentation of grief in older patients can facilitate appropriate referrals and access to support services; this is a key task for general practitioners, who are gatekeepers to the healthcare system.

KEYWORDS
Ageing; bereavement; general practice; primary care

Introduction

Grief is a natural response to a significant loss, like the death of a loved one. It is a whole-of-being experience that affects people cognitively, emotionally, physically, behaviorally, and practically. Grief can lead to personal reflections and growth (Bellet et al., 2018; Calhoun et al., 2010; Gerrish et al., 2009), but also to long-lasting health complications. There is an increased risk of psychological and physiological morbidity post-bereavement (Prigerson et al., 2009; Stroebe et al., 2007), including heightened risks of depression, anxiety, hopelessness (Hays et al., 1994; Siegel & Kuykendall, 1990) and major cardiac events (Carey et al., 2014). Bereaved people also have a 50–150% increased risk of death from suicide, accidents, and alcohol-related causes (Martikainen & Valkonen, 1996).

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Despite these challenges, many primary care (e.g., general practitioner, nurse, social worker, psychologist) and other healthcare staff are uncertain about how to best support bereaved people, and bereavement care is often varied (Pearce et al., 2021). The public health approach to bereavement support services proposes three levels of intervention: universal – targeting all bereaved people; secondary – targeting people at risk of complex mental and physical health problems associated with grief; and tertiary – targeting those with complex health problems associated with grief (Aoun et al., 2012). While 54–58% of bereaved adults cope with grief through informal support from family and friends, an additional 33% are at moderate risk of developing complex health problems and 9% have high needs; these latter groups would benefit from targeted and specialist professional help like community support groups and mental health services respectively (Aoun et al., 2012, 2015). Some groups, such as older people, may be particularly at risk of developing complex mental and physical health problems associated with grief; for example, as people age, exposure to bereavement becomes more frequent, which can lead to cumulative grief that reduces a person's ability to cope with subsequent losses (Goveas & Shear, 2020).

A recent Australian survey found that 21% of bereaved older adults showed signs of prolonged grief, which was associated with high levels of loneliness and low quality of life, especially among women, bereaved partners, or full-time carers (Engel et al., 2022). Prolonged grief disorder is a clinical diagnosis given when grief symptoms such as yearning for the deceased and preoccupation with the loss are so intense that they cause significant suffering, exceed social, individual and cultural norms, and impact a person's ability to function for longer than 6–12 months (American Psychiatric Association, 2022; World Health Organization, 2022). Prevalence rates of prolonged grief across all adult age groups are estimated at around 9.8% (Lundorff et al., 2017), yet may be more than twice as high in people over the age of 65 (Engel et al., 2022).

Repeated exposure to grief can have compounding physical and mental health effects, especially among older adults with preexisting medical conditions and limited social support (Engel et al., 2022; Gerber et al., 2022; Schladitz et al., 2021). Older people may therefore benefit from professional support. To access this support, general practitioners (GPs) and general practice nurses (GPNs) play an essential role in identifying bereavement complications, making specialist referrals, and providing ongoing help (Nielsen et al., 2020). Despite mental health concerns being the most common cause of presentation to an Australian GP (The Royal Australian College of General Practitioners, 2022), for people experiencing grief, the likelihood of being referred for (or receiving) mental health support is uncertain. It is therefore important to understand what may enable or hinder effective bereavement support and what can be done to address potential barriers in primary care.

This study's objectives are to shed light on these issues via an in-depth understanding of primary care staff's experiences with grief in older adults and to identify barriers/enablers to effective bereavement support. The current study is part of a larger mixed-methods research, comprising a nationwide survey (Engel et al., 2022) and in-depth interviews with bereaved older adults (Gerber et al., 2022; Melbourne Ageing Research Collaboration, 2020, 2022b).

Methods

An interpretivist-constructivist perspective underpinned the study, where semi-structured interviews were used to allow deep, iterative explorations of respondents' experiences; understand how they make meaning through language, action, and history of their particular social environments; and subsequently construct actions that can inform and improve healthcare practice (Burns et al., 2022). This study was approved by the Human Research Ethics Committee of Deakin University and received research governance approval from the National Ageing Research Institute.

Eligibility, recruitment and sampling

Non-proportional, purposive sampling was used to recruit GPs or GPNs currently practicing primary care in Australia and regularly working with older people. Using this type of non-probability sampling, the research team purposely decided to select

participants that represent GPs and GPNs with a broad range of years of experience. Participants were recruited through practice flyers, collaborators' websites, newsletters, primary health networks, and social media.

Data collection

Interviews were conducted by an independent psychological scientist (KG), with expertise in end-of-life, aging and mental health research, and qualitative methods. Interviews followed a semi-structured guide of open-ended questions, developed in collaboration with a multi-disciplinary research team and a consumer representative from a research community advisory group (Supplementary File 1). Following written informed consent, primary care staff were asked how often they encountered grief in older people, how they identified grief, whether they knew of prolonged grief and how they respond to grief in older patients. Interviews were conducted from June – July 2020, took between 43–61 minutes, and due to COVID restrictions and participants' geographic dispersion, were done online or via telephone. Data collection continued until all questions had been explored in sufficient depth, no new themes were raised, and adequate information power had been gained (Malterud et al., 2016). Participants were offered to review their interview transcript, have their transcripts turned into research poetry and review poem drafts. They received a gift voucher for their time and a resource sheet with available bereavement services to support their clinical practice (Melbourne Ageing Research Collaboration, 2022a).

Data analysis

Interviews were audio-recorded, de-identified and professionally transcribed before being entered into QSR International's NVivo ver. 12 to facilitate data analysis (Lumivero, 2020). To examine relevant themes, we used the analytical process outlined by Braun and Clarke (Braun & Clarke, 2012, 2022). Data analysis involved a continuous, iterative process of open coding (breaking raw data into initial codes), axial coding (merging codes with similar information; establishing thematic relationships), and selective coding (organizing codes into overarching themes). The coding process followed a bottom-up approach where codes were directly developed from the interviews rather than top-down from existing concepts generated from the literature. Two experienced qualitative researchers (KG, BB) developed the coding framework by independently coding two interviews each over three consecutive rounds and discussing emerging codes. The refined codes were then applied by KG and KL to the remaining transcripts. Coded themes were continuously scrutinized and corroborated throughout a repeated, reflexive process. Coding was complete when no new themes were identified. All authors were involved in thematic discussions and interpretation of results.

The sensitivity of the topic and the richness of our data suggested the utility of poetic narrative analysis, which is a novel, arts-based form of data analysis and representation in which researchers create poem-like prose from interview transcripts (Miller, 2019). Going beyond mere qualitative description, this unique convergence of art, health science and research offers immersive, emotive, first-hand insights into lived experiences of research participants and is a powerful way to connect audiences (e.g., the reader of this article) with participants on a deeper level and can evoke feelings of compassion, sympathy, and empathy, and thus greater understanding (Leavy, 2020). Such creative, arts-based forms of data presentation and research translation are increasingly being used in gerontological studies (Faulkner, 2016; Gerber et al., 2022; Miller, 2019). Poetic narrative analysis has previously been used to capture bereavement experiences of older adults and found to be highly engaging (Gerber et al., 2022). This analytical technique was therefore applied to capture the experiences of primary care staff with grief in older patients.

First, all participants were emailed and asked if they consented to portions of their interviews being converted into poems; six of 15 participants (two GPs and four nurses) replied affirmatively, the others did not reply at all. Thereafter, a poetic narrative analysis was completed on these six transcripts and involved the following steps (Gerber et al., 2022; Miller, 2019):

(1) Immersion: Researchers (KG, BB, KL) immersed themselves in the data by reading/re-reading transcripts in search of keywords and phrases.
(2) Creation: Then KG arranged/rearranged key phrases from individual interviews in a nonlinear fashion to craft individual poems (or poetic prose) using participants' exact words.
(3) Critical reflection: The poems were reviewed for their quality/accuracy by carefully contemplating titles, word choice, punctuation, sound, and emotion. Being truthful to participant's meaning and interview dialogue was prioritized over poetry genres (e.g., odes, sonnets) or ensuring consistency in poetic techniques (e.g., rhyming, lineation) across all the poems created. As such, most poems are written in free form.
(4) Considering ethics: Individual poems were sent to the participants whose interview they were created from, and participants were invited to reflect on the poems, make changes, and approve the final versions. Only one GP participant asked for one phrase from one poem to be changed to better clarify his meaning; no other changes were requested. Participants also decided which level of anonymity would be assigned to their poem and in some cases, they opted to record themselves reading their poems; in other instances, complete anonymity was maintained.
(5) Engagement: The poems have been shared with diverse audiences via publications, conferences, exhibitions, events, and online.

Results

Sample description

Fifteen interviews with seven GPs and eight GPNs from four Australian states were conducted, including ten participants from metropolitan areas and five from rural regions. As outlined in Table 1, nurses were on average 42 years old, and all were women. The sample included new and experienced nurses with work experience between 1.5–31 years. In contrast, GPs were on average 52 years old, 57% were men and they had worked in their profession between 9–36 years.

Table 2 summarizes our analyses, which showed primary care staff exposure to older people's grief and bereavement informed: 1. Staff's assumptions about older people's grief (e.g. that they were used to loss), 2. Ability to identify signs of grief, 3.Understanding how culture, gender, and grief intersected, and 4. How they could manage grief in general practice (e.g. staff as incidental counselors; how nurses could provide bereavement support). We further identified four themes of barriers/enablers to bereavement support: 1. Communication, 2. Access to support, 3. Time, 4. Knowledge/awareness of grief complications. As not all participants consented to their data being converted to research poems, we elaborate on these

Table 1. Demographic background of interview participants.

Variable	Category	GPNs (8)	GPs (7)	Total (15)
Interview length	Mean (range)	50 min (43–60)	52 min (45–61)	50.7 min (43–61)
Sex	Male	0	**4**	4
	Female	**8**	3	11
Age	Mean (range)	42 years (29–54)	52.3 years (37–62)	45.6 years (29–62)
Country of birth	Australia	7	**4**	**11**
	Outside of Australia	1	3	4
Time in profession	Mean (range)	15.4 years (1.5–31)	25.3 years (9–36)	20 years (1.5–36)

Table 2. Overview of identified themes and subthemes.

Primary Care Staff's Experiences			
1. Staff's beliefs about grief in older people	2. Identifying signs of grief	3. Culture, gender, and grief	4. Managing grief in general practice • The role of nurses in bereavement support
Barriers and Enablers to Bereavement Support in Primary Care			
(1) Communication • Within services • Between services	(2) Access to support • Availability • Affordability • Acceptability • Adequacy of support services	(3) Limited time • Time pressure • Time management strategies	(4) Knowledge and awareness • Knowledge of prolonged grief • Knowledge of the difference between grief and depression • Awareness of ageist stereotypes • Knowledge and awareness of available bereavement services/resources/support

findings through a unique combination of direct quotes and research poems.

Primary care staff's experiences with grief support

Primary care staff were essential for bereavement support of older people, as GPs were their first point of contact with the healthcare system. Especially older adults without family support depended on their GP after a loss. GPs and GPNs regularly encountered grieving older patients, which varied in frequency from *"a few times per year" (Nurse7)* to *"four days a week" (GP4).*

Theme 1. Staff's beliefs about grief in older people

GPs felt older patients were less impacted by grief than younger people. While acknowledging that older adults had often experienced multiple losses over time, GPs saw them as more resilient because of their life experience and frequent exposure with death and grief. Consequently, some primary care staff felt that older people's grief was shorter, less problematic, and resolved on its own. One GP commented: "*Their partners, friends have all passed away. They've become more used to dying, so they're not affected as severely as the younger patient." (GP2).* Another said: *"The oldies just see it as the next step in life." (GP4)*

Theme 2. Identifying signs of grief in older people

Bereaved older people frequently presented with physical symptoms that initially did not seem to be directly related to grief, like sleeping problems, weight changes, breathing or cardiovascular symptoms. GPs and nurses reported older people were reluctant to discuss their mental health, which made it challenging for healthcare staff to identify underlying grief. This is captured in the following poem based on a participating GP:

Hidden in the background
You don't see the grief
Like somebody arriving off the street
'Hello Doctor, I've come to see you
Because I'm grieving.'
For a consultation going
That's not their reason to present.
Grief is often hidden,
In the background,
Amongst consultations,
Amongst all their normal stuff.

Long-standing relationships with patients helped GPs and GPNs to identify subtle signs of grief and create the rapport needed for sensitive conversations about death, loss, and mental health. This familiarity between clinicians and patients existed more regularly in smaller/rural communities than in larger cities. However, since most GP consultations focused on older people's physical health, grief and mental health easily dropped off the radar.

Even though primary care staff frequently encountered depression in older adults, many struggled to differentiate grief from depression, which was sometimes seen as a normal part of aging. Depression was perceived as more pervading and potentially the consequence of grief. One GP described grief and depression as "*a bit mixed" (GP3).* A nurse added: *"The signs are quite similar . . . It's really hard to pick up." (Nurse5)*

Theme 3. Culture, gender, and grief

GPs and nurses reported the way grief was expressed varied between genders and cultures. Older men were perceived as more avoidant and less expressive when it came to grief. They were more likely to present late and with more physical symptoms. Concerns about suicide among bereaved older men were also expressed, as captured in this poem from a nurse:

The rifle
A lot of men won't accept it,
Counselling.
Stiff upper lip,
Some are angry,
Fall into apathy,
Lose interest, identity or purpose.
We had one gentleman,
Nursing his wife,
Until she passed away.
We made a deal.
We took his rifle off him,
Because we were concerned
He would do himself some harm.
He was so lost,
Grieving his role,
Grieving his purpose.

Primary care staff also noted that older people from certain cultural backgrounds were reluctant to display emotions and talk about personal matters like grief, pointing to a need for gender- and culturally tailored bereavement support.

> My Chinese patients, once they've passed away it's hush-hush. (GP3)

> I find [Aboriginal cultures] less forthcoming with information. If you talk to Sri Lankan cultures, Indian cultures - they don't like people upset. (Nurse4)

> We have a lot of Somali or Muslim patients, and the male is always present, and they feel it's not appropriate to share their distress. (Nurse5)

Theme 4. Managing grief in general practice

Primary care staff used several strategies to manage grief in older adults. Firstly, GPs and nurses offered empathic responses, finding themselves in the role of incidental counselors. Many encouraged patients to use informal support like families and friends, or pursue meaningful activities such as community groups or volunteering to deal with social isolation post-bereavement. One GP described how he had been *"suggesting things that they can do, whether they start getting involved in some sports organisation or volunteering at the local dogs' home or something like that. I try and encourage them to move on in their life rather than sit at home and fret about it." (GP5)*

If professional help was required, GPs would refer to psychologists or mental health specialists. Counseling was therefore the first line of treatment for more complex needs, followed by medication, most often antidepressants or sedatives.

> You only have to do something about derailed grief. For those, anti-depressants are a wonderful way of stopping them from noticing their pain in their knee, and their headaches, and their negative mindset. (GP1)

> I prefer antidepressants over sleeping tablets because I find you can become dependent and especially because they're old, they live on their own, I don't want there to be a risk of falls. (GP3)

In contrast to GPs practices, nurses felt they were well placed to help with grief because they had flexibility to offer longer conversations than GPs. They said they played an important role in caring for bereaved older patients as nursing care was perceived as very intimate. GPNs reported grief was brought up as a sideline conversation while they dressed wounds or gave flu shots. Nurses also encountered grief symptoms as part of annual, government-funded health assessments for people over 75 (Australian Government Department of Health and Aged Care, 2014). This included questions about mental health and support networks and was therefore seen as a useful conversation starter about grief.

Yet, some patients preferred speaking to a doctor. One nurse explained: *"You do get a lot of older people who are very set in their ways and they only will talk to the GP. So, our GPs end up doing a lot of mental health counselling without wanting to be in that role." (Nurse7)*. Many nurses saw themselves as an under-recognized and under-utilized workforce in bereavement support, as illustrated in the following poem.

> ***Perfect workforce***
> *Us general nurses – cheap as chips,*
> *Not worth anything apparently.*
> *Give them more funding*
> *So that there is time.*
> *You've got a workforce*
> *Who is willing and able.*
> *They've got the rapport.*
> *Give them skills and they'll do it.*
> *They're perfect*
> *To help with grief.*

Alternative or holistic therapies like mindfulness, relaxation or acupuncture were rarely considered. Similarly, clinicians seldom directed patients to support groups, bereavement services or online resources, mainly because they were unaware of what was available.

Barriers and enablers to effective bereavement support in primary care

Based on primary care staff's experiences with grief in older people, we identified four themes of barriers and enablers to effective bereavement support in primary care: (1) Communication, (2) Access to support, (3) Limited time, and (4) Knowledge.

Theme 1. Communication

Effective communication was important for bereavement support in primary care but there were challenges related to communication within and between services. Communication within GP clinic teams was essential to identify grief and arrange support where needed. Nurses sometimes learned about a recent bereavement during sideline conversations with older patients as they checked their blood pressure or updated their personal details. It was then imperative to pass this information on to treating GPs as these details "*might just come through the grapevine or the nurse picks it up." (GP7)*

Formal and informal team meetings were useful to share these "grapevine" discussions and tap into existing support, as this GP explained: *"Every week we have a meeting where we discuss cases. We also have an active chat room. We send a message out: 'Does anyone know any good psychologists or psychiatrists who have their books open?'" (GP2)*

Record keeping was paramount for team communication but there were gaps when it came to grief. Clinical notes focused on patients' physical needs and did not always capture recent bereavements. One GP emphasized that "*Grief is not really documented.'" (GP1)*

Communication between services was another challenge. GPs were not always informed by hospitals or palliative care services when patients had died. If GPs also cared for patients' immediate family, this communication gap could prevent timely bereavement support for the rest of the family: "*Some of the time the hospital will phone you up as the GP to let you know that [the patient] passed away. But sometimes they don't, so it can be very difficult." (GP5)*

Establishing standardized feedback loops between GPs, hospitals and palliative care services was seen as useful for bereavement support. Similarly, feedback from community nurses was important to identify grief complications early because they would see older clients in their homes and notice subtle signs of grief, e.g., when patients started to neglect their environment or themselves. These indicators of grief were difficult for GPs to detect from a distance, so feedback from community nurses was helpful, yet not always provided. This is captured in the following GP poem:

Down the gurgler
The community nurse rings you:
'Mary has not put her garbage out.
Newspapers stacking up in the house.
15-day old fish in the fridge.
It's stinking to high heaven.'
She's gone down the gurgler.
We don't see them
In their home.
You need somebody
To go into the house.
Community support
Is the way.

Communication between services also involved good connections to psychologists, which helped reduce waiting times for urgent cases. But this was rarely possible due to access issues.

Theme 2. Access

Access challenges concerned the availability, affordability, acceptability, and adequacy of support. Access to psychologists, mental health nurses and counselors was not readily available, especially in rural areas. GPs and nurses criticized waiting times to see publicly subsidized psychologists and costs of private psychologists. This is illustrated in the following poem based on a nurse:

Nowhere to refer
You have this grieving patient.
You need to do something.
The idea is you refer
But there's nowhere to refer.
Waiting lists – astronomical.
Private – you can forget.
If I said: "Go and see her.
She's only $140 a session."
They would laugh.
"I'll fly to the moon the next day."

Primary care staff also emphasized some older people being reluctant to accept counseling referrals. This was seen as a generational and gender issue related to the stigma of seeking mental health support and the perceived inadequacy/ineffectiveness of psychotherapy. One nurse explained: *"Sometimes they need more formalised care and then you have to take time negotiating with them to accept a referral. A lot of men particularly won't accept it." (Nurse3)*

Theme 3. Limited time

With the focus on older people's physical symptoms, GPs and nurses felt there was little time to discuss mental health and grief. That was partly because standard GP consultations are relatively short and because it takes patients some time to open up and share their grief. A GPs explained: *"They leave it until the last minute. I constantly have that problem. You spend 15 minutes building rapport and then they tell you. They drop the bomb at the end." (GP3)*

Some primary care staff were very dedicated and used time-management strategies to enable grief discussions. This included, for example:

- Pushing back other appointments if they needed more time with a bereaved patient;
- Blocking out unavailable times in case consultations went overtime;
- Scheduling another consultation with the bereaved patient;
- Making follow-up phone calls to check in on a bereaved patient;
- Pre-emptively scheduling longer appointments for a bereaved patient;
- Sacrificing breaks or working overtime.

However, some staff felt under so much time pressure they simply wanted to move on to the next patient, as this GP explained:

> I'm busy and I've got to see the next person. I don't want to sit here talking about grief for the next 25 minutes. If I can get it all over and done within five minutes that would make my life a whole lot easier. So, there's a bit of a conflict between me and them in those situations. (GP1)

Theme 4. Knowledge and awareness

Primary care staff reported identifying grief and providing bereavement support was not part of their medical/nursing education. Instead, their skills were acquired by learning on the job or observing others, as this GP discussed:

> It's just something you pick up along the way. It should be something that's taught. (GP7)

Gaps related to four main topics: (1) Knowledge of prolonged grief; (2) Differentiating grief from depression, (3) Awareness of ageist stereotypes, and (4) Knowledge of support services and resources. Very few participants had heard of prolonged/complicated grief or could define it. For example, one GP suggested complicated grief may occur when the circumstances of the death are complicated by family conflict or complex health conditions. Estimates of when prolonged grief should be diagnosed ranged between six weeks to over two years. Grief and depression were seen as similar conditions that primary care staff struggled to tell apart. These challenges in differentiating grief from depression can prevent adequate treatment.

Some healthcare providers also expressed ageist assumptions, e.g., that older people were well prepared to deal with grief because they had encountered so many bereavements throughout their lives or implying that depression is a common and normal part of aging. These ageist stereotypes can prevent older people from seeking and finding the right support.

Finally, some GPs and nurses were unsure which bereavement support services were available. One nurse said: *"Other than offering a counsellor, I don't even know if there is any bereavement support ... Some local councils have seniors groups but I don't know if there's actual grief support." (Nurse2)*. When interviewees were given a list of resources with information about Australian grief services after the interview, some acknowledged they had never heard of these national services before. For example, one GP said: *"It was interesting hearing you say about the bereavement services, how could we get those, because that made me realise that actually I'm not really aware of any bereavement services." (GP6)*. Support groups, online resources, alternative therapies and self-care measures like mindfulness, relaxation or acupuncture were rarely considered because practitioners were unaware of what was available and how to access it.

Discussion

This is the first study to use a combination of creative research poems and direct interview quotes to create unique insights into grief in

older adults from the perspective of primary care staff. Our findings reemphasize that older people are more likely to encounter bereavement- and non-bereavement-related losses than most other age groups (Goveas & Shear, 2020). Their frequent exposure to grief and loss should put them at the center of bereavement support services but this is not the case. Instead, as found in previous studies (Ghesquiere et al., 2014; Pearce et al., 2021), primary care providers were uncertain about how to best support bereaved people and bereavement care was often inconsistent and variable.

In particular, primary care providers struggled to differentiate grief from depression. Shear (2012) warned: "We do not want to diagnose grief as depression. Nor do we want to diagnose depression as grief." (p.463). Prolonged grief is directly connected to a bereavement and can be characterized by a persistent yearning for the deceased, preoccupation with the deceased, difficulty accepting the loss and feelings of shock or apathy centered around the bereavement (American Psychiatric Association, 2022; Boelen et al., 2010). In contrast, depression is more generalized and can emerge independent of a bereavement. This may include feelings of diminished joy, unhappiness, worthlessness, and low energy (Boelen et al., 2010). Of course, the stress of bereavement can trigger depressive symptoms or other psychiatric/medical conditions and clinicians need to be aware of these problematic responses to loss (Shear, 2012). Concurrently, healthcare providers need to be attuned to a well-established unconscious bias that perceives depression as a normal part of aging, which is an ageist assumption that can hinder timely and adequate care (Polacsek et al., 2020; Temple et al., 2021). Providers need to guard against the notion that older people are more resilient and less in need of bereavement services just because they have more exposure to death and bereavement; the opposite may well be the case, given that later life is associated with diminished social circles and supports, frailty, dependence on others, and major life events (De Leo, 2018), all of which have been amplified by the disproportionate impact of the COVID-19 pandemic on older people (Goveas & Shear, 2020).

Where complicated grief is identified, psychotherapeutic interventions are an effective first-line treatment to facilitate gradual acceptance of grief and overcoming of painful emotions (Shear et al., 2014; Supiano & Luptak, 2013). Primary care staff are often the first point of contact and gatekeepers to the healthcare system and the system therefore depends on them directing patients to relevant services. Yet, the present study showed how communication, access, time, and knowledge gaps hinder these processes, supporting that GP consultations may be a missed opportunity to identify and respond to grief in older adults. At the same time, practice and community care nurses can play an important role in supporting grieving older adult. Research from nursing care in residential and home care settings shows that nurses can play a profound role in validating older people's experience, listening to their life stories, and learning about their expectations, wishes, and fears (Van Humbeeck et al., 2020). Harnessing these important nursing skills in primary care is important given the identified access issues to specialist counseling services including cost, waiting times and availability of mental health support, especially in rural areas. These barriers must be addressed on a policy- and system-level, but in the interim, primary care staff need to be informed of freely available support services that exist in their country such as Grief Australia (Grief Australia, 2023) or At a Loss in the UK (At a loss, 2023). Non-specialist support like community groups or faith-based organizations could also be suggested to older patients who are reluctant to seek formal support.

Strengths and limitations

Comparing these research poems to those derived from bereaved older adults (Gerber et al., 2022), we reflect that the tone of poems from GPs and nurses is much more medical, distanced, practical and less emotive than the first-hand grief poems of older patients. This is unsurprising given that primary care staff were interviewed in their role as healthcare professionals and consequently responded using vocabulary, tone and syntax suited to their specialized role. These poems provide rare insights into the experiences of GPs and nurses using immersive language, metaphors, humor, and personal reflection. Such forms of data offer a dynamic and engaging way to

raise awareness among healthcare professionals about bereavement care for older people.

Other strengths of the study include a robust analytic approach underpinned by theory, literature and cross-checking by multiple researchers, including a consumer, as well as interview participants themselves. While relatively small, the sample size was deemed sufficient to reach adequate information power (Malterud et al., 2016) and answer the research objectives. We noted that all interviewed nurses were female, which reflects the gender distribution in nursing occupations. A volunteer bias also must be considered as GPs and nurses who agree to be interviewed for a study on grief in older adults may be more interested/educated in the topic than a random general practice cohort. It can therefore be argued that knowledge gaps on prolonged grief, bereavement, and aging-related challenges may be even more pronounced in a random sample of GPs and nurses.

Clinical implications

Based on the presented findings, the following suggestions are made to improve bereavement support for older people in primary care:

Timely assessment and documentation

Patients' bereavement experiences, grief symptoms and support needs must be assessed and clearly documented in clinical notes to enable effective team communication and patient follow-ups. Especially accurate assessments of prolonged grief disorder require additional training. Primary care staff must be allowed time for these important, yet neglected discussions. Limited remuneration for GPs to undertake mental health assessments may increase time pressure and negatively affect quality of care and patient outcomes (Vu et al., 2021). Validated screening tools like the 13 item Prolonged Grief Disorder Revised (PG-13-R) could be used to prompt discussions about grief and bereavement during consultations (Prigerson et al., 2021). Future research should investigate how often such tools are used in primary care and whether they benefit practitioners and patients.

Destigmatisation

The taboos around mental health, death and grief must be addressed and destigmatized to improve the acceptability of counseling services among older patients. On a clinic level, availing of mental health services could be reframed as something done for one's wellbeing, which does not imply the presence of mental illness. Support through mental health nurses may also increase acceptability of services. On a practitioner level, healthcare providers need to reflect on their own assumptions on aging and grief to carefully examine whether their personal biases affect the support they provide. On a policy level, public awareness campaigns and support services should specifically target older adults to address the stigma of seeking mental health support.

Targeted training

Primary care staff require access to tailored training on grief, age-, culture- and gender-specific needs and support resources for older people. This should be embedded in their medical/nursing education and become part of regular professional development. Training should particularly include the diagnostic criteria of prolonged grief disorder and the difference to major depressive disorder. This training should include both GPs and GPNs.

These clinical implications can be summarized as follows:

- Assessing and documenting patients' bereavement experiences and grief symptoms may enable more effective team communication and patient support in primary care.
- Destigmatizing counseling following a bereavement may help to make mental health referrals more acceptable to older patients.
- Continued training on grief – both normal grief reactions and prolonged grief disorder – is needed for GPs and GPNs to facilitate timely support.

Conclusions

Older adults require access to tailored support that address their experiences of repeated exposure to

loss, cumulative grief, physical symptoms that mask underlying mental health challenges and reluctance to access professional counseling. Support services also need to be age- and culturally appropriate to address ageism and stigma surrounding mental health. Training for primary care staff on prolonged grief disorder may enable more timely recognition and treatment of bereavement complications and their associated physical and mental health consequences for older patients. Additional funding and resources should be provided to primary care, e.g. for skill development, nurse-led interventions, and mental health assessments to enable this critical support.

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Data availability statement

De-identified data can be made available upon reasonable request.

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