Bereavement, Complicated Grief, and *DSM*, Part 2: Complicated Grief

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The Case of Ms B

Ms B is a 65-year-old woman who comes for an evaluation because she isn't getting past her intense grief over her deceased husband, who died of a myocardial infarction 4 years ago. Ms B is tearful, recalling how wonderful her husband was, that he was her soulmate, and that he loved her in a way no one else ever did. Although she thinks about her husband daily, she avoids looking at pictures, visiting the gravesite, or even going to places they used to enjoy together to try to ward off the intense bouts of misery these reminders provoke. At times, she seems angry, stating emphatically that he shouldn't have died. She is plagued by thoughts about the doctors who did not diagnose the impending heart attack. Even though she knows that it is irrational, she can't get the idea out of her mind that his doctor should have suspected that he had blocked arteries during a routine visit 1 week prior to his death and done something to save him. She often neglects to take her hypertension medication, knowing that this could be dangerous, and agrees that she is leaving life and death to chance. Religion used to be a source of comfort, but she no longer attends church regularly or finds companionship or support from the church community. Ms B maintains that no one can help her because no one can bring her husband back.

Many clinicians don't know quite what to make of Ms B's continued suffering. Her symptoms clearly reflect grief, yet the excessive avoidance and preoccupation with thoughts that her husband need not have died and the persistence of intense acute grief symptoms over a 4-year period seem atypical. She has some mood symptoms, but does not meet criteria for major depressive disorder (MDD). Her avoidance behaviors and preoccupation with her husband's death resemble the symptoms of PTSD, but the focus of her thoughts is related to her loss rather than reexperiencing a dangerous event, and she feels sadness rather than fear. She does not meet criteria for posttraumatic stress disorder (PTSD). Her grief symptoms have not changed much since her husband died 4 years ago. She and her family feel she is stuck in her grief. Does she have a definable, serious, treatable disorder? Not according to the *DSM-IV-TR*.[1] The rest of this review will describe the syndrome of *complicated grief*, a condition that describes Ms B's state and that also requires a specific, targeted treatment.

The Central Dilemma

Bereavement is an inevitable fact of life, and grief is the natural reaction to bereavement. It is the price we pay for love and attachment.[2,3] No one wants to medicalize a normal, adaptive process, nor, conversely, does anyone wish to needlessly prolong agony or increase risk for morbid outcomes by ignoring clinically significant, treatable depressive symptoms. Sometimes, the progress of grief is impeded and people suffer a form of grief that remains distressing and impairing for a prolonged period of time. The challenge is in knowing how to recognize and appropriately treat complicated grief. The absence of a *DSM* diagnosis for complicated grief, while safeguarding against stigma, puts certain bereaved individuals at risk by institutionalizing misdiagnoses and discouraging sufferers from obtaining treatment. This review summarizes the rationale for including complicated grief as a diagnosis in *DSM-V*.

Definitions

The terms *bereavement* and *grief* are used inconsistently in the literature to refer to either the state of having lost someone to death or the response to such a loss. Researchers have suggested that the term *bereavement* be used to refer to the fact of the loss. The term *grief* is then used to describe emotional, cognitive, and behavioral responses to the death. Manifestations of grief vary from person to person and from moment to moment and involve all aspects of the bereaved's being. The term *grief* is often used more broadly to refer to the response to other kinds of loss; people grieve the loss of their youth, of opportunities, of functional abilities and a myriad of other misfortunes. Complicated grief, sometimes referred to as *prolonged*, *unresolved,* or *traumatic* grief, is the current designation for a syndrome of prolonged and intense grief that is accompanied by complications that derail the progress of grief and is associated with substantial impairment in work, health, and social functioning.

Bereavement and Adaptive Grief

Bereavement has been described as one of the most gut-wrenchingly painful experiences an individual ever faces. Shock, anguish, loss, sadness, sorrow, yearning, anger, guilt, regrets, anxiety, fear, intrusive images, depersonalization, feeling overwhelmed, and loneliness are some of the symptoms bereaved people experience. Specific features and their evolution over time are unique for each person and for each episode. It is normal for these feelings to fluctuate in their expression and intensity over time, or to be absent at times. Feelings of anguish and despair may seem ever-present immediately after the loss, or they may occur in pangs or bouts of grief brought on by internal or external reminders of the deceased. Healthy, well-adapted people may never have experienced such an emotional roller coaster before and may find the intense, uncontrollable emotionality of acute grief disconcerting or shameful. But grief is not only about pain. For most people, painful experiences and memories are intermingled with positive feelings,[4] such as relief, peace, and happiness, which foster resilience.

Coming to terms with the death of a loved one is a difficult process that progresses in fits and starts. For the majority of bereaved individuals, acute grief symptoms gradually subside as the reality and finality of the loss are grasped, and the individual experiences restored interest and enjoyment in ongoing life. The hallmark of adaptive grief is its evolution over time associated with the capacity to engage in meaningful activities and to enjoy the companionship and love of others. The time period during which these goals are achieved has not been definitively established, but most experts agree that progress is usually apparent by 6 months. Grief is never completed but gradually recedes into in the background as a person goes about his or her life.[3,5] Even in this subdued state, intense grief symptoms may emerge periodically during certain times throughout the calendar year, sometimes called "anniversary reactions."[6]

Most people adjust to even the most difficult losses, generally with support of close friends and family. There is no evidence that uncomplicated grief requires formal treatment or professional intervention. For most bereaved individuals, the arduous journey through grief will ultimately culminate in adjustment to a life without their loved one. For some, new capacities, wisdom, unrecognized strengths, meaningful relationships, and broader perspectives emerge in the aftermath of loss. Certainly, if someone struggling with uncomplicated grief seeks help, they should have access to empathic support and information that validates that their response is typical after a loss. When support, reassurance, and information generally provided by family, friends, and, sometimes, clergy are not available or sufficient, mutual support groups may help fill the gap. Support groups can be particularly helpful after traumatic losses, such as the death of a child, a suicide, or deaths from other "unnatural" causes.

For a significant minority, grief is complicated by rumination or excessive avoidance that derails the progress of grief. The result is that acute grief is prolonged by the failure to integrate the reality of the death into autobiographic memory or to restore satisfaction in ongoing life. Available evidence and clinical experience support that people with complicated grief reactions require clinical attention and specific treatment interventions. Without intervention, complicated grief can be chronic and persistently disabling.

Complicated Grief

The syndrome of complicated grief is characterized by continued severe separation distress and by the dysfunctional thoughts, feelings, or behaviors related to the loss that complicate the grief process. Symptoms of separation distress include intense yearning—a persistent, strong desire to

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Table 1. Proposed Criteria Set for Complicated Grief

A. The person has been bereaved, ie, experienced the death of an important person, for at least 6 months
B. There is continued intense separation distress as manifest in 1 or more of the following ways:
   1. Intense yearning or overwhelming desire to be with the person again
   2. Inability or refusal to accept the death
   3. Frequent thoughts or images of the deceased
   4. Frequent compulsion to see, touch, or smell things to try to feel close to the deceased person, including a persistent wish to die in order to find or to join the deceased loved one
C. Distressing thoughts, dysfunctional behaviors, or emotional responses related to the loss, as indicated by at least 3 of the following:
   1. Frequent troubling thoughts (eg, rumination) about circumstances or consequences of the death
   2. Frequent intense feelings of anger or bitterness
   3. Disturbing emotional or physiologic reactivity to reminders of the loss
   4. Excessive avoidance of reminders of the loss
   5. Isolation or estrangement from others who seem hostile or not empathic
   6. Excessive confusion or uncertainty about one's role in the world since the loved one died
   7. Belief that life is empty, meaningless, or unbearable because this person has died
   8. Belief that joy and satisfaction are no longer possible because of the death
D. The duration of the disturbance (symptoms in criteria B and C) is more than 1 month
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

be with the deceased—and by the inability or refusal to accept the death, preoccupation with thoughts or images of the person who died, and compulsive proximity-seeking (eg, keeping reminders of the person who died close by). Complicating features include ruminating about circumstances or consequences of the loss,[3,5,7] unrelenting anger or bitterness, intense physical or emotional reactivity to reminders, avoidance of reminders, social estrangement, feeling lost and unfocused, and believing that ongoing life is now empty and meaningless and that joy is no longer possible. We draw attention to the fact that all patients with complicated grief should be carefully assessed for suicidality. Suicidal thoughts are very common in complicated grief and are of concern as suicide attempts also occur. Suicidal urges are usually related to hopes of finding or joining the deceased loved one or feeling that life without the deceased person is unbearable.

The 19-item Inventory of Complicated Grief[8] is a good screening instrument for complicated grief. Many studies have found a score of ≥ 25 to predict a range of negative health outcomes.[8] In addition, specific diagnostic criteria for complicated grief have been proposed.[9–11] Table 1 provides one such proposal, stemming from the authors' review of the literature and extensive experience with over 300 participants in treatment studies of complicated grief.

Complicated grief occurs in about 10% of bereaved individuals, usually among individuals with a close, identity-defining relationship to the person who died. Risk may be increased among those with a history of mood or anxiety disorder, and possibly following a violent death or suicide.[2] Overall, complicated grief has a recognizable symptom profile that is associated with ongoing suffering and distress, functional impairment, psychobiological dysfunction, and medical morbidity.[12,13] Bereaved individuals with symptoms of complicated grief at 6 months may be at increased risk for increases in smoking, eating, depression, and high blood pressure by 13 months; by 25 months, they may be at an increased risk to develop new-onset cardiovascular or neoplastic disease.[2,5,13] In addition, complicated grief has been associated with a high rate of suicidal ideation, a history of suicide attempts, and indirect suicidal behavior not explained by co-occurring MDD and with elevated rates of lifetime suicide attempts in bipolar patients.[12] Potential biologic markers have been identified.[14] Once established, complicated grief tends to be chronic and unremitting if left untreated. Clearly, complicated grief must be taken seriously and treated appropriately.

Complicated grief can be differentiated from "normal," adaptive grief, MDD, and PTSD in a number of ways including differential response to treatment.[13,15,16] There is evidence that complicated grief responds very differently from depression to interpersonal psychotherapy and that it can be effectively treated using strategies and techniques that specifically target the syndrome of complicated grief.[15] Complicated Grief Therapy utilizes a dual focus on coming to terms with the loss and restoring the capacity for pleasure and satisfaction in ongoing life and contains elements of interpersonal therapy, cognitive-behavioral therapy, and motivational interviewing. The role of medications is not clear, but there is preliminary evidence that antidepressant medications may provide some relief[15–18] and may augment Complicated Grief Therapy.[16]

Summary and Recommendations

On the basis of the evidence reviewed here, we recommend that *DSM-V* include complicated grief as a new disorder. Furthermore, we recommend that the V-code bereavement should not be used when symptoms can be better explained by MDD, adjustment disorder, PTSD, or complicated grief. A full description of the features and course of ordinary grief that is healthy, adaptive, and "within normal limits," as distinct from complicated grief, and the phenomenological distinctions between grief-related dysphoria and dysphoria associated with MDD would be more useful than the current V-code.

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doi:10.4088/JCP.10ac06391blu

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