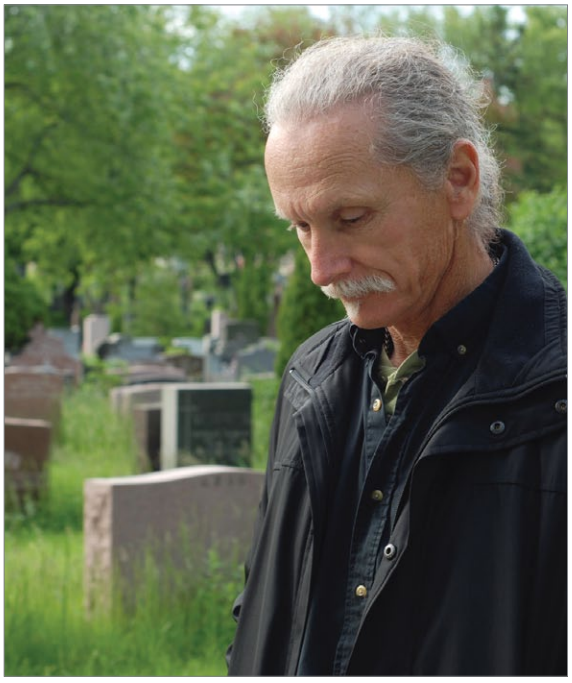
Current PSYCHIATRY

Web audio at CurrentPsychiatry.com

Dr. Marques: How to distinguish complicated grief from 'normal' grief

Recognizing and treating complicated grief



© CRIS KELLY

Donald J. Robinaugh, MA
Clinical Fellow, Department of Psychiatry
Massachusetts General Hospital

Luana Marques, PhD
Assistant Professor
Harvard Medical School
Department of Psychiatry
Massachusetts General Hospital

Eric Bui, MD, PhD
Research Fellow, Department of Psychiatry
Massachusetts General Hospital

Naomi M. Simon, MD, MSc
Associate Professor
Harvard Medical School
Director, Center for Anxiety and Traumatic Stress Disorders
Director, Complicated Grief Program
Department of Psychiatry
Massachusetts General Hospital

. . . .

Boston, MA

Timing and severity of symptoms can help identify this distinct syndrome

Nearly 2.5 million persons die each year in the United States.[1] For the bereaved, these deaths may be among the most painful and disruptive events they will experience. In this article, we evaluate the growing body of research on complicated grief (CG)—which also has been called prolonged grief, chronic grief, traumatic grief, and pathological grief—with an emphasis on how to identify CG and distinguish it from other adaptive and maladaptive reactions to the loss of a loved one. In addition, we review empirical evidence on treating CG, including psychotherapy, pharmacotherapy, and combined treatment approaches.

The bereavement-specific syndrome we refer to as CG currently is being reviewed for possible inclusion in DSM-5 as an official diagnosis. At press time, proposals for DSM-5 included a bereavement-related adjustment disorder within the new Trauma- and Stressor-Related Disorders category, as well as a provisional diagnosis of CG entitled Persistent Complex Bereavement-Related Disorder, which, upon acceptance, would be listed in Section III.[2]

What is 'normal' grief?

Grief is highly variable across individuals and time and may range from an absence of distress to severe and persistent pain and anguish. There's no simple definition of "normal grief." However, as clinicians, it's necessary to understand the range of usual reactions. We recommend 2 considerations when evaluating grief reactions.

First, be aware that grief encompasses a range of cognitions, emotions, and behaviors. It may range from a relative lack of painful thoughts and emotions to intense and disrup-

tive sadness, loneliness, anger, guilt, intrusive thoughts, difficulty concentrating, preoccupation with loss, social withdrawal, and a sense of being overwhelmed by the loss and its consequences. In the months after a loss, bereaved individuals may look for the deceased in a crowd, speak to them, or even experience auditory or visual hallucinations of the deceased. Nonetheless, positive feelings such as relief, peace, and happiness also are common following a loss.[3] Moreover, laughter and smiling when discussing a lost loved one predicts reductions in grief symptoms over time.[4] Overall, grief research suggests that, far from proceeding along standard and uniform stages,[5] grief is complex and comprises a broad spectrum of thoughts, feelings, and behaviors that vary within and among individuals.

Second, note that in the absence of complications, grief progresses. For those who experience elevated levels of distress, the pain and disruption of loss initially may feel overwhelming but will subside in intensity over time for most individuals.[5] This is not to say that an individual will never again feel sadness or longing for the deceased; elements of grief are likely to remain. Although the trajectory of grief symptoms varies among individuals and may progress in fits and starts, over time grief becomes more intermittent, less interfering, and is balanced with a sense of interest and purpose in life.

What is CG?

As research on grief experiences has grown, there's increasing recognition that a minority of bereaved individuals experience more extreme grief symptoms that cause substantial, persistent distress and impairment despite the passage of many months or years. Shear et al[6] proposed a set of CG diagnostic criteria (***Table, page 33***) in which a cluster of symptoms of intense and persistent separation distress are defined as core symptoms. Similar to other psychiatric diagnoses, the symptoms must be associated with significant distress or impairment.

Assessing CG symptoms

Among those with persistent elevated distress, a CG diagnosis must be considered in the context of the individual's social and cultural environment, time since the loss, and duration of symptoms. The hallmark symptom of CG is separation distress with a focus of cognitive, behavioral, and emotional symptoms on the loss and its consequences. CG is associated with substantial distress, functional impairment, and an increased risk for suicide. See this article at CurrentPsychiatry.com for a case study.

Many individuals with CG remain undiagnosed and untreated for years despite high levels of distress and impairment and high risk for negative consequences such as suicide.[7] Accordingly, there's a need for greater CG screening. Clinically useful tools for assessing CG include a brief, 5-item dimensional screening assessment[6] and the patient-rated Inventory of Complicated Grief.[8]

Distinguishing complicated and uncomplicated grief. Exhibiting CG symptoms in the first several months after a loss does not mean an individual has or will develop CG. Most bereaved adults report painful thoughts and emotions in the weeks and months following the loss, including distressed yearning, waves of intense grief, persistent and intrusive thoughts, images related to the death, somatic distress, and a feeling of being disconnected from others. For most individuals, the intensity of this response diminishes within 6 to 18 months after the loved one's death.[5] Although the optimal length of time to wait before establishing a diagnosis remains debatable, the earliest CG should be diagnosed is 6 months after a loss.

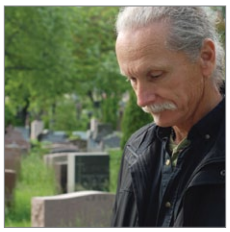
It's common for grief to occasionally rise in intensity for days or weeks. This surge may occur many months or years after the loss, even in people who exhibited relatively little distress or impairment. In particular, anniversaries, holidays, or periods of stress may trigger increased grief intensity. However, these surges typically subside naturally within a short time. Accordingly, CG should be diagnosed only when symptoms persist for >1 month.

CG vs other post-loss disorders. CG, major depressive disorder (MDD), and posttraumatic stress disorder (PTSD) often are comorbid in bereaved adults. Simon et al[9]

Clinical Point

A minority of the bereaved experience extreme grief symptoms that cause substantial distress and impairment

See this article at CurrentPsychiatry.com for a case study of a patient with complicated grief



Complicated grief

found 72% of CG patients in a treatment-seeking sample reported a lifetime history of MDD and 53% reported a lifetime history of PTSD. However, CG can be distinguished from these disorders. In the same study, 25% of CG patients had no other axis I diagnosis.[9] After accounting for comorbid disorders, researchers associated CG severity with work and social impairment. These findings provide clear evidence for the incremental validity of CG—ie, a CG diagnosis gives clinicians additional information that predicts impairment above and beyond other disorders. However, future research needs to further examine CG and its overlap and differentiation from MDD and PTSD.

Distinguishing CG and MDD. Intense yearning or preoccupation with the deceased is a common symptom of CG but not MDD. In addition, CG symptoms possess intentionality. For example, emotional distress such as sadness and anger are prominent features of both CG and MDD. However, in CG, these symptoms are specific to the loss or circumstances of the loss, whereas in MDD they generally are more nebulous and generalized. Similarly, CG entails proximity seeking related to the deceased, and avoidance of reminders of the deceased, whereas MDD includes a more general social withdrawal and anhedonia.

Distinguishing CG and PTSD. CG and loss-related PTSD are distinguished by the predominant emotions and focus of concern associated with each disorder. The predominant emotion in PTSD is fear, whereas in CG it is sadness and longing. In PTSD, intrusive thoughts and memories associated with the trauma generally are associated with the event itself and produce an ongoing sense of threat.[10] Avoidance in PTSD is intended to reduce this threat feeling. By contrast, in CG, intrusive memories focus on the deceased or the circumstances of the death, and avoidance is aimed at preventing painful reminders of the loss or its permanence. Importantly, both syndromes may be present.

Clinical Point

CG, MDD, and PTSD often are comorbid in bereaved adults; however, CG can be distinguished from these disorders

Treating CG

When is treatment indicated? For years, bereavement theorists emphasized the need to work through emotions and memories related to the deceased with particular focus on negative material. However, evidence suggests that universal application of treatment to all bereaved individuals is unhelpful. In a recent meta-analysis, Neimeyer et al[11] found that the outcomes of grief therapy applied indiscriminately to all bereaved adults or all members of high-risk populations—such as parents whose child experienced a violent death—were no better than would be expected by the passage of time. In contrast, grief therapy applied only to those who develop elevated and persistent distress (eg, CG) led to greater and more enduring improvement in post-loss distress than was observed in control conditions.

These results suggest that most grieving individuals who do not meet criteria for CG (or other psychiatric disorders) will not require intervention. Those who do seek treatment for grief-related distress in the acute grief period should be assessed for bereavement-related depression, anxiety, and suicidality, and treated or referred to professional or community-based resources for support or counseling as clinically indicated.

Evidence for psychotherapy. For those who meet CG criteria, psychotherapy targeting the specific symptoms of CG is helpful. The evidence is strongest for CG treatment (CGT), a 16-session, manualized psychotherapy developed by M. Katherine Shear, MD.[12] CGT is based on an attachment model and cognitive-behavioral therapy (CBT) principles, and is informed by the dual-process theory proposed by Stroebe et al.[13] According to this theory, natural healing following loss comprises 2 processes:

- a loss-oriented process in which the patient comes to terms with the loss, and
- a restoration-oriented process in which the patient reinvigorates a sense of purpose and meaning in life without the deceased.

CGT focuses on both processes. To address the former, it includes clinician-guided exercises in which the patient revisits the time of the death and planned activities in which the patient reengages with people, places, or thoughts that remind him or her of

Table

Proposed diagnostic criteria for complicated grief

Symptom domain	Criteria
Separation distress	The patient has ≥1 of the following 4 symptoms:
	1) Persistent, intense yearning or longing for the deceased
	2) Frequent feelings of intense loneliness or emptiness
	3) Recurrent negative thoughts about life without the deceased or recurrent urge to join the deceased
	4) Preoccupying thoughts about the deceased that impair daily functioning
Thoughts	The patient has ≥2 of the following 8 symptoms:
	1) Rumination about circumstances of the death
	2) Frequent disbelief or inability to accept the death
Feelings	3) Persistent feeling of being shocked, stunned, or emotionally numb since the death
	4) Recurrent feelings of anger or bitterness regarding the death
	5) Difficulty trusting or caring about others since the loss
	6) Experiencing pain or other somatic symptoms the deceased person had, hearing the voice of the deceased, or seeing the deceased person
	7) Intense emotional reactions to memories of the deceased
Behaviors	8) Excessive avoidance or excessive preoccupation with places, people, and things related to the deceased or death

Source: Adapted from reference 6

the deceased. CGT aims to allow the patient to gain an increased tolerance of the distressing thoughts and emotions associated with the loss so that these thoughts can be processed and the finality of the death and its circumstances can be accepted.

The restoration process is addressed by having patients generate and discuss personal goals and aspirations for the near and distant future, as well as scheduling pleasurable and rewarding events. This is accomplished by having patients imagine what they would want for themselves if their grief was less intense and planning concrete steps to take toward these goals. The restoration-oriented process is addressed concurrent with the loss-oriented process to encourage the oscillation between processes thought to be characteristic of a natural healing process following the loss of a loved one.

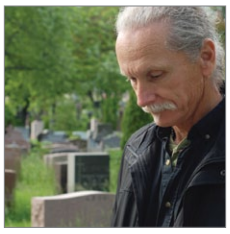
Other psychotherapy approaches (eg, support groups) may have a role for some individuals, and future research may suggest alternative approaches to CGT. To date, CGT is the most targeted evidence-based psychotherapy with randomized controlled data supporting its use in CG.

Pharmacotherapy for CG. Early research suggested that antidepressants—in particular tricyclics—may effectively reduce depressive symptoms in bereavement-related depression; their effect on CG symptoms, however, may not be as strong.[14] Research on pharmacologic treatment that targets CG symptoms is developing. Because of the overlap between CG, PTSD, and MDD, researchers have hypothesized that antidepressants may be effective. Two open-label studies reported that the selective serotonin reuptake inhibitor (SSRI) escitalopram may be effective for CG.[15,16] Although a post-hoc comparison of paroxetine and nortriptyline[17] showed significant reduction in CG and depressive symptoms with both agents, effects could not be separated from concomitant psychotherapy. Furthermore, an examination of naturalistic data on combining antidepressants with CGT suggested that antidepressants may improve outcomes for individuals receiving CGT.[18] A multicenter, randomized controlled trial funded by the National Institute of Mental Health is examining the potential efficacy of citalopram, an SSRI, alone or in combination with CGT.[19]

continued

Clinical Point

Most grieving adults who do not meet criteria for complicated grief will not require treatment



Complicated grief

Clinical Point

Evidence is strongest for CG treatment, a manualized psychotherapy based on an attachment model and CBT principles

Related Resources

- Center for Anxiety and Traumatic Stress Disorders. Massachusetts General Hospital. www.bostongrief.com.
- Zisook S, Shear K. Grief and bereavement: what psychiatrists need to know. World Psychiatry. 2009;8(2):67-74.
- Bonanno G. The other side of sadness: what the new science of bereavement tells us about loss. New York, NY: Basic Books; 2009.

Drug Brand Names

Citalopram • Celexa
Escitalopram • Lexapro
Nortriptyline • Aventyl, Pamelor
Paroxetine • Paxil

Disclosures

Mr. Robinaugh and Drs. Marques and Bui report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Dr. Simon receives grant or research support from the American Cancer Society, the American Foundation for Suicide Prevention, the Department of Defense, Forest Laboratories, and the National Institute of Mental Health.

The efficacy of benzodiazepines, which commonly are prescribed for bereaved individuals, has not been assessed in CG. However, recent research suggests they may not be useful for medically managing recent grief[20] and that their use in the aftermath of a loss may lead to long-term dependence in geriatric patients.[21]

References

1. Kochanek KD, Xu J, Murphy SL, et al; U.S. Department of Health and Human Services. Deaths: preliminary data for 2009. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_04.pdf. Published March 16, 2011. Accessed June 19, 2012.
2. American Psychiatric Association. Trauma- and stressor-related disorders. http://www.dsm5.org/ProposedRevision/Pages/TraumaandStressorRelatedDisorders.aspx. Accessed June 19, 2012.
3. Bonanno GA, Kaltman S. Toward an integrative perspective on bereavement. Psychol Bull. 1999;125(6):760-776.
4. Bonanno GA, Keltner D. Facial expressions of emotion and the course of conjugal bereavement. J Abnorm Psychol. 1997;106(1):126-137.
5. Bonanno GA, Wortman CB, Lehman DR, et al. Resilience to loss and chronic grief: a prospective study from preloss to 18-months postloss. J Pers Soc Psychol. 2002;83(5):1150-1164.
6. Shear MK, Simon N, Wall M, et al. Complicated grief and related bereavement issues for DSM-5. Depress Anxiety. 2011;28(2):103-117.
7. Boelen PA, Prigerson HG. The influence of symptoms of prolonged grief disorder, depression, and anxiety on quality of life among bereaved adults: a prospective study. Eur Arch Psychiatry Clin Neurosci. 2007;257(8):444-452.
8. Prigerson HG, Maciejewski PK, Reynolds CF 3rd, et al. Inventory of Complicated Grief: a scale to measure maladaptive symptoms of loss. Psychiatry Res. 1995;59(1-2):65-79.
9. Simon NM, Shear KM, Thompson EH, et al. The prevalence and correlates of psychiatric comorbidity in individuals with complicated grief. Compr Psychiatry. 2007;48(5):395-399.
10. Brewin CR, Holmes EA. Psychological theories of posttraumatic stress disorder. Clin Psychol Rev. 2003;23(3):339-376.
11. Neimeyer RA, Currier JM. Grief therapy: evidence of efficacy and emerging directions. Curr Dir Psychol Sci. 2009;18(6):352-356.
12. Shear K, Frank E, Houck PR, et al. Treatment of complicated grief: a randomized controlled trial. JAMA. 2005;293(21):2601-2608.
13. Stroebe M, Schut H. The dual process model of coping with bereavement: rationale and description. Death Stud. 1999;23(3):197-224.
14. Reynolds CF 3rd, Miller MD, Pasternak RE, et al. Treatment of bereavement-related major depressive episodes in later life: a controlled study of acute and continuation treatment with nortriptyline and interpersonal psychotherapy. Am J Psychiatry. 1999;156(2):202-208.
15. Simon NM, Thompson EH, Pollack MH, et al. Complicated grief: a case series using escitalopram. Am J Psychiatry. 2007;164(11):1760-1761.
16. Hensley PL, Slonimski CK, Uhlenhuth EH, et al. Escitalopram: an open-label study of bereavement-related depression and grief. J Affect Disord. 2009;113(1-2):142-149.
17. Zygmont M, Prigerson HG, Houck PR, et al. A post hoc comparison of paroxetine and nortriptyline for symptoms of traumatic grief. J Clin Psychiatry. 1998;59(5):241-245.
18. Simon NM, Shear MK, Fagiolini A, et al. Impact of concurrent naturalistic pharmacotherapy on psychotherapy of complicated grief. Psychiatry Res. 2008;159(1-2):31-36.
19. U.S. National Institutes of Health. A study of medication with or without psychotherapy for complicated grief (HEAL). http://clinicaltrials.gov/ct2/show/NCT01179568. Published June 24, 2012. Accessed June 25, 2012.
20. Warner J, Metcalfe C, King M. Evaluating the use of benzodiazepines following recent bereavement. Br J Psychiatry. 2001;178(1):36-41.
21. Cook JM, Biyanova T, Marshall R. Medicating grief with benzodiazepines: physician and patient perspectives. Arch Intern Med. 2007;167(18):2006-2007.

Bottom Line

Complicated grief (CG) is a loss-specific syndrome distinct from posttraumatic stress disorder and major depressive disorder. A type of manualized, targeted psychotherapy called complicated grief treatment effectively reduces CG symptoms. Uncontrolled data suggest antidepressants also may relieve symptoms.

Box

Unable to move on: A case study of complicated grief

Mr. C, age 67, presents to a local emergency department (ED) with his daughter. His daughter reports that he has not been himself since his wife died in a car accident 2 years ago. He continues to live in the house he shared with his wife, despite not needing the extra space and being unable to maintain it. Although Mr. C and his daughter used to talk about her mother a great deal, she says she now tries to avoid the subject because it upsets him. More recently she became concerned when Mr. C began to tell her that his life was meaningless without his wife. He said he frequently thinks about taking his own life to end his pain and loneliness.

Mr. C tells the ED psychiatrist he feels an intense wave of grief and loneliness every morning when he realizes his wife is not with him. He often stays in bed for hours, longing for her and thinking about their time together. At times, he thinks he hears her voice downstairs but when he searches for her, she is not there. Mr. C has been unable to go through his wife's belongings, and feels nothing should be moved in their home. He will look at her photos, yet avoids other reminders of her (eg, partaking in their favorite hobbies, going to their favorite restaurants). He feels bitter and angry about his wife's death, and becomes agitated when describing the car accident that took her life. Mr. C feels guilty for not being with his wife when she died. He assures the psychiatrist that he loves his children, but says he feels increasingly distant from them and doesn't understand how they can move on after their mother's death.

Mr. C reports symptoms consistent with a diagnosis of complicated grief. Further assessment is appropriate to determine if his symptoms are severe enough to warrant treatment.