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Treating Complicated Grief

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Abstract

IMPORTANCE—The death of a loved one is one of life's greatest, universal stressors to which most bereaved individuals successfully adapt without clinical intervention. For a minority of bereaved individuals, grief is complicated by superimposed problems and healing does not occur. The resulting syndrome of complicated grief causes substantial distress and functional impairment even years after a loss, yet knowing when and how to intervene can be a challenge.

OBJECTIVE—To discuss the differential diagnosis, risk factors for and management of complicated grief based on available evidence and clinical observations.

EVIDENCE REVIEW—MEDLINE was searched from January 1990 to October 2012. Additional citations were procured from references of select research and review articles. Available treatment studies targeting complicated grief were included.

RESULTS—A strong research literature led to inclusion of complicated grief in the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) (termed persistent *complex bereavement disorder* as a subtype of other specified trauma and stressor-related disorders), although it is a condition for which more research is formally recommended, and there is still ongoing discussion about the optimal name and diagnostic criteria for the disorder. Reliable screening instruments are available, and the estimated prevalence rate is 7% of bereaved people. Randomized controlled data support the efficacy of a targeted psychotherapy including elements that foster resolution of complicating problems and facilitate the natural healing process. Preliminary studies suggest antidepressant medications may be helpful.

CONCLUSION AND RELEVANCE—Individuals with complicated grief have greater risk of adverse health outcomes, should be diagnosed and assessed for suicide risk and comorbid conditions such as depression and posttraumatic stress disorder, and should be considered for treatment.

DR BURNS Ms T is a 60-year-old woman whose husband was diagnosed with stage IV esophageal cancer and who died 9 months later. Although Ms T lost her mother as a teenager and her father and close friend more recently, nothing had prepared her for the loss of her husband. Ms T and her husband were inseparable through 28 years of marriage. They did not have children.

Ms T was emotionally paralyzed following the death of her husband. She began seeing a psychiatrist who recommended taking citalopram, 20 mg daily, and joining a survivor's support group. Although initially Ms T accepted these suggestions reluctantly, she ultimately concluded that they were helpful.

Ms T has no prior history of depression and denies any suicidal or homicidal ideation. On the 19-item Inventory of Complicated Grief assessment,¹ Ms T scored 48. A score of more than 30 is considered a cut point for identifying complicated grief for intervention.² Ms T reported that she thinks about her deceased husband so much that it's hard for her to resume her daily life. She feels herself longing for her deceased husband, and she has had a feeling of being lost since her husband died.

Ms T: Her View

He was diagnosed with a malignant tumor in his esophagus, but 2 days before he won the men's singles tennis championship at our club. He was in incredible physical condition. The most distressing part is we did everything together. Part of the problem was learning to breathe again, and another piece of it was trying to understand how someone so healthy and strong could have such an incredibly horrible diagnosis without any warning whatsoever. We were just completely unprepared. It is also hard not to feel like I failed him. He was in my care, but I could not save him.

My psychiatrist probably saved me. We did therapy sessions every single week, and she brought me to a bereavement counselor so that I was seeing each of them. We introduced citalopram, although I did it kicking and screaming.

I have to create a routine that I am not used to, and sometimes I am energized to do it and sometimes not. When I am faithful and I take my medication, then I feel a little more stimulated and able to do it. I am making myself available a bit more to get together with friends. I do not always know, however, on a given day what I am going to feel like, so I try not to plan too far out.

This journey has been a true test. I have never been to the point of wanting to do away with myself, but I have not wanted to be here without him. I keep grieving what he lost. I have not reached my loss yet. This is how each of us deals with the grief. I am not good at letting go, so it will be harder for me.

Overview of Complicated Grief

DR SIMON Nearly 2.5 million people die each year in the United States,³ so exposure to the death of a loved one is inevitable. The death of a close friend or relative remains one of the most intense, distressing, and traumatic events a person will experience.⁴ Acute grief includes a wide range of strong emotions, including shock or disbelief that the loved one is truly gone, intense separation distress, longing, and sadness. Bereaved individuals may become preoccupied with thoughts, memories, and images of the person and may focus predominantly on the loss, decreasing other activities for a time. Building on the work of Bowlby⁵ and Hofer,⁶ Shear and others have conceptualized bereavement as a significant

stressor or trauma to the attachment system, a psychological behavioral system hypothesized to provide a sense of emotional security and safety through close relationship bonds. As a result, the death of a loved one can lead to a range of initial symptoms of traumatic distress, separation distress, caregiver self-blame (with survivor guilt), and decreased engagement in life.⁷

There is, however, no single way to grieve. Grief and mourning are natural responses to loss that most people successfully navigate without clinical intervention. During the initial days to months after a loss, acute grief can vary in intensity, nature, and time course based on a combination of individual and loss-related factors, as well as cultural and religious factors. Because loss is forever, so too is the state of being bereaved, yet grief changes over time for the vast majority of individuals who ultimately adapt to the loss with a reduction in grief intensity and return to a revised but meaningful and satisfying life without the deceased. Far from a single path or stage progression, there are a wide range of experiences and longitudinal trajectories for responses to loss that can include a mix of positive and negative emotions, as well as oscillation between different states over time.^{8–11} Bonanno and colleagues,^{12,13} observed over 18 months an intensity of grief and depressive responses that range from consistently minimal, initially intense but subsiding, delayed but heightened over time, to chronically high or prolonged.

Although the precise length of time that marks acute grief remains debated, longitudinal studies^{13,14} have reported 6 to 12 months as marking a common period after which many will have moved through a natural mourning process to a less intense form of grief termed *integrated grief*, in which the reality and meaning of the death are assimilated with a return to ongoing life. In integrated grief, the deceased is not forgotten and some longing and sadness remain but these feelings are less intense or have moved from the center stage, except during periodically heightened periods around anniversaries, holidays, and other important reminders of the loss. There is an ability to achieve joy and return to meaningful relationships and activities. In integrated grief, the permanence of the loss and its life consequences are accepted, the relationship with the deceased is revised, and life goals and plans are adapted. Ms T has been unable to reach this state and continues to grieve acutely 16 months following her husband's death, almost as if the loss had just occurred.

Risk Factors for Complicated Grief

Common problems that complicate grief include intrusive thoughts about the circumstances of the death, excessive avoidance of reminders of the loss, and ineffective emotion regulation. Risk factors for these complications include a combination of pre-loss variables, loss-related variables, as well as peri-loss variables (Box 1).

Ms T's pre-loss risk factors for complicated grief include her sex, her history of multiple prior losses including her mother at age 17 years after a 7-year battle with illness, her best friend 17 years ago, and her father 2 years prior to her husband. Ms T has no children and describes her 28-year relationship as strong and identity-defining. Ms T's loss-related risk factors include the death of her husband of 28 years only 9 months after an unexpected cancer diagnosis. She was her husband's caretaker and advocate throughout his illness and

death but notes they chose to focus on aggressively treating his cancer, preferring not to discuss the negative prognosis together or with health care professionals. Ms T describes her response to her husband's death (*peri-loss*) as "emotionally paralyzing," with prominent shock and disbelief to the extent that she needed to "learn to breathe again." Thus, Ms T has a number of risk factors likely contributing to her persistent, unrelenting grief.

Identification and Clinical Assessment of Complicated Grief

Although not included in *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) (*DSM-IV*), growing evidence supports a persistent grief-related condition^{14,15}; complicated grief is estimated to occur in about 7% of those bereaved.¹⁶ Persistent grief has had various descriptions including pathological grief, traumatic grief, and prolonged grief. Although we use the term *complicated grief* for consistency in this manuscript, the condition is now included as Persistent Complex Bereavement Disorder in the *DSM's* fifth edition, Section III (Box 2). Section III includes conditions requiring more research, suggesting that criteria and even the name of this grief-related condition might change as research and clinical experience grow. To ensure that people who receive the diagnosis are severe enough to warrant clinical intervention, they must have high-distress levels or grief-related impairment persisting at least 12 months following the loss and have symptoms "out of proportion or inconsistent with cultural, religious, or age-appropriate norms." Complicated grief fits conceptually into the new *DSM-5* category of Trauma and Stressor-Related Disorders and is also referenced in this section as a subtype of other specified trauma and stressor-related disorders.

In complicated grief, the progress of adapting to and accepting the finality of the loss is complicated, slowed, or halted. Complicated grief symptoms include intense longing, intrusive preoccupation with the circumstances of the loss, self-blame, avoidance of thoughts or memories of the deceased, avoidance of previously shared activities, and inadequate adaptation to the loss. Complicated grief is associated with many negative outcomes including reduced quality of life, functional impairment, high-risk behaviors, increased rates of cardiovascular illness and cancer, sleep disturbance, and heightened suicidal ideation and behaviors even after adjustment for comorbid depression and posttraumatic stress disorder.^{7,30–37} There is a need to screen bereaved individuals for complicated grief and to perform safety risk assessments in those who screen positive.

Self-rated scales exist to assess for the presence of complicated grief. These include the 19-item self-rated Inventory of Complicated Grief.¹ Scores ranging from 25 to 30 are associated with significant symptoms. Scores higher than 30 have been used in treatment research.² Versions of the assessment can identify complicated grief in international samples,^{1,38,39} and the Inventory of Complicated Grief questions clustered together as a single group of symptoms in a diverse and predominantly treatment-seeking bereaved sample.⁴⁰ A 5-item tool, the Brief Grief Questionnaire, is also useful for initial screening and can be used in a primary care setting (Box 3).^{41,42}

Ms T was identified by her clinicians as likely experiencing complicated grief, now 16 months (>1-year minimum) after her husband's death. Her Inventory of Complicated Grief

score was 48, much higher than established cut points of 25 or 30. Ms T's grief has become "stuck" with persistent very high levels of distress and impairment, including emotional paralysis, feeling lost, and daily longing for and thinking about her deceased husband so much that daily activities are hard to accomplish. She has trouble seeing or planning a future beyond the day. It remains hard for her to believe that he is dead, and she still questions if she "did everything" she could to save his life. She feels that her life is empty and that it is unfair to live when her husband has died, suggesting an increased risk of suicide. Although she has started to take small steps to reconnect with others, she remains withdrawn from most of her prior activities and relationships, related to both work (now unemployed) and social life, and struggles to find purpose and manage household affairs. She notes she was so focused on trying to maintain hope and aggressively treat his cancer in the 9 months after his diagnosis, she really never had an opportunity to process the possibility or meaning of his death, a likely complication contributing to her development of complicated grief.

Differential Diagnosis of Complicated Grief

Bereavement is a stressor that can also trigger major depressive disorder, posttraumatic stress disorder (PTSD), and substance use disorders.^{43–45} Ms T's clinicians had to evaluate each of these diagnoses to establish her treatment plan. Similar to mood and anxiety disorders, complicated grief is a distinct diagnosis^{32,46,47} but can also complicate anxiety disorders, PTSD, and depression as comorbid conditions. For example, in a treatment-seeking sample of patients with complicated grief, 25% had no comorbid conditions; whereas concomitant comorbidities of major depressive disorder were present in 55% of patients, PTSD in 49%, and both major depressive disorder and PTSD in 36%.³⁵

Death of a loved one is a major stressor. Overlap exists between the persistence of acute responses to clearly defined stressors in complicated grief and PTSD associated with failure to adapt. Complicated grief may be considered as a PTSD-like stress response condition^{48,49} and, consequently, a postloss stress disorder.⁵⁰ Posttraumatic stress disorder and complicated grief are also different and thus require different treatment approaches. In PTSD, which may be diagnosed 1 month after a trauma, the prominent emotion is a persistent and overgeneralized learned fear. Interventions such as exposure-based psychotherapies can help individuals extinguish this fear and learn that they are not in danger in their current environment. In complicated grief, the prominent emotions are longing and sadness. Focusing on fear reduction is not clinically relevant. Because the loss is permanent, individuals are challenged with separation distress and adapting to life without their loved one. Ms T reports persistent shock and disbelief that her husband is dead. She has emotional numbing and feels stuck in a state of persistent unchanging, intense grief. She persistently avoids previously shared activities because they remind her that her husband is dead and result in emotional distress. However, she does not experience fear. These findings indicate the presence of complicated grief rather than PTSD. Her best therapeutic option is one specifically addressing complicated grief.

The symptoms sadness, guilt, decreased function, and suicide risk overlap in major depressive disorder and complicated grief. Complicated grief is characterized by longing and guilt related to the death, preoccupation with thoughts and memories of the deceased,

and avoidance of reminders of the deceased. In contrast, major depressive disorder is associated with general sadness, guilt, shame, or low self-esteem. Ms T avoids activities previously shared with her husband. Her primary emotions are longing and deep sadness related to missing her husband. She continues to experience disbelief about and preoccupation with his death circumstances. She experiences positive emotions when thinking about the wonderful times they shared. Consequently, she does not have major depression criteria. Complicated grief is associated with deficits in imagining a future without the deceased⁵¹; Ms T reports significant difficulty in coping with a future without her husband and sometimes thinks she would prefer to die in order to be with him.

Clinical Management of Complicated Grief: When to Intervene

Considerable debate exists regarding the suitability of grief as a clinical condition appropriate for intervention. Loss is universal and permanent. Grief does not fully resolve. It changes form and most individuals successfully adapt and achieve integrated grief without intervention. Various individual, societal, religious, and cultural responses to loss exist. Because no single way to grieve exists, identification of patients needing intervention is difficult. A subset of individuals become fixed in an intense, persistently distressing, disruptive, and functionally impairing form of grief. The grief does not improve for months to years after the death. Patients with this response may benefit from interventions to help them better cope with their grief.^{2,52–61} Intervention is indicated when grief is prolonged and severe (Box 4). All treatment-seeking bereaved individuals should be screened for suicide risk and concomitant mood and anxiety disorders. These may require treatment before the 6 to 12 months currently recommended as a minimum time since the loss to diagnose and treat complicated grief.

Ms T scored 48 on the Inventory of Complicated Grief assessment more than 16 months after her loss. She experienced persistent difficulty accepting the finality of the loss, ruminations about the circumstances of the loss, avoidance of shared activities, inability to envision a future without her husband, an intermittent wish to die, and significant functional impairment despite some minor gains reconnecting with friends. These findings indicate a need for complicated grief intervention.

Clinical Management of Complicated Grief: Treatment Approaches

Community or peer-based bereavement support groups enhance social support. They can be a very helpful intervention for bereavement-related distress. Although the content of such groups may not be standardized and efficacy data for complicated grief are lacking, bereaved patients should be informed about local support groups. Ms T's treatment included a bereavement support group, citalopram at 20 mg/d, and individual psychotherapy, which she notes "probably saved me." She may mean this literally because she struggled with despair and passive suicidal ideation, even though she has not been able to progress in her grief.

The best studied treatment for complicated grief is a targeted psychotherapy (Table 1). A recent meta-analysis suggested benefits from a range of psychotherapeutic interventions.⁶³ The largest randomized controlled trial was the Complicated Grief Therapy trial, a 16-week

targeted psychotherapy approach. Complications or issues that interfere in the healing process are identified and addressed to allow the natural bereavement process to move forward. Complicated grief therapy was significantly more effective than interpersonal psychotherapy, which focuses more on relationship issues^{2,64} (Table 1). Complicated grief therapy emphasizes loss processing and restoration of life without the deceased, using a range of techniques including cognitive behavioral therapy, interpersonal therapy, and motivational interviewing. Teaching about what complicated grief is and a psychological model of how it develops, termed *psychoeducation*, is also included. Other studies of psychotherapy approaches for complicated grief (Table 1)^{58–60} support this basic approach. Growing evidence supports interventions that include repeatedly telling the story of the death.^{58–60} A recent open-label study in which participants underwent 10 weeks of group therapy and 4 weeks of individual cognitive behavioral therapy for complicated grief using strategies and techniques similar to those used in complicated grief therapy (psychoeducation, discussing positive and negative memories of the deceased, telling the story of the death, addressing errors in thoughts—cognitive restructuring, a communication with the deceased exercise, and goal and pleasant event setting⁵⁸), also found beneficial effects. In another trial, participants randomized to a 5-week Internet-based intervention similarly focusing on revisiting bereavement related situations, cognitive restructuring, positive memories, creating a life narrative including the loss, as well as social support and goals had greater reduction in symptoms related to death than those who were randomized to a wait list.⁶⁰

Even without specialty referral, trusted clinicians can offer some simple interventions informed by these studies such as psychoeducation about the condition including the notion that issues or behaviors that interfere with the grieving process (grief complications) can be addressed with treatment, which can alone provide relief and hope for improvement. Clinicians should obtain a detailed history to help the patient understand and address issues contributing to a lack of grief progression and reengagement in their own life after the death of a loved one. One example of a grief complication is avoidance of previously shared friends, family events, and pleasurable activities that serve as reminders of the deceased, leading to social isolation and inadequate participation in enjoyable activities. Clinicians can explain how complicated grief is associated with avoidance of reminders of the loss. They can encourage reduction in these avoidance behaviors. Other misbeliefs, such as the notion that grief is the only way to honor and stay connected with the deceased, or the mistaken perception that the patient was responsible for the death, can also be corrected. Anniversary dates may trigger acute worsening of grief. Helping the patient anticipate and plan for these events and provision of social support is beneficial. Psychiatric referral for psychotherapy, medication, or both is indicated for patients who have persistent symptoms, significant comorbidity, or suicidal ideation or behaviors.

Pharmacotherapy data are limited. Benefits may be derived from treatment with serotonin selective reuptake inhibitors antidepressants such as escitalopram and paroxetine as demonstrated in case series and open-label trials (which included a total of 50 participants with complicated grief; Table 2). Antidepressants have also been shown to improve adherence and augment response to complicated grief therapy, although benzodiazepines did

not improve outcomes, findings similar to the ineffectiveness of benzodiazepines in PTSD.⁶⁵ Viewing complicated grief as a stress-response condition with symptom overlap with PTSD and depression suggests that antidepressants, but not benzodiazepines, are likely to be beneficial in treating complicated grief. Benzodiazepine treatment can result in psychological and physical dependence and may interfere with learning and memory, important for psychological adaptation to a loss. Use of an antidepressant with a low-risk profile such as serotonin selective reuptake inhibitors is recommended. Open-label studies (Table 2) support the use of 10 to 20 mg/d of escitalopram and 20 to 50 mg/d of paroxetine. However other serotonergic antidepressants and dosing strategies may prove effective as well. Overall, the limited information about pharmacotherapy risk-benefit profiles suggest a complicated grief therapy-like approach when available should be considered as the first treatment with medication considered as an adjunct for patients with complicated grief; however, the presence of significant comorbid depression, suicidal ideation, or both would support earlier treatment with antidepressant medication.

Ms T may benefit by maximizing her antidepressant dose titrated to response and tolerability because she had a partial improvement with citalopram at 20 mg/d. She might also consider referral to a specialist trained in a complicated grief therapy-like targeted psychotherapy.

What the Future Holds

Despite a significant and rapidly growing body of research in grief and management of its complications, many clinicians, including those in specialty psychiatry settings, are not aware of available evidence regarding grief management because evidence-based treatment guidelines for complicated grief are not yet available. They may also be unaware of how to identify patients at risk of complicated grief (Box 1) in order to intervene effectively. Educating primary care and specialty clinicians about the evidence supporting complicated grief as a syndrome, which causes substantial distress and impairment, and alerting them to the Inventory of Complicated Grief,¹ a brief 19-item self-report questionnaire that identifies complicated grief, should enhance their skills regarding counseling bereaved patients, monitoring their progress over time, and learning how to identify and refer patients experiencing complicated grief or other DSM-5 conditions in the wake of a difficult loss. Although available data already provide guidance for diagnosis, psychotherapeutic intervention, and early support for antidepressant use for management of complicated grief, studies are under way to continue to optimize treatment and to better understand psychological and biological processes that underpin this condition.

Questions and Discussion

QUESTION Is medication adherence and how the medication works over time something general physicians should address?

DR SIMON Similar to administering antidepressant medications for mood and anxiety disorders, it is important to educate patients about the rationale and expected time course of antidepressant effects. Patients should be told that antidepressant medications must be administered every day for the medication to work. They are not effective if taken only when the patient is symptomatic.

QUESTION How would you compare psychodynamic therapy to a more targeted therapy for complicated grief?

DR SIMON Psychodynamic psychotherapy has not been tested. In our experience we have seen many patients who received and failed this type of treatment. One problem is that most psychodynamic psychotherapists are unfamiliar with complicated grief. Complicated grief therapy is based on an attachment theory model of bereavement, grief, and mourning and might ultimately be compatible with a psychodynamic approach.⁵ However, as with cognitive behavioral therapy approaches to mood and anxiety disorders, working with patients with complicated grief over a time-limited period in a more structured focused way has been very helpful.⁶⁶

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References

1. Prigerson HG, Maciejewski PK, Reynolds CF III, et al. Inventory of Complicated Grief: a scale to measure maladaptive symptoms of loss. *Psychiatry Res.* 1995; 59(1–2):65–79. [PubMed: 8771222]
2. Shear K, Frank E, Houck PR, Reynolds CF III. Treatment of complicated grief: a randomized controlled trial. *JAMA.* 2005; 293(21):2601–2608. [PubMed: 15928281]
3. Hoyert, DL.; Xu, J. Deaths: Preliminary Data for 2011. Washington, DC: US Dept of Health and Human Services, Centers for Disease Control and Prevention; 2012.
4. Shear MK. Getting straight about grief. *Depress Anxiety.* 2012; 29(6):461–464. [PubMed: 22730310]
5. Bowlby, J. Attachment and Loss. Vol. 3. New York, NY: Basic Books; 1980.
6. Hofer MA. Relationships as regulators: a psychobiologic perspective on bereavement. *Psychosom Med.* 1984; 46(3):183–197. [PubMed: 6739679]
7. Shear K, Monk T, Houck P, et al. An attachment-based model of complicated grief including the role of avoidance. *Eur Arch Psychiatry Clin Neurosci.* 2007; 257(8):453–461. [PubMed: 17629727]
8. Genevro JL, Marshall T, Miller T, Center for the Advancement of Health. Report on bereavement and grief research. *Death Stud.* 2004; 28(6):491–575. [PubMed: 15317140]
9. Stroebe M, Schut H. The dual process model of coping with bereavement: rationale and description. *Death Stud.* 1999; 23(3):197–224. [PubMed: 10848151]
10. Stroebe M, Schut H. The dual process model of coping with bereavement: a decade on. *Omega (Westport).* 2010; 61(4):273–289. [PubMed: 21058610]
11. Maciejewski PK, Zhang B, Block SD, Prigerson HG. An empirical examination of the stage theory of grief. *JAMA.* 2007; 297(7):716–723. [PubMed: 17312291]
12. Bonanno GA, Wortman CB, Nesse RM. Prospective patterns of resilience and maladjustment during widowhood. *Psychol Aging.* 2004; 19(2):260–271. [PubMed: 15222819]
13. 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. [PubMed: 12416919]
14. Prigerson HG, Horowitz MJ, Jacobs SC, et al. Prolonged grief disorder: psychometric validation of criteria proposed for *DSM-V* and *ICD-11*. *PLoS Med.* 2009; 6(8):e1000121. [PubMed: 19652695]
15. Shear MK, Simon N, Wall M, et al. Complicated grief and related bereavement issues for *DSM-5*. *Depress Anxiety.* 2011; 28(2):103–117. [PubMed: 21284063]
16. Kersting A, Brähler E, Glaesmer H, Wagner B. Prevalence of complicated grief in a representative population-based sample. *J Affect Disord.* 2011; 131(1–3):339–343. [PubMed: 21216470]

17. Newson RS, Boelen PA, Hek K, Hofman A, Tiemeier H. The prevalence and characteristics of complicated grief in older adults. *J Affect Disord.* 2011; 132(1–2):231–238. [PubMed: 21397336]
18. Fujisawa D, Miyashita M, Nakajima S, Ito M, Kato M, Kim Y. Prevalence and determinants of complicated grief in general population. *J Affect Disord.* 2010; 127(1–3):352–358. [PubMed: 20580096]
19. Tal Young I, Iglewicz A, Glorioso D, et al. Suicide bereavement and complicated grief. *Dialogues Clin Neurosci.* 2012; 14(2):177–186. [PubMed: 22754290]
20. Meert KL, Shear K, Newth CJ, et al. Eunice Kennedy Shriver National Institute of Child Health and Human Development Collaborative Pediatric Critical Care Research Network. Follow-up study of complicated grief among parents eighteen months after a child's death in the pediatric intensive care unit. *J Palliat Med.* 2011; 14(2):207–214. [PubMed: 21281122]
21. Dyregrov K, Nordanger D, Dyregrov A. Predictors of psychosocial distress after suicide, SIDS and accidents. *Death Stud.* 2003; 27(2):143–165. [PubMed: 12678058]
22. Neria Y, Gross R, Litz B, et al. Prevalence and psychological correlates of complicated grief among bereaved adults 2.5–3.5 years after September 11th attacks. *J Trauma Stress.* 2007; 20(3): 251–262. [PubMed: 17597124]
23. Mutabaruka J, Séjourné N, Bui E, Birmes P, Chabrol H. Traumatic grief and traumatic stress in survivors 12 years after the genocide in Rwanda. *Stress Health.* 2012; 28(4):289–296. [PubMed: 22282057]
24. Hargrave PA, Leathem JM, Long NR. Peritraumatic distress: its relationship to posttraumatic stress and complicated grief symptoms in sudden death survivors. *J Trauma Stress.* 2012; 25(3):344–347. [PubMed: 22685096]
25. Bui E, Simon NM, Robinaugh DJ, et al. Periloss dissociation, symptom severity, and treatment response in complicated grief. *Depress Anxiety.* 2013; 30(2):123–128. [PubMed: 23212730]
26. Boelen PA, Keijsers L, van den Hout MA. Peritraumatic dissociation after loss: latent structure and associations with psychopathology. *J Nerv Ment Dis.* 2012; 200(4):362–364. [PubMed: 22456592]
27. Mancini AD, Robinaugh D, Shear K, Bonanno GA. Does attachment avoidance help people cope with loss? the moderating effects of relationship quality. *J Clin Psychol.* 2009; 65(10):1127–1136. [PubMed: 19437503]
28. Gupta S, Bonanno GA. Complicated grief and deficits in emotional expressive flexibility. *J Abnorm Psychol.* 2011; 120(3):635–643. [PubMed: 21766973]
29. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 5. Washington, DC: American Psychiatric Publishing; 2013.
30. Simon NM, Pollack MH, Fischmann D, et al. Complicated grief and its correlates in patients with bipolar disorder. *J Clin Psychiatry.* 2005; 66(9):1105–1110. [PubMed: 16187766]
31. Latham AE, Prigerson HG. Suicidality and bereavement: complicated grief as psychiatric disorder presenting greatest risk for suicidality. *Suicide Life Threat Behav.* 2004; 34(4):350–362. [PubMed: 15585457]
32. 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. [PubMed: 17629728]
33. Boelen PA, van den Bout J. Complicated grief and uncomplicated grief are distinguishable constructs. *Psychiatry Res.* 2008; 157(1–3):311–314. [PubMed: 17916387]
34. Silverman GK, Jacobs SC, Kasl SV, et al. Quality of life impairments associated with diagnostic criteria for traumatic grief. *Psychol Med.* 2000; 30(4):857–862. [PubMed: 11037094]
35. 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. [PubMed: 17707245]
36. Germain A, Caroff K, Buysse DJ, Shear MK. Sleep quality in complicated grief. *J Trauma Stress.* 2005; 18(4):343–346. [PubMed: 16281231]
37. Prigerson HG, Bierhals AJ, Kasl SV, et al. Traumatic grief as a risk factor for mental and physical morbidity. *Am J Psychiatry.* 1997; 154(5):616–623. [PubMed: 9137115]

38. Prigerson H, Ahmed I, Silverman GK, et al. Rates and risks of complicated grief among psychiatric clinic patients in Karachi, Pakistan. *Death Stud.* 2002; 26(10):781–792. [PubMed: 12440418]
39. Stammel N, Heeke C, Bockers E, et al. Prolonged grief disorder three decades post loss in survivors of the Khmer Rouge regime in Cambodia. *J Affect Disord.* 2013; 144(1–2):87–93. [PubMed: 22871529]
40. Simon NM, Wall MM, Keshaviah A, Dryman MT, LeBlanc NJ, Shear MK. Informing the symptom profile of complicated grief. *Depress Anxiety.* 2011; 28(2):118–126. [PubMed: 21284064]
41. Ito M, Nakajima S, Fujisawa D, et al. Brief measure for screening complicated grief: reliability and discriminant validity. *PLoS One.* 2012; 7(2):e31209. [PubMed: 22348057]
42. Shear KM, Jackson CT, Essock SM, Donahue SA, Felton CJ. Screening for complicated grief among Project Liberty service recipients 18 months after September 11, 2001. *Psychiatr Serv.* 2006; 57(9):1291–1297. [PubMed: 16968758]
43. Zisook S, Simon NM, Reynolds CF III, et al. Bereavement, complicated grief, and *DSM, II*: complicated grief. *J Clin Psychiatry.* 2010; 71(8):1097–1098. [PubMed: 20797383]
44. Reynolds CF III, 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. [PubMed: 9989555]
45. Galatzer-Levy IR, Bonanno GA. Beyond normality in the study of bereavement: heterogeneity in depression outcomes following loss in older adults. *Soc Sci Med.* 2012; 74(12):1987–1994. [PubMed: 22472274]
46. Barnes JB, Dickstein BD, Maguen S, Neria Y, Litz BT. The distinctiveness of prolonged grief and posttraumatic stress disorder in adults bereaved by the attacks of September 11th. *J Affect Disord.* 2012; 136(3):366–369. [PubMed: 22154886]
47. Golden AM, Dalgleish T. Is prolonged grief distinct from bereavement-related posttraumatic stress? *Psychiatry Res.* 2010; 178(2):336–341. [PubMed: 20493535]
48. Langner R, Maercker A. Complicated grief as a stress response disorder: evaluating diagnostic criteria in a German sample. *J Psychosom Res.* 2005; 58(3):235–242. [PubMed: 15865947]
49. Horowitz MJ, Siegel B, Holen A, Bonanno GA, Milbrath C, Stinson CH. Diagnostic criteria for complicated grief disorder. *Am J Psychiatry.* 1997; 154(7):904–910. [PubMed: 9210739]
50. Simon NM. Is complicated grief a post-loss stress disorder? *Depress Anxiety.* 2012; 29(7):541–544. [PubMed: 22761109]
51. Maccallum F, Bryant RA. Imagining the future in complicated grief. *Depress Anxiety.* 2011; 28(8):658–665. [PubMed: 21796741]
52. Simon NM, Thompson EH, Pollack MH, Shear MK. Complicated grief: a case series using escitalopram. *Am J Psychiatry.* 2007; 164(11):1760–1761. [PubMed: 17974946]
53. Bui E, Nadal-Vicens M, Simon NM. Pharmacological approaches to the treatment of complicated grief: rationale and a brief review of the literature. *Dialogues Clin Neurosci.* 2012; 14(2):149–157. [PubMed: 22754287]
54. Mancini AD, Griffin P, Bonanno GA. Recent trends in the treatment of prolonged grief. *Curr Opin Psychiatry.* 2012; 25(1):46–51. [PubMed: 22156937]
55. Hensley PL, Slonimski CK, Uhlenhuth EH, Clayton PJ. Escitalopram: an open-label study of bereavement-related depression and grief. *J Affect Disord.* 2009; 113(1–2):142–149. [PubMed: 18597854]
56. Shear, MK.; Fagioli, A.; Houck, P., et al. Escitalopram for complicated grief: a pilot study. Paper presentation at: 46th Annual Meeting of New Clinical Drug Evaluation Unit; June 3, 2006; Boca Raton, FL.
57. Zygmunt 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. [PubMed: 9632035]
58. Maccallum F, Bryant RA. Autobiographical memory following cognitive behaviour therapy for complicated grief. *J Behav Ther Exp Psychiatry.* 2011; 42(1):26–31. [PubMed: 21074003]

59. Boelen PA, de Keijser J, van den Hout MA, van den Bout J. Treatment of complicated grief: a comparison between cognitive-behavioral therapy and supportive counseling. *J Consult Clin Psychol*. 2007; 75(2):277–284. [PubMed: 17469885]
60. Wagner B, Knaevelsrud C, Maercker A. Internet-based cognitive-behavioral therapy for complicated grief: a randomized controlled trial. *Death Stud*. 2006; 30(5):429–453. [PubMed: 16610157]
61. Pasternak RE, Reynolds CF III, Schlernitzauer M, et al. Acute open-trial nortriptyline therapy of bereavement-related depression in late life. *J Clin Psychiatry*. 1991; 52(7):307–310. [PubMed: 2071562]
62. Durlak JA. How to select, calculate, and interpret effect sizes. *J Pediatr Psychol*. 2009; 34(9):917–928. [PubMed: 19223279]
63. Wittouck C, Van Autreve S, De Jaegere E, Portzky G, van Heeringen K. The prevention and treatment of complicated grief: a meta-analysis. *Clin Psychol Rev*. 2011; 31(1):69–78. [PubMed: 21130937]
64. Weissman, MM.; Markowitz, JC.; Klerman, G. *Comprehensive Guide to Interpersonal Psychotherapy*. New York, NY: Basic Books; 2000.
65. 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. [PubMed: 18336918]
66. Hofmann SG, Asnaani A, Vonk IJJ, Sawyer AT, Fang A. The efficacy of cognitive behavioral therapy: a review of meta-analyses. *Cognit Ther Res*. 2012; 36(5):427–440.

Box 1**Risk Factors for the Development of Complicated Grief****Pre-loss Risk Factors**

Female sex
Preexisting trauma (particularly childhood trauma)
Prior loss
Insecure attachment
Preexisting mood and anxiety disorders
Nature of the relationship^{15–18}

Loss-Related Factors

Relationship and caretaking roles: spouses, mothers of dependent children, caretakers for chronically ill
Nature of the death itself: violent, sudden, prolonged, due to suicide^{15–22}

Peri-loss Factors

Social circumstances
Resources available following the death
Poor understanding of the circumstances of the death event: ie, lack of information about the death
Interference with natural healing process: inability to follow usual cultural practices of death and mourning, alcohol or substance use, low social support^{23–28}

Box 2**Provisional Criteria for Complicated Grief: Persistent Complex Bereavement Disorder^a**

The individual experienced the death of someone with whom he or she had a close relationship.

Since the death, at least 1 of the following symptoms is experienced on more days than not and to a clinically significant degree has persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:

Persistent yearning or longing for the deceased. In young children, yearning may expressed in play and behavior, including behaviors that reflect being separated from, and also reuniting with, a care-giver or other attachment figure.

Intense sorrow and emotional pain in response to the death.

Preoccupation with the deceased.

Preoccupation with the circumstances of the death. In children this preoccupation with the deceased may be expressed through the themes of play and behavior and may extend to preoccupation with possible death of others close to them.

Since the death, at least 6 of the following symptoms are experienced on more days than not and to a clinically significant degree, and they have persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:

Reactive distress to death:

Marked difficulty accepting the death. In children, this is dependent on the child's capacity to comprehend the meaning and permanence of death.

Experiencing disbelief or emotional numbness over the loss.

Difficulty with positive reminiscing about the deceased.

Bitterness or anger related to the loss.

Maladaptive appraisals about oneself in relation to the deceased or the death (eg, self-blame).

Excessive avoidance of reminders of the loss (eg, avoidance of individuals, places, or situations associated with the deceased; in children, this may include avoidance of thoughts and feelings regarding the deceased).

Social or identity disruption:

A desire to die in order to be with the deceased.

Difficulty trusting other individuals since the death.

Feeling alone or detached from other individuals since the death.

Feeling that life is meaningless or empty without the deceased or the belief that one cannot function without the deceased.

Confusion about one's role in life or a diminished sense of one's identity (eg, feeling that a part of oneself has died with the deceased).

Difficulty or reluctance to pursue interests since the loss or to plan for the future (eg, friendships, activities).

The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

The bereavement reaction must be out of proportion or inconsistent with cultural, religious, or age-appropriate norms.

Specify if with traumatic bereavement:

Bereavement due to homicide or suicide with persistent distressing preoccupations regarding the traumatic nature of the death (often in response to loss reminders), including the deceased's last moments, degree of suffering and mutilating injury, or the malicious or intentional nature of the death.

^aBased on Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition), Section III.²⁹

Box 3**Brief Grief Questionnaire^a**

Each question is rated as: 0 = Not at all, 1 = Somewhat, or 2 = A lot

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 she/he died or other thoughts about the death that really bother you?
4. Are there things you used to do when _____ was alive that you do not 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?
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?

^aIncluded with permission from M. Katherine Shear, MD, and Susan Essock, PhD, who developed the scale. A score of 5 or more suggests complicated grief may be present and additional evaluation is indicated.⁴²

Box 4**Indications for Intervention for Complicated Grief**

Persistently high symptom severity

Lack of temporal improvement in the grief response

Functional impairment

Treatment-seeking behaviors

Hopelessness

Suicidal ideation or behaviors

Table 1

Trials Evaluating Targeted Psychotherapy for the Treatment of Complicated Grief

Source	Design	Treatment	No. of Participants, Treatment Groups	Percent Improvement in Grief Symptom ^d	Pretreatment-Posttreatment Effect Size ^b	P Value
Maccallum and Bryant, ⁵⁸ 2011	Open-label	10-Week group CBT plus 4 individual sessions	20	33, Semistructured CG assessment symptom reduction	2.54	<.001
Boelen et al., ⁵⁹ 2007	Investigator-assigned conditions	Individual CBT	23, CR+ET 20, ET+CR 11, Supportive counseling	24, ICG reduction 36, ICG reduction 12, ICG reduction	0.94 1.61 0.46	<.05 ^c <.05 ^d
Wagner et al., ⁶⁰ 2006	RCT	Individual Internet-based CBT	26, Internet CBT 25, Waitlist	47, IES intrusion 65, IES avoidance 58, Failure-to-adapt scale 14, IES intrusion 6, IES avoidance 18, Failure-to-adapt scale	1.26 0.33	<.002, Intrusion <.001, Avoidance <.01, Failure to adapt ^e
Shear et al., ² 2005	RCT	Individual CGT	49, CGT 46, IPT	51, CGI scale response rate 38, ICG reduction 28, CGI scale response rate 29, ICG reduction	2.15 1.29	.02 ^f

Abbreviations: CBT, cognitive behavioral therapy; CG, complicated grief; CGI, Clinical Global Improvement; CGT, complicated grief therapy; CR, cognitive restructuring; ET, exposure therapy; IES, impact of event scale; IPT, interpersonal therapy; ICG, Inventory of Complicated Grief; RCT, randomized controlled trial.

^aCalculated percent baseline to end point symptom reductions because not all used same or CG-specific scales.

^bPretreatment-posttreatment effect sizes were calculated by (posttreatment mean – pretreatment mean)/pretreatment standard deviation.⁶²

^cCompares CR plus ET with supportive therapy.

^dCompares ET plus CR with supportive therapy.

^eCompares CBT with waitlist for each grief characteristic.

^fCompares CGT with IPT.

Table 2

Trials Evaluating Selective Serotonin Reuptake Inhibitors Among Patients With Complicated Grief or Bereavement-Related Depression With Complicated Grief Symptoms

Source	No. of Participants	Diagnosis	Design	Drug, mg/d	Percent Improvement in Grief Symptom ^a	Pretreatment-Posttreatment Effect Size ^b	P Value
Hensley et al, ⁵⁵ 2009	14	Major depressive disorder and complicated grief	Open-label (SC)	Escitalopram, flexible 10–20	21	1.09	.006
Simon et al, ⁵² 2007	4	ICG score 25	Open-label (ITT)	Escitalopram, flexible 10–20	76	4.38	.001
Shear et al, ⁵⁶ 2006	17	ICG score 30	Open-label (modified ITT)	Escitalopram, flexible 10–20	24	1.12	NA
	7	ICG score 30	Open-label (SC)	Escitalopram, flexible 10–20	35	1.48	NA
Zygmunt et al, ⁵⁷ 1998	15	ICG score 20	Open-label (SC)	Paroxetine, flexible 20–50	48	1.60	<.001
Pasternak et al, ⁶¹ 1991	13	Bereavement-related major depressive disorder and Hamilton-depression score 15	Open-label trial	Nortriptyline, mean dose 49.2	9.3 ^c	0.66	NS

Abbreviations: ICG, Inventory of Complicated Grief; ITT, intention to treat; NA, not available because insufficient data to calculate; NS, not significant; SC, study completers.

^a Pretreatment-posttreatment effect sizes were calculated by (posttreatment mean – pretreatment mean)/pretreatment standard deviation.⁶²

^b Grief symptom improvement rates are based on the ICG assessment.

^c Grief symptom improvement rates based on the Texas Revised Inventory of Grief.