

## CLINICAL PRACTICE

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## Complicated Grief

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*This Journal feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the author's clinical recommendations.*

**A 68-year-old woman seeks care from her primary physician because of trouble sleeping 4 years after the death of her husband. On questioning, she reveals that she is sleeping on a couch in her living room because she cannot bear to sleep in the bed she shared with him. She has stopped eating regular meals because preparing them makes her miss him too much; she still has meals that she cooked for him in her freezer. The patient often ruminates about how unfair it was for her husband to die, and she is alternately angry with the medical staff who cared for him and angry at herself for not recognizing his illness earlier. She finds it too painful to do things that she and her husband used to do together, and she thinks about him constantly and often wishes she could die to be with him. How should this patient be evaluated and treated?**

## THE CLINICAL PROBLEM

## BEREAVEMENT AND GRIEF

Bereavement, the experience of losing a loved one to death, is one of the most painful occurrences in life, and it has physical, psychological, and social ramifications. Loved ones provide support and contribute to a person's identity and sense of belonging. Grief, the response to bereavement, includes a variety of psychological and physiological symptoms that evolve over time. The manifestations and temporal evolution of grief are variable and unique to each loss; however, there are commonalities that clinicians can recognize.

## ACUTE GRIEF

The period of acute grief, which begins after a person learns that a loved one has died, includes elements of both the "separation response" (i.e., a specific response to separation from a loved one) and the response to stress. There is strong yearning, longing, and sadness, and thoughts and images of the deceased person are prominent. The experience of hearing the deceased person's voice, seeing the person, or sensing his or her presence may occur as a benign form of hallucination and is usually not a cause for concern.<sup>1</sup> The bereaved person may become confused about his or her identity or social role, may tend to disengage from usual activities, and may have a sense of disbelief or shock that a loved one is gone. Symptoms of acute grief, including dysphoria, anxiety,<sup>2</sup> depression,<sup>3</sup> and anger, may be associated with physiological changes such as an increased heart rate or blood pressure,<sup>4</sup> increased cortisol levels,<sup>5</sup> sleep disturbance,<sup>6</sup> and changes in the immune system.<sup>4</sup>

The early bereavement period has been associated with increased risks of health problems such as myocardial infarction, Takotsubo (stress) cardiomyopathy, or both.<sup>7,8</sup> The death of a loved one is also associated with an increased risk of the development of mood, anxiety, and substance-use disorders.<sup>9</sup>

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## KEY CLINICAL POINTS

## COMPLICATED GRIEF

- Complicated grief is unusually severe and prolonged, and it impairs function in important domains.
- Characteristic symptoms include intense yearning, longing, or emotional pain, frequent preoccupying thoughts and memories of the deceased person, a feeling of disbelief or an inability to accept the loss, and difficulty imagining a meaningful future without the deceased person.
- Complicated grief affects about 2 to 3% of the population worldwide and is more likely after the loss of a child or a life partner and after a sudden death by violent means.
- Randomized, controlled trials provide support for the efficacy of a targeted psychotherapy for complicated grief that provides an explanation of this condition, along with strategies for accepting the loss and for restoring a sense of the possibility of future happiness.
- Other treatments include other forms of psychotherapy as well as antidepressant medication, although pharmacotherapy for this condition has not been studied in randomized trials.

## ADAPTATION TO LOSS

The process of adapting to a difficult loss can be lengthy, and emotions may wax and wane unpredictably. Overall, the intensity of grief diminishes as the finality and consequences of the loss are understood and future hopes and plans are revised.<sup>10</sup> However, emotions may still surge at difficult occasions such as the anniversary of the death, family holidays, and group celebrations. Moreover, sometimes maladaptive thoughts or behaviors<sup>11</sup> or serious concurrent problems can complicate grief, slowing or halting the process of adaptation.

## COMPLICATED GRIEF

The condition of complicated grief,<sup>12</sup> which is also called prolonged grief disorder,<sup>13</sup> affects about 2 to 3% of the population worldwide.<sup>14,15</sup> This condition is characterized by intense grief that lasts longer than would be expected according to social norms and that causes impairment in daily functioning. Complicated grief can follow the loss of any close relationship. Complicated grief has a prevalence of approximately 10 to 20% after the death of a romantic partner and an even higher prevalence among parents who have lost children<sup>16</sup>; it is more likely when a death is sudden or violent (e.g., by suicide,<sup>17,18</sup> homicide,<sup>19</sup> or accident<sup>20</sup>) and less common after the loss of a parent, grandparent, sibling, or close friend. The prevalence of complicated grief is highest among women who are older than 60 years of age.<sup>15</sup> Clinical experience suggests that without treat-

ment, symptoms of complicated grief diminish slowly and can persist.

Neuropsychological studies suggest that certain abnormalities are associated with complicated grief, including alterations in functioning of the reward system (in response to reminders of the deceased person) detected on functional magnetic resonance imaging<sup>21</sup> and abnormalities in autobiographical memory,<sup>22</sup> neural systems involved in emotional regulation,<sup>23</sup> and neurocognitive functioning.<sup>24,25</sup> Complicated grief is associated with other health problems, such as sleep disturbance, substance abuse, suicidal thinking and behavior, and abnormalities in immune function; studies have also shown associated increased risks of cardiovascular disease and cancer.<sup>4</sup> Sleep disturbance, in particular, may contribute to other negative health consequences of complicated grief. In addition, complicated grief may interfere with adherence to prescribed therapeutic regimens for a range of diseases.

As in acute grief, the hallmark of complicated grief is persistent, intense yearning, longing, and sadness; these symptoms are usually accompanied by insistent thoughts or images of the deceased and a sense of disbelief or an inability to accept the painful reality of the person's death. Rumination is common and is often focused on angry or guilty recrimination related to circumstances of the death. Avoidance of situations that serve as reminders of the loss is also common, as is the urge to hold onto the deceased person by constantly reminiscing or by viewing,

touching, or smelling the deceased person's belongings. People with complicated grief often feel shocked, stunned, or emotionally numb, and they may become estranged from others because of the belief that happiness is inextricably tied to the person who died. They may have a diminished sense of self or discomfort with a changed social role and are often confused by their seemingly endless grief. Friends and relatives are often frustrated that they cannot help, and they may become critical or stop contacting the bereaved person, increasing his or her feelings of isolation.

The cause of complicated grief is probably multifactorial. Risk factors include a history of mood or anxiety disorders, alcohol or drug abuse, and multiple losses. Depression in persons who have been caregivers during a loved one's terminal illness<sup>26</sup> and depression early in bereavement<sup>27</sup> are predictors of complicated grief later in bereavement. Personal factors such as these may interact with characteristics of the relationship with the deceased or with the circumstances, context, or consequences of the death to increase the risk. Losing someone with whom one has

had a close relationship can be especially hard if the bereaved person had a difficult upbringing or if there are unusually stressful consequences of the death, inadequate social supports, serious conflicts with friends or relatives, or major financial problems after the death.

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## STRATEGIES AND EVIDENCE

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### EVALUATION AND DIAGNOSIS

Consensus is currently lacking regarding the criteria and formal name for complicated grief. The Working Group on the Classification of Disorders Specifically Associated with Stress drafted a proposal, based on a review of the literature, to include a diagnosis called prolonged grief disorder in the *International Classification of Diseases, 11th Revision*. This proposal is accompanied by suggested consensus guidelines that are currently undergoing field testing (Reed GM: personal communication) (Table 1). Two proposals for criteria<sup>12,13</sup> that were presented to the working group for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, resulted in the inclusion in the DSM-5 of an entity

**Table 1. Provisional Proposed Guidelines for the Diagnosis of Prolonged Grief Disorder in the *International Classification of Diseases, 11th Revision*.\***

#### Essential features

History of bereavement after the death of a partner, parent, child, or other loved one

A persistent and pervasive grief response characterized by longing for or persistent preoccupation with the deceased, accompanied by intense emotional pain (e.g., sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self, an inability to have a positive mood, emotional numbness, or difficulty in engaging with social or other activities)

A grief response that has persisted for an abnormally long period of time after the loss, clearly exceeding expected social, cultural, or religious norms; this category excludes grief responses within 6 mo after the death and for longer periods in some cultural contexts

A disturbance that causes clinically significant impairment in personal, family, social, educational, occupational, or other important areas of functioning; if functioning is maintained only through substantial additional effort or is very impaired as compared with the person's prior functioning or what would be expected, then he or she would be considered to have impairment due to the disturbance

#### Features overlapping with normal bereavement

Grief reactions that have persisted for <6 mo or for longer periods that are within a normative period of grieving given the person's cultural and religious context are viewed as normal bereavement responses and are generally not assigned a diagnosis

In assessing whether the duration of the grief reaction exceeds cultural expectations, it is often important to consider whether people in the patient's environment (e.g., family, friends, and community members) regard the response to the loss or the duration of the reaction as exaggerated or within normal limits

#### Additional features

Persistent preoccupation may be manifested as preoccupation with the circumstances of the death or as behaviors such as the preservation of all the deceased person's belongings exactly as they were before the death; oscillation between excessive preoccupation and avoidance of reminders of the deceased may occur

Other emotional reactions may include difficulty accepting the loss, problems coping without the loved one, difficulties in recalling positive memories of the deceased, difficulty in engaging with social or other activities, social withdrawal, and feeling that life is meaningless

Increased tobacco, alcohol, and other substance use, as well as increased suicidal ideation and behavior may be present

\* Information is from G.M. Reed (personal communication).

called “persistent complex bereavement disorder” (incorporating some of the criteria from each proposal) as a condition requiring further research.

Questions about important losses should be part of a standard diagnostic evaluation, especially in the case of older patients, for whom loss is common. The presence of thoughts and behaviors that are indicative of complicated grief should be assessed with the use of a clinical interview. Intense grief is not pathologic; however, complicating thoughts and behaviors that impede adaptation to the loss should be identified along with grief that is inordinately intense and prolonged. Patients are sometimes ashamed of their persistently intense grief, so it is important for clinicians to ask direct questions in a sensitive and empathic way. A semistructured-interview format to facilitate assessment of complicated grief (see the Supplementary Appendix, available with the full text of this article at NEJM.org) is a shortened version of a validated instrument. The Brief Grief Questionnaire (which is also included in the Supplementary Appendix) and the Inventory of Complicated Grief are self-report questionnaires that can be used to screen patients for complicated grief. The clinical evaluation of a bereaved person should also include screening for other psychiatric and medical disorders, since coexisting conditions are common.<sup>28</sup>

Complicated grief must be distinguished from major depression and post-traumatic stress disorder (Table 2). Evidence to date suggests that complicated grief is best understood as an unusually severe and prolonged form of acute grief rather than a completely unique entity.<sup>29</sup> Complicated grief is characterized by excessive avoidance of reminders of the loss, troubling maladaptive rumination about circumstances or consequences of the death, and persistence of intense and impairing acute grief symptoms beyond what is expected according to social and cultural norms. However, determination of what constitutes prolonged grief can be problematic because views on grief differ across cultures, and data are lacking to inform this determination. In addition, the typical time frame for grief reactions varies according to the circumstances of the death. For example, studies indicate that the majority of bereaved parents have positive results on screening for complicated grief 18 months after losing a child.<sup>16</sup> The current practice is to

offer treatment for complicated grief as early as 6 months after the death.<sup>13,30</sup>

#### RISK ASSESSMENT

Survey data indicate that rates of suicidal ideation among patients with complicated grief are high<sup>31</sup>; data on rates of completed suicide in this population are lacking. Careful evaluation of suicidal intent and suicide plans should always be a part of an assessment of complicated grief. Unusual risk-taking behaviors and neglect of one's health problems (in order to leave death to chance) are also more common in patients with complicated grief, and patients should be asked about them specifically.<sup>32</sup>

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### MANAGEMENT

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#### PSYCHOTHERAPY

Randomized, controlled trials have shown that psychotherapy is efficacious for complicated grief, so it is the first-line treatment. A short-term approach called complicated grief treatment<sup>30,33-35</sup> is the treatment that has been most extensively studied to date. Its objectives are to identify and resolve complications of grief and to facilitate adaptation to loss. The treatment includes two key areas of focus: restoration (i.e., restoring effective functioning by generating enthusiasm and creating plans for the future) and loss (i.e., helping patients find a way to think about the death that does not evoke intense feelings of anger, guilt, or anxiety). A portion of each of 16 weekly sessions is allotted to each area of focus. Grief monitoring and other weekly activities are assigned at the end of each session. The seven main components of treatment for complicated grief are described in Table 3.

Therapy for complicated grief has been directly compared with interpersonal psychotherapy,<sup>46</sup> which targets interpersonal problem areas, including grief, with the goal of improving mood. As compared with therapy for complicated grief, interpersonal psychotherapy is less structured, devotes less time to discussing the death or addressing avoidance of reminders of the loss, and does not involve evoking memories of or imagined conversations with the deceased person, grief monitoring, or other homework assignments. In a trial comparing therapy for complicated grief with interpersonal psychotherapy,<sup>30</sup> response rates were significantly bet-

**Table 2. Differential Diagnosis of Complicated Grief, Major Depression, and Post-Traumatic Stress Disorder (PTSD).**

Characteristic	Complicated Grief	Major Depression	PTSD
<b>Affective symptoms</b>			
Depressed mood (sadness)	Prominent; focused on the loss; core symptom	Prominent; diagnostic criterion	May be present
Anhedonia (loss of interest or pleasure)	Not usually present (and interest in thoughts of deceased is usually maintained)	Prominent and pervasive; diagnostic criterion	May be present
Anxiety	May be present; focused on loss and insecurity without the deceased	May be present	Prominent; focused on fear of recurrent danger; diagnostic criterion
Yearning or longing	Prominent, frequent, and intense; core symptom	Not usually present	Not usually present
Guilt	Common; focused on regrets related to the deceased	Usually present, related to feeling worthless and undeserving	May be present; focused on the traumatic event or its aftermath
<b>Cognitive or behavioral symptoms</b>			
Difficulty concentrating	May be present; not a core symptom	Common; diagnostic criterion	Common; diagnostic criterion
Preoccupying thoughts	Common; focused on thoughts and memories of the deceased; core symptom	May be present, focused on negative thoughts about self, others, or the world	Negative, exaggerated, distorted thoughts related to event; diagnostic criterion
Recurrent preoccupying images or thoughts	Common; focused on thoughts or memories of the deceased	May be present	Common; focused on event; usually associated with fear; diagnostic criterion
Avoidance of reminders of the loss	Common; focused on reminders of the finality of the loss and associated emotional distress	May be present, related to general social withdrawal	Common; focused on loss of sense of safety or reminders of event; diagnostic criterion
Seeking proximity to the deceased person	Common; focused on wanting to feel close to the deceased	Not usually present	Not usually present
Suicidal thinking and behavior	Suicidal ideation often present; increased risk of suicidal behavior	Suicidal ideation present; diagnostic criterion; increased risk of suicidal behavior	Suicidal ideation present; increased risk of suicidal behavior
Abnormal eating behaviors	Avoiding certain foods or meal times to avoid reminders of the loss or eating favorite foods to feel close to the deceased	Change in eating due to change in appetite; diagnostic criterion	Not usually present
<b>Sleep</b>			
Disturbed sleep	Sleep disturbance related to avoiding bed or other reminders of the loss or rumination about troubling aspects of the death	Sleep disturbance common; diagnostic criterion	Sleep disturbance related to anxiety; diagnostic criterion
Nightmares	Not usually present	May be present	Related to the traumatic event; diagnostic criterion

**Table 3. Core Components of Treatment for Complicated Grief.**

Component	Description	Evidence from Randomized, Controlled Trials
Establishing lay of the land	Discussion of the nature of loss, grief, and adaptation to loss; description of complications of grief and their effects; description of the treatment and rationale for procedures in the treatment	Shear et al., <sup>30</sup> Shear et al., <sup>35</sup> Boelen et al., <sup>36</sup> Acierno et al., <sup>37</sup> Rosner et al., <sup>38</sup> Bryant et al., <sup>39</sup> Kersting et al., <sup>40</sup> Litz et al., <sup>41</sup> Wagner et al., <sup>42</sup> Papa et al., <sup>43</sup> Shear et al. <sup>44</sup>
Promoting self-regulation	Self-monitoring, self-observation, and reflection; re-appraisal of troubling thoughts and beliefs; extending compassion to oneself; “dosing” emotional pain by confronting it and setting it aside	Shear et al., <sup>30</sup> Shear et al., <sup>35</sup> Boelen et al., <sup>36</sup> Rosner et al., <sup>38</sup> Bryant et al., <sup>39</sup> Kersting et al., <sup>40</sup> Litz et al., <sup>41</sup> Wagner et al., <sup>42</sup> Rosner et al. <sup>45</sup>
Building connections	Strategies for meaningful connections with others; sharing pain and letting others help	Shear et al., <sup>30</sup> Shear et al., <sup>35</sup> Rosner et al., <sup>38</sup> Kersting et al., <sup>40</sup> Wagner et al., <sup>42</sup> Rosner et al. <sup>45</sup>
Setting aspirational goals	Exploring ambition for personal goals and activities that engender eagerness and hope; generating enthusiasm and other positive emotions in ongoing life; creating sense of purpose and possibilities for future happiness	Shear et al., <sup>30</sup> Shear et al., <sup>35</sup> Acierno et al., <sup>37</sup> Bryant et al., <sup>39</sup> Litz et al., <sup>41</sup> Papa et al. <sup>43</sup>
Revisiting the world	Strategies for confronting or revisiting avoided situations	Shear et al., <sup>30</sup> Shear et al., <sup>35</sup> Boelen et al., <sup>36</sup> Acierno et al., <sup>37</sup> Rosner et al., <sup>38</sup> Bryant et al., <sup>39</sup> Kersting et al., <sup>40</sup> Rosner et al. <sup>45</sup>
Storytelling	Recounting and reflecting on the story of the death in order to create an acceptable account; practice in confronting pain and setting it aside	Shear et al., <sup>30</sup> Shear et al., <sup>35</sup> Boelen et al., <sup>36</sup> Rosner et al., <sup>38</sup> Bryant et al., <sup>39</sup> Wagner et al., <sup>42</sup> Rosner et al. <sup>45</sup>
Using memory	Reviewing positive memories of the deceased and inviting reminiscence of negative memories; describing an imagined conversation with the deceased	Shear et al., <sup>30</sup> Shear et al., <sup>35</sup> Rosner et al., <sup>38</sup> Bryant et al., <sup>39</sup> Wagner et al., <sup>42</sup> Rosner et al. <sup>45</sup>

ter among patients who were randomly assigned to therapy for complicated grief (51% vs. 28%); the findings of another trial<sup>35</sup> were similar (69% vs. 32%).

Other (generally smaller) randomized, controlled trials have tested treatments similar to therapy for complicated grief; these forms of treatment are administered individually,<sup>36,37</sup> in groups,<sup>38,39</sup> or over the Internet.<sup>40-42</sup> Treatment for complicated grief has primarily been compared with supportive counseling or placement on a wait list for treatment. Taken together, these trials suggest that interventions that include strategies to reduce avoidance of thoughts about the death and avoidance of activities and places that are reminders of the loss are more effective than those that do not. Two small studies<sup>41,43</sup> have suggested that interventions focused on behavioral activation (i.e., increasing enjoyable activities) alone are effective, though these methods also include encouraging patients to do things even when these activities are reminders of the loss. Whereas therapy for complicated grief that has been proved to be efficacious is currently the preferred form of treatment, in patients for whom this is not available, a reason-

able approach is an intervention<sup>37</sup> that provides information about adaptation to grief and includes both strategies to reduce avoidance of reminders of the loss and strategies for behavioral activation.

#### PHARMACOTHERAPY

Although data are lacking from randomized trials to inform the use of pharmacotherapy for complicated grief, antidepressant medication is used commonly in practice. Five open-label trials that involved a total of 50 patients suggested improvement in patients who received antidepressants, but not benzodiazepines.<sup>47,48</sup> In addition, in a study of therapy for complicated grief, rates of completion of this therapy were significantly higher among participants who continued to receive stable doses of antidepressants than among those who were not receiving antidepressants (91% vs. 58%). In addition, the rates of response to therapy for complicated grief (61%) and to interpersonal therapy (40%) among patients who were receiving antidepressants were higher than those among patients who were not receiving antidepressants (42% and 19%, respectively), although these differences were not significant.<sup>49</sup>

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**AREAS OF UNCERTAINTY**


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Data are lacking on risk factors for complicated grief, its frequency among bereaved persons in various age groups, and its natural history. Consensus is needed regarding diagnostic criteria. Data are also lacking on associated sleep disturbance and its treatment, as are data from randomized, double-blind trials evaluating the effects of antidepressants and other medications (e.g., oxytocin) on patients with complicated grief. A multicenter trial (ClinicalTrials.gov number, NCT01179568) is under way to assess the efficacy of antidepressant medication alone or in combination with therapy for complicated grief.

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**GUIDELINES**


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There are currently no professional guidelines for management of complicated grief, although some have been proposed (Table 1).

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**CONCLUSIONS AND  
RECOMMENDATIONS**


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Four years after the death of her husband, the woman in the vignette continues to have severe yearning and sadness and preoccupying thoughts and memories of him that are impairing all aspects of her daily functioning. Complicating features are present, including extensive avoidance of reminders of her husband and troubling rumination about the circumstances of his death.

Further assessment should include specific questions regarding other features of complicated grief (see the Supplementary Appendix), the patient's history with respect to mood disorders or anxiety and use of alcohol or drugs, and determination of whether the patient has suicidal ideation or plans. Attention to other medical problems is also warranted, as is adherence to associated treatment recommendations.

Treatment options — including various forms of psychotherapy and pharmacotherapy — should be discussed with the patient. If a therapist who is skilled in therapy for complicated grief is available, I would recommend such therapy, since data from randomized trials show a greater benefit associated with this form of therapy than with other forms of psychotherapy. If this therapy is not available, I would recommend psychotherapy focused on accepting the loss and restoring effective functioning; the patient should be gently encouraged to return to activities that she has been avoiding because of associations with her husband. In addition, although data are lacking from randomized trials of the use of antidepressant medication for complicated grief, clinical experience and limited observational data suggest that this option warrants consideration, either in conjunction with psychotherapy or alone if the patient has no access to or interest in psychotherapy.

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