

Pathological Grief

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INTRODUCTION

At present, no universal definition or description of pathological grief exists nor does it appear as an established clinical entity in official diagnostic manuals.¹ The concepts of grief and bereavement have been around for some time, but the question remains, when is grief pathological? Some researchers believe that the onset, duration, and intensity of the grief are determining factors. Some believe it is directly related to attachment to or ambivalence toward the deceased person prior to their death. Others believe the circumstances surrounding the death (ie, unexpected, sudden, violent) may cause pathological reactions.

Most societies mandate expectations and time course for the grief process.² In the United States, the bereaved typically are expected to return to school or work within a few weeks, establish an equilibrium within a few months, and be capable of pursuing new relationships within 1 year.² However, the process of grief does not end within a defined interval.

The term “grief” is sometimes used interchangeably with “bereavement.” Bereavement can be defined as an objective state in the wake of death, whereas grief may consist of diverse reactions to the death, including syndromal clusters of cognitive, emotional, somatic, and behavioral symptoms.³

Uncomplicated or normal grief is believed to proceed through a series of anticipated stages (**Table 1**). There are also episodic depressive periods that may occur as reactions to certain holidays or anniversaries, sometimes referred to as “holiday blues” or “anniversary reactions,” respectively.² These are not pathological by definition but should be considered high-risk times for vulnerable individuals.²

Pathological grief involves maladaptive reactions to bereavement that manifest as psychological and physical impairments.³ The boundary where normal grief ends and pathological grief begins is vague. As Middleton states, “The field is still struggling to validate and operationalize the construct of ‘normal’ grief. ... [W]hen the focus is extended to include a range of ‘abnormal’ forms of grief, the difficulties are compounded.”⁴

In the last 4 decades, Western countries have produced sufficient evidence to indicate the negative effects of bereavement on psychiatric and physical morbidity, including an increased risk of depressive symptoms, anxiety, poor physical health, immunological dysfunction, increased adrenocortical activity, and increased mortality.³ Bereavement reactions can be considered complicated if the medical or psychiatric outcomes are adverse.²

At this time, there are no operationalized criteria for grief, and research to date has not clearly identified areas of psychopathology that are grief-specific.⁵ When a patient presents for psychiatric care following the death of a loved one, the most common diagnoses applied are posttraumatic stress disorder (PTSD), depressive disorders, adjustment disorders, and personality disorders.⁶ The best studied of the potential pathologies is depression.² Grief is not synonymous with depression or anxiety, but there is some overlap. There are references to bereavement and grief in the DSM-III-R and DSM-IV-TR,⁷ but these references are always associated with other diagnostic categories or V codes. Development of valid criteria would help distinguish grief from other bereavement-related emotional disorders.

THEORETICAL CONSTRUCTS

When researchers and scientists in the field of grief and bereavement were surveyed regarding theoretical constructs and views on pathological grief, most nominated attachment theory (75.7%) and psychodynamic theory (65.7%) as useful models.⁵ Sociological, cognitive, behavioral, the ethological constructs were considered less useful. The following discussion outlines these 2 perspectives.

PSYCHOANALYTIC THEORY

One focus of Freud’s self-analysis was the loss of his father; loss and the internalization of lost objects remains central to psychoanalytic theory.⁵ Freud differentiated mourning (ie, normal grief) from melancholia (ie, pathological grief). Freud’s 4 components of normal mourning were: (1) profoundly painful dejection;

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Pathological Grief

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Cover Illustration by mb cunney

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Table 1. Stages of Uncomplicated or Normal Grief

Initial stage	The first few weeks after the loss; characterized by feelings of shock and disbelief
Intermediate stage	The first year; distinguished by feelings of loneliness and thoughts about the death, why it happened, and how it could have been prevented
Recovery stage	Usually begins in the second year, when the individual seeks out social situations

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(2) loss of capacity to adopt new love objects; (3) inhibition of activity or turning away from activity not connected with thoughts of the loved person; and (4) loss of interest in the outside world insofar as it does not recall the deceased.⁵

Freud believed both mourning and melancholia have in common the experience of pain and sadness, and both are brought on by loss. The difference exists in that the individual in mourning maintains a position of self regard, whereas the individual with melancholia feels dejected, loses interest in the world, and shows a diminished capacity to love. Freud theorized that in the context of the loss of an ambivalently held object, the ego incorporates or forms narcissistic identification with the object. Hostility which was originally felt toward the object is redirected toward the self, resulting in torment and suffering.⁸

Klein described the depressive position, an infantile developmental stage associated with the ability to recognize and relate to "whole objects." If a person experiences pathological grief in later life, then that person has not achieved a good object relationship that allows him to feel secure in his inner world.⁵

Lindemann noted delayed grief could last years, and grieving could be precipitated by subsequent loss. He discussed morbid grief reactions as "distortions of normal grief," and various presentations included psychosomatic illness, progressive social isolation, furious hostility, agitated depression, and self-punitive behavior.⁵ Psychoanalytic theorists dating back nearly a century remain influential in understanding grief and its complications.

ATTACHMENT THEORY

Bowlby integrated analytic and ethological concepts in the development of attachment theory.⁵ He noted similarities between infants separated from their mothers and adults facing bereavement. Grief was described as an extension of the general response to separation;

Table 2. Forms of Pathological Grief

Chronic grief	Indefinite prolongation of grief with exaggeration of symptoms
Inhibited grief	Most symptoms of normal grief are absent
Delayed grief	Painful emotions were avoided for a time

Adapted with permission from Stroebe MS, Stroebe W, Hansson RO, editors. *Handbook of bereavement: theory, research, and intervention*. Cambridge: Cambridge University Press; 1993:48.

grief in adulthood was described as a form of separation anxiety when the attachment bond was disrupted.⁵ Healthy or normal mourning could last much longer than previously thought and included anger (ie, toward the deceased person, self, and others), disbelief, and an often unconscious tendency to search for the deceased person.⁵ Attachment theory linked pathological grief to the patient's childhood experiences and parental attachment behavior. Bowlby stated patients with "pathogenic parenting" were especially vulnerable and described 3 forms of disordered attachment: (1) anxious attachment (ie, insecure attachments to marital partners, overly dependent); (2) compulsive-self reliant (ie, reluctant to accept care in developmental years, insisted on doing everything him/herself); and (3) compulsive caregiver (ie, always taken role of giver rather than receiver, even in childhood).⁵ Bowlby's theory was that individuals with anxious attachment are likely to exhibit chronic grief, and those who were compulsive-self reliant were likely to deny loss and exhibit delayed grief.^{5,9}

Parkes also applied attachment theory and described 4 phases: denial and numbing, searching for the lost object, anger and guilt, and finally mitigation and defense.¹⁰ Parkes identified 3 forms of pathological grief (**Table 2**).

Attachment theory posits a disposition to seek proximity to others for security and protection in times of stress.^{9,11} Secure attachment develops from having a significant other who is attentive and responsive to the needs of the individual; this promotes self image and the realization that other satisfying affective bonding is possible.¹¹ Basic to this theory is that those with insecure attachment often resist accepting the reality of a loss.

CHARACTERIZING PATHOLOGICAL GRIEF

The definition of pathological grief has been debated for many years, and as of yet the literature shows no

consensus on an operational definition. Some researchers use multiple descriptive terms based on intensity, onset, quality, or duration of grief. Others take into account the circumstances of the loss, cultural and religious background of the bereaved, and premorbid functioning of the individual. Most researchers argue that it is not the type but rather the severity of grief symptoms that makes a grief reaction pathological.¹ Ultimately, it is important that we do not discount the benefits of normal grief and the growth that occurs secondarily. There is evidence that some manifestations of grief may last for many years but are not necessarily pathological (eg, missing the lost one, responding to reminders of them).⁸

Several prominent researchers have studied the grief process extensively and have identified variations from the course of normal grief. Prigerson considers grief to be complicated only if symptoms observed are found to predict long-term functional impairments.¹² Prigerson et al found qualitative differences between bereavement, depression, and complicated grief. Bereavement-related depression was characterized by hypochondriasis, apathy, insomnia, anxiety, suicidal ideation, guilt, and depressed mood. Complicated grief emerged as a discrete set of symptoms that were relatively independent of those associated with bereavement-related depression, including crying, searching and yearning for the deceased, preoccupation with thoughts of the deceased, disbelief about the death, and being stunned by the death.¹² Prigerson stated the presence of symptoms after 6 months puts the bereaved at increased risk for enduring social, psychological, and medical impairment, and concludes that the core indicators of complicated grief appear to be yearning for the deceased and preoccupation with thoughts of the deceased.¹²

Horowitz, another prominent researcher in this area, believed that pathological grief is an intensification of posttraumatic processes where emphasis is on the "activation of negative latent self images," referring to the psychodynamic model.¹³ Horowitz et al argued that "pathological grief deserves a place in the diagnostic nomenclature," either separately or under PTSD.¹³ He views grief as incorporating intense posttraumatic stress reactions such as denial and re-experiencing. This research supports a single set of criteria for pathological grief and more recently for complicated grief disorder, which encompasses variations in response that are personality-based.¹³

Jacobs argued for subtypologies of pathological grief; he aligned himself with the attachment model, stating that the pathological variants of grief should be defined in terms of the absence or extreme intensifica-

tion of separation anxiety.¹⁴ Jacobs stated, "...the syndromes of pathological grief, with one exception [absent grief], do not differ qualitatively from those of normal grief. They are dysfunctional departures from a tolerable intensity of separation distress or deviations in the duration of such distress. ...[S]yndromes of pathological grief are functional disorders in which normal attachment behavior and physiology, which are evoked by a loss, become aberrant."^{14,15}

Marwit addressed the overlap of complicated grief and PTSD in terms of symptom characteristics and precipitating factors.⁶ He highlighted the impact on the primary relationship network (universal in grief, not in trauma) and the patient's sense of safety in the world (often challenged in trauma, not always in grief).⁶ He concluded that complicated grief syndrome may not require 4 distinct diagnoses to describe the phenomenon adequately; therefore, symptoms factor into 2 dimensions (ie, intensity and duration).⁶

Middleton et al asked researchers, clinicians, and other identified experts whether they endorsed 6 syndromes of grief pathology and, if so, what distinguishing features each contained.¹⁶ The 6 syndromes of grief were absent, delayed, inhibited, chronic, distorted, and unresolved.⁵ The general consensus was that delayed, chronic, and absent grief exist and should be recognized. Delayed grief was defined as lasting from weeks to years. Absent grief was defined as the inhibition or absence of typical expression, denial of feelings about loss, and no external signs of grieving. Chronic grief was defined as prolonged, unending, unchanging grief associated with depression, guilt, self reproach, marked sadness, withdrawal, and prolonged preoccupation.^{5,16}

Those who cope by repressing grief are more vulnerable to sleep disorders, depression, and hypochondriacal symptoms. Those who express intense distress and cannot stop grieving go on to suffer chronic grief; this may reflect a dependent relationship or ambivalence in the relationship toward the deceased.¹ These 2 patterns of grieving often seem to occur in "avoiders" (people with the tendency to avoidance) and "sensitizers" (those with the tendency to obsessive preoccupation), respectively.¹⁷ It is important to identify those at risk for developing pathological grief. Factors increasing risk of developing pathological grief are outlined in **Table 3**. If clinicians are aware of these risks, interventions in both preventive psychiatry and treatment models can be instituted.

A panel of experts in bereavement, trauma, and psychiatric nosology convened in January 1999 to discuss the need for diagnostic criteria for complicated grief or traumatic grief.¹⁷ They identified studies demonstrating that

symptoms of separation distress (eg, yearning, searching for the deceased, excessive loneliness resulting from the loss) form a cluster with symptoms of traumatic distress (eg, intrusive thoughts about the deceased, feelings of numbness, disbelief about the loss, being stunned or dazed, a fragmented sense of security and trust).¹⁷ These symptoms are distinct from depressive and anxiety clusters. The identified cluster also is associated with disability such as impaired role performance, functional impairment, subjective sleep disturbance, and low self-esteem. The cluster predicts substantial morbidity, including high cancer risk, cardiac disorders, alcohol and tobacco use, and suicidal ideation. Furthermore, these symptoms, unlike depressive symptoms, do not respond to interpersonal psychotherapy and/or tricyclic antidepressants (ie, nortriptyline).¹⁷ The panel concluded there is justification for distinct diagnostic criteria.

RELATED DISORDERS

Whether pathological grief is a separate entity or a complication of other disorders, such as PTSD, depression, somatic disorders, and personality disorders, remains to be seen. Thus far, research has not afforded empirical data to resolve this issue. There have been many reports of pathological grief that involve symptoms from each of the listed categories, but further research must be pursued to define symptoms exclusive to the grief process if they indeed exist. It is likely that circumstances of the loss, premorbid functioning, prior mental illness, and character traits affect presentation of this syndrome.

DEPRESSION

Depression is a common finding throughout grief literature. The DSM-III-R states that "a full depressive syndrome frequently is a normal reaction to such a loss, with feelings of depression and such associated symptoms as poor appetite, weight loss, and insomnia."⁵ DSM-IV describes bereavement as a V code, noting 6 specific pathological grief symptoms. It is debatable whether meeting the criteria of major depressive disorder after a loss should be viewed as a form of depressive illness or form of grief.³

Many assessment measures have utilized depression scales or implied that bereavement reactions should be interpreted in terms of depressive symptoms.⁵ Several overlapping symptoms have been identified, including sad/blue feelings, loss of interest, and sleep and appetite disturbances. Clayton's depression model of grief¹⁸ focuses on the emotional reaction of depression

Table 3. Factors Increasing Risk After Bereavement

Traumatic circumstances

- Death of a spouse or child
- Death of a parent (particularly in early childhood or adolescence)
- Sudden, unexpected, and untimely deaths (particularly if associated with horrific circumstances)
- Multiple deaths (particularly disasters)
- Deaths by suicide
- Deaths by murder or manslaughter

Vulnerable people

General

- Low self-esteem
- Low trust in others
- Previous psychiatric disorder
- Previous suicidal threats or attempts
- Absent or unhelpful family

Specific

- Ambivalent attachment to deceased person
- Dependent or interdependent attachment to deceased person
- Insecure attachment to parents in childhood (particularly learned fear and learned helplessness)

Adapted with permission from Parkes CM. Bereavement in adult life. *BMJ* 1998;316:858.

following a life event, specifically bereavement. Differences in symptom patterns of grief and clinical depression were described.⁵ Moreover, hallucinations were possible in bereavement but never delusions. Clayton ultimately defined pathological grief as a "continued depressive symptom."

Stroebe and Stroebe¹⁹ saw clinical depression as one form or outcome of pathological grief and felt that timing, intensity, and duration of depressive type phenomenology may ultimately determine whether or not depressive illness is diagnosed after loss. There are data that almost 25% of bereaved meet the criteria for major depressive disorder at 2 months after the loss and again at 7 months.²⁰

Prigerson et al proposed 2 categories as previously mentioned: bereavement-depression and complicated grief.¹² Bereavement and major depressive disorder are contrasted in **Table 4**. Further, researchers note complicated grief is distinct from major depressive disorder as evidenced by failure of grief to respond effectively to antidepressant therapy.¹⁴

Table 4. Differentiating Depressive Symptoms Associated with Bereavement from Major Depressive Disorder

Bereavement	Major Depressive Disorder
Symptoms may meet syndromal criteria for major depressive episode, but survivor rarely has morbid feelings of guilt and worthlessness, suicidal ideation, or psychomotor retardation	Any symptoms as defined by DSM-IV
Dysphoria often triggered by thoughts or reminders of the deceased	Dysphoria often autonomous and independent of thoughts or reminders of the deceased
Onset is within the first 2 months of bereavement	Onset at any time
Duration of depressive symptoms is less than 2 months	Depression often becomes chronic, intermittent, or episodic
Functional impairment is transient and mild	Clinically significant distress or impairment
No family or past personal history of major depressive disorder	Family or past personal history of major depressive disorder

PTSD

PTSD and other anxiety disorders are not as frequently considered as is depression in relation to the grief process but should be given equal consideration. The circumstances of bereavement are important to consider, especially when researching the association between anxiety and grief. Bereavement may be associated with a traumatic event, especially in cases of unexpected loss or losses related to terrorism or natural disasters.⁵ Most of the literature in the anxiety spectrum focuses on PTSD. The more sudden, unexpected, and unnatural the death, the more likely for overlap with traumatic stress reaction.² In this scenario, the individual may have a mixture of grief symptoms and traumatic stress, resulting in what some have called traumatic grief.

Schut found that while duration of illness was not significant in the grief process, perceptions that death was unanticipated or that farewells were inadequate both correlated with PTSD.^{5,21}

Pynoos and Nader et al attempted to separate PTSD from the grief reaction by utilizing the Grief Reaction Inventory and the PTSD Reaction Index.^{5,22} They found that relieving anxiety related to the trauma takes psychological priority over mourning. Lindy et al^{5,23} studied trauma associated with disaster-related bereavement situations. They also suggested that in psychotherapy dealing with the disaster following a nightclub fire, there is need to work through the effects of trauma before the individual can grieve. There is evidence that anxiety plays a significant role in the grief process and likely has important treatment implications yet to be discovered.

SOMATIC DISORDERS

The correlation between bereavement as a stressor

and the development of somatic symptoms is complicated and unresolved.⁵ As early as several decades ago, Parkes identified the “broken heart” effect of bereavement, and stated there may be an association with increased cardiac mortality.¹⁰ After a major loss, it is now known that there is increased risk of heart disease and suicide, and that bereavement contributes to many psychosomatic illnesses. Maddison found an increase in somatic symptoms and health care utilization following the loss of a loved one.^{5,24} Also following the loss of a loved one, there is vulnerability to a wide range of health problems and substance abuse.¹

Other developments in bereavement biology describe endocrine responses, immunological changes, and sleep disturbances.^{1,2} From an endocrinology standpoint, there is increase in adrenocortical activity related to separation distress and increases in both growth hormone and serum prolactin. The immunological changes include inhibited lymphocyte stimulation responses to several mitogens during the first several weeks after the loss and impaired natural killer cell activity. **Table 5** describes the physical and psychiatric complications of bereavement. Sleep studies are frequently abnormal and show decreased rapid eye movement (REM) latency and deep sleep as well as increased total REM sleep.³ Circadian rhythm abnormalities and sleep pattern disturbances also are common.² Knowledge of these physiological changes is vital to the comprehensive assessment of the bereaved individual presenting with somatic complaints.

PERSONALITY DISORDERS

The correlation between personality disorders and grief was not researched until 1984.⁵ Alarcon²⁵ noted that the impact of personality on the experience of grief had

Table 5. Complications of Bereavement

Physical

- Impairment of immune response system
- Increased adrenocortical activity
- Increased serum prolactin
- Increased growth hormone
- Psychosomatic disorders
- Increased mortality from heart disease (especially in elderly widowers)

Psychiatric

Nonspecific

- Depression (with or without suicide risk)
- Anxiety or panic disorders
- Other psychiatric disorders

Specific

- Posttraumatic stress disorder
- Delayed or inhibited grief
- Chronic grief

Adapted with permission from Parkes CM. Bereavement in adult life. *BMJ* 1998;316:858.

been ignored. He hypothesized that in the absence of a major affective disorder, "complicated" bereavement is primarily a reflection of a personality disorder.⁵ The hypothesis was that instead of the pathology being specific to the grief, pathological grief was an expansion of preexisting pathology. Personality development is clearly influenced by the formation of attachments, and patterns of adult attachment have been shown to reflect similar attachment.⁵ The DSM-IV describes diagnostic criteria for dependent personality disorder as follows: "feels uncomfortable or helpless when alone, urgently seeks another relationship...when a close relationship ends, and is unrealistically preoccupied with fears of being left to take care of himself or herself."^{5,7} Although grief may accentuate preexisting pathology, there is a lack of empirical evidence to support the assumption that pathological grief is personality-based or to explain how such factors impact on the etiology of pathological grief. This spectrum, as well as the aforementioned categories, needs further exploration.

AN ENTITY UNTO ITSELF?

Over time, the diagnostic and statistical manuals clinicians use have altered the way in which grief is defined

Table 6. DSM-IV-TR V Code 62.82 Bereavement

- Focus of clinical attention is reaction to the death of a loved one
- Some individuals present with symptoms of major depressive episode (ie, sadness, insomnia, poor appetite, weight loss)
- The individual usually regards the depressed mood as "normal" after the loss but seeks help for insomnia, anorexia
- Expression and duration may vary depending on cultural group
- Major depressive disorder if symptoms present for 2 months
- Symptoms that help differentiate major depressive disorder from bereavement
1. Guilt about things other than actions taken or not taken by the survivor at the time of the death
 2. Thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person
 3. Morbid preoccupation with worthlessness
 4. Marked psychomotor retardation
 5. Prolonged and marked functional impairment
 6. Hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person

Adapted with permission from Diagnostic and statistical manual of mental disorders: DSM-IV-TR. 4th ed, text revision. Washington (DC): American Psychiatric Association; 2000:740-1.

or categorized. **Table 6** presents the DSM-IV-TR V code definition of bereavement. The 6 symptoms listed at the end of Table 6 are not considered part of a "normal" grief reaction.³ The DSM-IV-TR endorses that bereavement may be associated with complicated reactions; "simple bereavement" is no longer excluded as a relevant feature in the classification of PTSD.¹⁴ In DSM-III-R and DSM-IV, "uncomplicated bereavement" is excluded from diagnostic features of both major depressive episode and PTSD. The DSM-IV-TR clarifies the boundary between major depressive episode and bereavement:⁷

After the loss of a loved one, even if depressive symptoms are of sufficient duration and number to meet criteria for a major depressive episode, they should be attributed to bereavement rather than to major depressive episode unless they persist for more than 2 months or include marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

The statement leaves room for the clinician's interpretation.

Table 7. Proposed Criteria for Traumatic Grief

Criterion A

1. The person has experienced the death of a significant other
2. The response involves intrusive, distressing preoccupation with the deceased person (eg, yearning, longing, searching)

Criterion B

In response to the death, the following symptom(s) is/are marked and persistent:

1. Frequent efforts to avoid reminders of the deceased (eg, thoughts, feelings, activities, people, places)
2. Purposelessness or feelings of futility about the future
3. Subjective sense of numbness, detachment, or absence of emotional responsiveness
4. Feeling stunned, dazed, or shocked
5. Difficulty acknowledging the death (eg, disbelief)
6. Feeling that life is empty and meaningless
7. Difficulty imagining a fulfilling life without the deceased
8. Feeling that part of oneself has died
9. Shattered world view (eg, lost sense of security, trust, control)
10. Assumes symptoms or harmful behaviors of, or related to, the deceased person
11. Excessive irritability, bitterness, or anger related to the death

Criterion C

The duration of the disturbance (symptoms listed) is at least 2 months

Criterion D

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

Adapted with permission from Prigerson HG; Shear MK, Jacobs SC, et al. Consensus criteria for traumatic grief. A preliminary empirical test. *Br J Psychiatry* 1999;174:70-1.

When considering the connection between adjustment disorder classification and bereavement, DSM-IV itself implies a distinction, stating that the diagnosis of adjustment disorder does not apply when the symptoms represent bereavement because adjustment disorder also is distinguishable from complicated grief.^{6,7} Adjustment disorder begins within 3 months of a stressor and lasts no longer than 6 months after the stressor or its consequences have ceased, although chronicity is a specifier.^{6,7}

Researchers have noted that pathological grief deserves a separate category in diagnostic manuals; however,

Table 8. Proposed Criteria for Complicated Grief Disorder

Event criterion/prolonged response criterion

Bereavement (loss of a spouse, other relative, or intimate partner) at least 14 months ago (12 months is avoided because of possible intense disturbance from an anniversary reaction)

Signs and symptoms criteria

Intrusive symptoms

- Unbidden memories or intrusive fantasies related to the lost relationship
- Strong spells or pangs of severe emotion related to the lost relationship
- Distressingly strong yearnings or wishes that the deceased were there

Signs of avoidance and failure to adapt

- Feelings of being far too much alone or personally empty
- Excessively staying away from people, places, or activities that remind the subject of the deceased
- Unusual levels of sleep disturbance
- Loss of interest in work, social, caretaking, or recreational activities to a maladaptive degree

Adapted with permission from Horowitz MJ, Siegel B, Holen A, et al. Diagnostic criteria for complicated grief disorder. *Am J Psychiatry* 1997;154:909.

only a small portion of the literature has been derived empirically.⁶ Horowitz, Marwit, and Prigerson all have produced support for distinguishing characteristics of a complicated grief process. Marwit's design previously has been used to demonstrate that an existing thanatological system (Worden's) is more reliable than the DSM indexing of complicated grief.⁶ Simultaneous to the development of consensus criteria for traumatic grief by Prigerson and colleagues,¹² Horowitz and colleagues published criteria for complicated grief disorder.¹³ Consensus criteria are outlined in **Tables 7** and **8**. Both criteria emphasize decompensation in functioning as criterion; both sets emphasize severe symptoms of separation distress.¹⁷ Both criteria also include avoidance symptomatology, loss of interest in usual pursuits, and reference to feelings of emptiness and loneliness.¹⁷ Important differences include temporal relationships between the loss and the onset of symptoms. Complicated grief disorder lists a 1-month duration and at least 14 months following the death (to acknowledge anniversary reactions); traumatic grief lists a 2-month duration and no defined duration in relation to the death.¹⁷ Overall, the 2 sets exhibit considerable consistency and agreement, suggesting independent valida-

tion is required as well as professional consideration in the next published diagnostic manual.¹⁷

TREATMENT

There is little data in the area of treatment since the grief syndrome itself is not yet clearly defined. Treatment strategies should aim to decrease symptoms associated with this disorder (separate from depression) and thereby increase the quality of life of the bereaved through enhanced physical, psychological, and social functioning.¹

If a depressive syndrome occurs in the course of bereavement, the clinician should assess the severity, circumstances of the loss, associated symptoms, pervasiveness, and patient's past history when deciding whether to treat.² Grief work allows survivors to redefine their relationship with the deceased and form new but enduring ties (eg, psychological and symbolic ways of keeping the memory of the deceased alive).² Therapists should make supportive interventions that address role functioning deficits; taking the patient's functioning level into account allows appropriate recognition and utilization of the patient's resources for engaging in psychotherapy.¹ To support the bereaved, assurance regarding the normality of grief and permitting the individual to express grief are important.

The majority of the grief literature consists of theoretical and clinical contributions; controlled clinical studies of psychotherapy for complicated grief are rare.¹¹ Reviews of the few studies which have examined psychotherapy for complicated grief indicate small to moderate effect sizes. Because complicated grief is a maladaptive reaction to the loss of a close significant relationship, the interpersonal functioning of the person is an important area to explore as a predictor of grief therapy outcome.

Ogrodniczuk et al measured 3 pertinent factors in each of the bereaved prior to treatment with psychotherapy.¹¹ Attachment to the lost person, quality of object relations, and level of social role functioning were evaluated, then subjects underwent different forms of therapy. Patients with higher quality of object relations had more favorable outcomes in interpretive therapy, while those with lower quality of object relations had more favorable outcomes in supportive therapy. A more secure attachment to the deceased person and better social role functioning were associated with more favorable outcome in both forms of therapy. Horowitz et al found evidence suggesting that exploratory techniques

were more suitable for patients with higher quality of object relations and less suitable for patients with lower quality of object relations.¹³ Supportive therapist actions were found to be more suitable for patients with lower quality of object relations.¹¹

Shear et al²⁶ found that the traditional focus on depression for the treatment of traumatic grief leaves the grief symptoms unattended. Her group developed traumatic grief treatment, which incorporates strategies from interpersonal psychotherapy for depression and cognitive behavior therapy for PTSD. The goal of traumatic grief treatment is to reconfigure the patient's relationship to the deceased so that they undergo a normal grief process. Ideally the bereaved comes to find the death acceptable but does not let go of the deceased.

American Psychiatric Association guidelines suggest that antidepressant medication or psychotherapy should be used when the reaction to the loss is particularly prolonged and psychopathology and functional impairment persist.²⁰ Recent research suggests that antidepressant medications, while effective in reducing depressive symptoms, do not substantially reduce intensity of bereavement as defined by scores on the Texas Revised Inventory of Grief. Pasternak et al²⁷ and Jacobs et al¹⁴ both found antidepressants were ineffective in reducing grief-related symptoms.²⁸ Although grief and depression are not synonymous, effective treatment of depression facilitates the work of grief.² Treating grief as if it were depression may neglect the need for specific treatment of complicated grief.

Another aspect of treatment involves reimbursement from third parties, given that pathological grief is not at this time a diagnostic entity. Clinicians are using various categories and coding systems when treating the grief process (ie, adjustment disorder, major depressive episode, PTSD). Validation of complicated grief could facilitate study, treatment, and reimbursement for this disorder.

There are multiple reasons to pursue appropriate and effective treatment methods for those suffering pathological grief. Most importantly, the bereaved deserve quality psychiatric care that is evidence-based. There is literature that suggests that treating pathological grief as we do depression is incomplete, and recognition of the grief process will lead to improved assessment techniques and inclusive treatment instituting biological, psychological, and social interventions.

CONCLUSION

Several problems regarding pathological grief have

been identified: the definition of pathological grief, the diversity in conceptualizations, the problem of distinguishing normal from pathological grief, and the complexity of relationships with other psychiatric disorders.¹⁴ Grief should be viewed as a complex and evolving process, requiring the use of a multidimensional model.⁵ Defining pathological grief is an unresolved issue, but recently researchers have proposed criteria for consideration in future diagnostic manuals. It is important to avoid pathologizing normal grief or to discount the function and value of grief as a normal emotional process. Ultimately, the grief process leaves most patients stronger and wiser as a result of the experience.¹

It is possible that pathological grief is described more accurately by symptom clusters as proposed by Prigerson et al¹² and Horowitz et al¹³ rather than by categories of excess or absence of grief reaction as proposed by Worden.²⁹ It also is possible that pathological grief is described most accurately by some combination of behavioral symptoms along with attention to intensity and duration as suggested by Marwit.^{6,30} Knowledge of the factors that predict problems in bereavement enables these to be anticipated and prevented during the course of treatment.¹

Pathological grief is, by definition, a mental disorder, since pathology describes abnormal or diseased conditions.⁴ Including pathological grief in diagnostic systems may help patients gain easier access to health care and financial aid programs and would acknowledge pathological grief as a problem that warrants professional attention.¹⁴

BOARD REVIEW QUESTIONS

- One theoretical basis for pathological grief is typically attributed to:
 - Attachment theory
 - Behavioral theory
 - Ego psychology
 - Modern structural theory
 - Self psychology
- Currently, pathological grief is:
 - A clinical entity in DSM-IV-TR
 - A V code
 - A complex and evolving concept
 - Known as traumatic grief
 - Resultant bereavement following the death of a loved one to suicide
- Complications of bereavement include all of the following EXCEPT:
 - Impairment of immune response system
 - Increased adrenocortical activity
 - Decreased serum prolactin
 - Increased growth hormone
 - Increased mortality from heart disease
- Advantages to adding pathological grief as a diagnostic category to the next DSM include all of the following EXCEPT:
 - Promotes continuing research in the area
 - Ability to anticipate pathologic grief by incorporating risk factors in preventive psychiatry programs
 - Ensures development of treatment strategies specific to pathological grief, which will improve biological, psychological, and social functioning
 - Pathologizing normal grief
 - Improved mental health care because of recognition of syndrome and subsequent reimbursement for its treatment
- A panel of experts on bereavement and trauma convened in 1999 and found that there exists a unidimensional symptom set exists for traumatic distress which is associated with all of the following EXCEPT:
 - Clinical improvement with interpersonal psychotherapy and nortriptyline
 - Functional impairment and low self-esteem
 - High cancer risk and tobacco use
 - Subjective sleep disturbance
 - Suicidal ideation

ANSWERS

1. A 2. C 3. C 4. D 5. A

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