Complicated grief

When the path of adjustment leads to a dead-end

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A primary task for those helping bereaved people is to determine whether or not the survivor's reaction to a loss is within the realm of a normal adjustment. This decision can then guide the way in which grief should be managed. Complicated and uncomplicated grief reactions are described here in an attempt to help bereavement carers to distinguish between these two paths of adaptation, and suggestions made for treatments which may help those suffering from complicated grief.

An encouraging conclusion to be drawn from bereavement research is that the vast majority of friends and family members ultimately adjust fairly well to the death of a loved one. We found that about 80-90% of those we studied reacted in this way. These 'normal' or uncomplicated grief reactions, though painful, move the survivor toward an acceptance of the loss and an ability to carry on with his or her life.

This is not to deny that most bereaved people feel very sad and distressed about their loss, and that they miss the person who has died, sometimes profoundly. It is not uncommon for people who survive someone they loved dearly to feel the pangs of grief again from time to time for the remainder of their lives. However, the important distinction between complicated and uncomplicated grief is that in the latter instance, the survivors are able to move on with their lives and pave a new way for themselves.

Indicators of a relatively adaptive, uncomplicated adjustment include the capacity to feel that life still holds meaning, a sustained sense of identity, effectiveness and trust in others, and an ability to reinvest in interpersonal relationships and activities. Survivors may initially exhibit many of the symptoms of complicated grief, but by six months post-loss there is usually some improvement in their ability to focus on other things and move beyond the loss. It is those who have elevated levels of a specific set of symptoms (see Table on p39) for more than six months after the death who may be cause for concern.

COMPLICATED GRIEF

Before providing a description of what we mean by complicated grief, it is important to clarify some potential sources of confusion. First, we do not wish to imply that complicated grief is the only, or even the primary, complication that may follow from bereavement. Other psychiatric disorders, such as major depression or PTSD, frequently follow the loss of someone dear. Bereaved people may exhibit symptoms of identification that give rise to concern about their adaptation to loss (eg feel pain in the same part of the body as the person who has died, or assume their behaviours or characteristics).

Second, our conceptualisation of complicated grief specifies that the particular distress symptoms persist for at least six months, regardless of when those six months occur. As a result, delayed and chronic subtypes of grief may both come under our complicated grief diagnosis as long as, whatever the delay in onset, symptoms then continue for six months. Typically, however, the overwhelming feelings of those whom we diagnose with complicated grief are not delayed; it is much more often the case that their grief has been intense and unrelenting since the death.

In contrast with survivors with uncomplicated grief, those with complicated grief resemble vehicles inextricably stuck in the morass of mourning, wheels spinning, going over and over in their minds the events that led up to the death. They are preoccupied by their sorrow and with regrets concerning the loss. Their ruminations and inability to concentrate on other things and their sense of disconnection from the people with whom they were closest before the death, drive them deeper into misery and isolation. Recurrent intrusive and distressing thoughts about the loss make it harder for them to dig themselves out and move beyond an acute sense of mourning. Complicated grief tends to be a stagnant state of wallowing in self-pity and sorrow over a loss. The road to recovery and readjustment has ended in a swamp.

Most of those who work with bereaved people will be familiar with the characteristics of the 10-20% of survivors who remain dysfunctional in their intense grief. Many, however, may not be aware of research that has identified a set of symptoms that are consistently shown to be distinct from other psychiatric disorders (such as depression), that are associated

EDITOR'S NOTE

The observation that grief can sometimes take abnormal forms is widely agreed but there has, until recently, been little systematic research to justify this claim. As a result pathological or complicated grief has been omitted from the authoritative *Diagnostic Statistical Manual* of the American Psychiatric Association, now in its fourth edition (*DSM-IV*, 1997).
Holly Prigerson, and her colleagues at Yale University, have carried out and published a series of careful studies that provide the scientific justification that is needed. Subtypes of complicated grief, such as chronic grief and delayed grief, are subsumed within the category of complicated grief, which is itself distinct from other non-specific psychiatric disorders. Her paper summarises this work, and draws some conclusions from other studies of the efficacy of interventions aimed at relieving complicated grief. *CMP*

with significant distress, and predictive of long-lasting disability and the onset of health problems[eg 1-8]. Results of our recent work reveal the severity and mix of symptoms that typify complicated grief. These are a set of sensitive and specific criteria for identifying those who will have enduring disability and impairment of their quality of life. The Table below shows a current formulation of these symptoms. Reactions from *Bereavement Care* readers to this 'work-in-progress' (a refinement of our initially proposed consensus criteria for complicated grief[9]) would be welcome.

DIAGNOSTIC DISTINCTIVENESS

Research[1-4, 6-9] has found the symptoms of complicated grief to be distinct from symptoms of major depression, generalised anxiety disorder and post-traumatic stress disorder (PTSD), as they are defined in the *DSM-IV*. In fact our research, and studies conducted independently by many others[eg 10, 11], repeatedly demonstrate that the symptoms of complicated grief form a cluster that hangs together cohesively and that is distinct from depression and anxiety symptom clusters. So, for instance, symptoms of feeling sad or blue that characterise depressive episodes are not characteristic of complicated grief. Similarly, neither are the avoidance, hyperarousal, fear or horror that characterise PTSD.

Yearning, pining, disbelief that the deceased is really gone, and feeling uneasy and guilty about moving on with one's life are all symptoms related to attachment issues. These symptoms characterise complicated grief but they do not define depression or PTSD. In fact, we find a relatively poor degree of overlap between those people who meet criteria for complicated grief and those who meet criteria for major depression, generalised anxiety disorder and PTSD. Complicated grief may co-occur with these other disorders, but it contains symptoms and is a function of psychological issues which are not part of other diagnoses.

Research has not only demonstrated the distinctive range of complicated grief symptoms, but also that the risk factors, clinical course, treatment response, and outcomes set it apart from other psychiatric disorders.

Risks

Unlike PTSD which seems to be a fear-based response to a life-threatening situation, complicated grief appears to be more of an attachment disturbance, rooted in an insecure and unstable sense of self and one's relationships to others[12-13]. For example, we have found that relationships with the deceased that previously provided security, that were close, confiding and dependent, are not a risk for major depression, but that they are among the leading risk factors for complicated grief[12-14]. Among a community-based sample of late-life bereaved people[15], childhood abuse and serious neglect were specific risks for complicated grief but not PTSD. Findings from work under preparation with the same sample suggest that for them childhood separation anxiety also poses a significant risk factor for complicated grief, but much less so for major depression and PTSD.

We have also found that those who are averse to lifestyle changes (eg people who like things to remain the same and who dislike novelty) have a vulnerability to complicated grief[16], whereas those who report being prepared for a death are significantly less likely to develop it[17]. Those who have ample social support and who are frequent users of the internet and email have also been shown to be at significantly lower risk of developing complicated grief[18]. To summarise these risk factors, complicated grief appears most common in those who were, in a sense, glued together by the presence and support of the deceased person and who find themselves correspondingly torn apart by their absence.

Outcomes and use of the health service

Complicated grief has been shown to be a substantial risk for suicidal thoughts and behaviours, incidence of cardiac events, high blood pressure and even cancer, in studies that took into account the effects of major depression and generalised anxiety disorder[3-8]. It is a risk factor for quality of life impairments (eg poor social interactions and role functioning, loss of energy, describing oneself as ill), disability (eg functional impairment, days of work lost), and adverse health behaviours (eg changes in patterns of consumption of alcohol, food and tobacco)[1,2,4-10,19].

Interestingly, bereaved people with complicated grief are significantly less likely to visit either a mental health or physical health care professional than those without grief complications[20], whereas it is the other way about for sufferers of major depression. In other words, those bereaved people most in need of assistance are the least likely to seek out the services they need. This suggests a need for greater outreach here: we should make

CRITERIA FOR DIAGNOSING COMPLICATED GRIEF

CRITERION A **Chronic and persistent yearning, pining, longing for the deceased, reflecting a hunger that cannot be satiated by others. Daily intrusive and disruptive sense of heartache.**

1. Yearning/longing/heartache *'Do you feel yourself yearning and longing for the person who is gone?'*

CRITERION B **The person should have four of the following eight remaining symptoms at least several times a day or to a marked degree:**

1. Trouble accepting the death *'Do you have trouble accepting the loss of ___?'*

2. Inability to trust others *'To what extent has it been hard for you to trust others since the loss of ___?'*

3. Excessive bitterness or anger related to the death *'Do you feel angry about the loss of ___?'*

4. Uneasy about moving on *"Sometimes people who lose a loved one feel uneasy about moving on with their life. To what extent to do you feel that moving on (for example, making new friends, pursuing new interests) would be difficult for you?'*

5. Numbness/detachment *'Do you feel emotionally numb or have trouble feeling connected with others since ___ died?'*

6. Feeling life is empty or meaningless without deceased *'To what extent do you feel that life is empty or meaningless without ___?'*

7. Bleak future *'Do you feel that the future holds no meaning or prospect for fulfilment without ___?'*

8. Agitated *'Do you feel on edge or jumpy since ___ died?'*

an extra effort to identify appropriate services and encourage those with complicated grief to use them.

Pharmacotherapy and psychotherapy

Our initial work indicated that whereas interpersonal psychotherapy and tricyclic antidepressants were effective for reducing bereavement-related depressive symptoms, they were not very effective for ameliorating symptoms of complicated grief[21-22]. Recent trials suggest that selective serotonin reuptake inhibitors (Paxil)[23] and Bupriopion (Wellbutrin)[24] may be effective for treating both symptoms of major depression and complicated grief, though results await confirmation from randomised controlled trials.

William Piper's interpretative and supportive group therapies[25], Katherine Shear's traumatic grief therapy[26], and Mardi Horowitz's eclectic integrated cognitive-dynamic approach to case formulation and treatment[27] are all promising psychotherapeutic techniques for complicated grief although, again, conclusive results await publication of randomised controlled trials. Treatments that get at the meaning of the loss to the survivor's sense of self and attitudes towards their surrounding environment, and interventions that enhance the survivor's sense of their prospects for future fulfilment, would target the core attachment issues that lay at the root of this disorder.

Behavioural therapies in which a survivor confronts feelings, phobias or anxieties about a traumatic event (in this case, the death) and relives it in the therapy situation, may be misguided particularly when the death does not occur from objectively traumatic circumstances. Treatments that foster a sense of competence and independence in the survivor, that promote the development of new, meaningful relationships, as well as those that instil hope for a productive and satisfying future, would appear the most beneficial for addressing the bereavement issues central to survivors with complicated grief. BC

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Resilience in bereavement. Study day at St Christopher's Hospice with Linda Machin, Marilyn Relf. London. 29 June. Contact the Education Administrator ☎ 020 8768 4656; education@stchristophers.org.uk

Measuring success: evaluating children's bereavement services, 2 Feb; **Supporting adolescents facing the death of a parent,** 21 Feb; **When grief becomes complicated,** 22 Feb; **Responding to 'uncomplicated' grief,** 2 March; **Researching palliative care bereavement services,** 17 March. Study days. Oxford, UK. Contact Sir Michael Sobell House ☎ 01865 225886; ssc@orh.nhs.uk

Dealing with grief in relationships. 9th annual conference of Bereavement and Loss, Training and Support. Northwood, Middx, UK. 16 February. Keynote speaker, Corinne Sweet. Apply to Conference Coordinator, BLTS, 36 Hillcroft Ave, Pinner HA5 5AR, UK; ☎ 020 8930 7375