

# COMPLICATED GRIEF

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Grief is normal. Grief is a common, natural response one experiences after a significant and permanent loss. Grief is usually caused by death of the loved one, but may be caused by the death of a pet, the end of a relationship (i.e. divorce), or the loss of property.<sup>1</sup> Over time, grief lessens in intensity and the grieving individual returns to a normal or near normal level of functioning.

Complicated grief, on the other hand, is abnormal. It is a state of intense, unrelenting, and disabling sorrow. Complicated grief is a distinct psychiatric syndrome requiring specific treatment.

### **What is “normal” grief?**

While everyone agrees grief is normal, few people agree on a precise definition of “normal” grief. Grief is a complex reaction that includes emotional, physical, cognitive, and psychological components.

One of the oldest and well-known models of grief is the five-stage model proposed by Elizabeth Kübler-Ross. She said a grieving individual will normally progress through denial, anger, bargaining, and depression and then ultimately come to accept the loss.<sup>2</sup> Newer research suggests many people do not experience grief in a sequential order and may also experience symptoms such as emotional numbness, yearning, and despair.<sup>3</sup>

Perhaps because of this multistage progression, grief has been viewed as something from which one “recovers.” Grief is a process, not a state. It progresses in fits and starts and may ebb and flow. It is generally felt in waves of intense sadness, loss, and separation. One does not simply “get over” the loss of a loved one, just as one does not get over graduation or a wedding. The loss of a loved one is a major life event that will be remembered and contemplated. It will cause emotions that may be unpleasant, painful, and powerful. One hopes the waves of emotion even out into ripples over time.<sup>4</sup>

Most people assume the grieving person will have feelings of loss and sadness soon after the death or separation, which lessen over time as the person moves through the stages of grief. In fact, most people do not experience grief in this way.<sup>4</sup> For many people, grief is never really over. Instead, the grieving person finds herself in one of four categories: resilience, chronic grief, depressed improved, and chronic depression.<sup>5</sup> People who grieve in one of these four normal ways regain a reasonable level of functioning; people with complicated grief do not.

### *Resilience*

People who experience the resilience grief pattern show very few signs of grief, sadness, or loss. Instead, they show a relatively low level of chronic distress or simply no outward signs of grief whatsoever. This pattern was previously considered abnormal. People with this grieving style were encouraged to “let out their emotions” and “stop trying to be strong.”

Careful research of the resilience pattern has revealed it is not abnormal at all. In fact, 46% of people experience grief in a resilience pattern.<sup>4,6,7</sup> Moreover, people in this category have positive coping styles and healthy adjustment to the loss. They have few or no symptoms of depression at six or 18 months after the loss.<sup>6</sup> Not only is resilience the most common grief pattern, but it appears to cause the least number of functional and psychological problems. Resilient grievers experience and express positive emotions and remember their lost love one fondly. Individuals in this group may experience occasional pangs of loss and continued yearning, but still function at their normal level.<sup>8</sup>

### *Chronic Grief*

A small percentage of people experiencing grief will manifest a chronic grief pattern. People in this category will experience significant pangs

of loss and sadness and sustained yearning for the lost individual. Chronic grief occurs most commonly in widows/widowers who were quite dependent on their deceased spouse. Chronic grief eventually resolves within four years on average as the person integrates the loss into normal living.<sup>8</sup>

### *Depressed Improved*

One in ten individuals who have lost a spouse exhibit a depressed improved pattern grieving.<sup>6</sup> This pattern occurs most often when the deceased suffered a long health problem prior to death or the couple had an unhappy relationship. The depressed phase of the depressed improved pattern occurs before the loss and the improved phase begins upon death. The grieving individual is able to focus on positive memories of the deceased, finds meaning in the loss of the deceased, and visualizes/experiences the benefits of living without the deceased. The loss of a loved one is the loss of a chronic stressor. Thus, death releases the grieving person from a difficult relationship or from caregiving duties associated with caring for a chronically ill loved one.

### *Chronic Depression*

People who experience the chronic depression pathway of grief share an important feature with the depressed improved individual, namely experience depression before the loved one dies. Unlike people in the third group, the depression of chronically depressed grievers does not begin to resolve with the loved one's death. Instead, the depression remains or worsens. The ongoing depression may last for four years or more after the loss and may reflect a long-standing mood disorder rather than simple grief.<sup>2</sup>

In summary, resilience, chronic grief, depressed improved, and chronic depression are considered normal pathways or patterns of grief. Those who experience one of these four patterns of grief may experience mild functional difficulty, yet all

four patterns are distinct from complicated grief.

## **Complicated Grief: Features and Symptoms**

Approximately 7% of those who experience grief will develop complicated grief.<sup>9</sup> The rate is even higher among those who have suffered the loss of a life partner or child, especially to a violent death. Complicated grief is most common in women over the age of 60.<sup>9</sup>

Complicated grief is an unusually severe and prolonged form of grief that impairs the sufferer's ability to function.<sup>10</sup> In most cases, people with complicated grief will experience persistent, intense yearning and sadness accompanied by frequent thoughts of the deceased and an inability to accept the person is gone. Sufferers tend to ruminate on the factors surrounding the death itself. For example, sufferers may be angry with those they deem responsible for the death or guilty that they did not do more to prevent death or prolong the life of the deceased.<sup>10</sup>

Like those with post-traumatic stress disorder, people with complicated grief tend to avoid situations that may evoke feelings of grief or reminders of loss. On the other hand, this same person may spend inordinate amounts of time viewing photos, mementos, or belongings of the deceased.

In some cases, the person with complicated grief has a diminished sense of self, meaning the sufferer cannot imagine a life without the lost loved one, causing the sufferer to withdraw from work, family, and social ties. As a result, the sufferer's support system is strained, frustrating family members and friends, causing them to further distance themselves from the grieving person. Thus, the sufferer's sense of isolation is perpetuated.

The most common features of complicated grief are yearning for the deceased and feeling upset by memories of the deceased. In a survey of nearly 300 patients with complicated grief, researchers

identified the most common symptoms, in order of decreasing frequency:<sup>11</sup>

- Yearning for the deceased (88% of those surveyed)
- Feeling upset by memories of the deceased (82%)
- Loneliness (81%)
- Feeling life is empty (80%)
- Disbelief (76%)
- Inability to accept the death (70%)

### **Complicated Grief: Diagnosis**

Ordinarily, psychiatrists and psychologists in the United States use diagnostic criteria laid out in the American Psychiatric Association's

Diagnostic and Statistical Manual (DSM) to diagnose mental health conditions, diseases, and syndromes. Currently, there is no entry for complicated grief in the latest edition of the DSM, the DSM-5.

Complicated grief is called Persistent Complex Bereavement Disorder in the DSM-5 and is discussed in appendix of the manual entitled "Conditions for Further Study."<sup>12</sup> It is quite possible the next edition of the DSM will include full diagnostic criteria for this disorder, but the next update is not anticipated until at least 2025. Here is the description of Persistent Complex Bereavement Disorder in the appendix of the DSM.

#### **Provisional DSM-5 Criteria for Persistent Complex Bereavement Disorder<sup>12</sup>**

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 be 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.

In the absence of DSM diagnostic criteria, the gold standard assessment for distinguishing between complicated grief and normal grief is the Inventory for Complicated Grief (ICG). The ICG is a 19-item questionnaire that has been validated in patients with complicated grief. It is usually administered in a physician's or psychologist's office.

## Inventory for Complicated Grief

For each item, describe how you feel right now using one of these five terms:

- Never
- Rarely
- Sometimes
- Often
- Always

			Answer
1.	I think about this person so much that it's hard for me to do the things I normally do...		
2.	Memories of the person who died upset me...		
3.	I feel I cannot accept the death of the person who died...		
4.	I feel myself longing for the person who died...		
5.	I feel drawn to places and things associated with the person who died...		
6.	I can't help feeling angry about his/her death...		
7.	I feel disbelief over what happened...		
8.	I feel stunned or dazed over what happened...		
9.	Ever since s/he died, it is hard for me to trust people...		
10.	Ever since s/he died, I feel like I have lost the ability to care about other people or I feel distant from people I care about...		
11.	I have pain in the same area of my body or have some of the same symptoms as the person who died...		
12.	I go out of my way to avoid reminders of the person who died...		
13.	I feel that life is empty without the person who died...		
14.	I hear the voice of the person who died speak to me...		
15.	I see the person who died stand before me...		
16.	I feel that it is unfair that I should live when this person died...		
17.	I feel bitter over this person's death...		
18.	I feel envious of others who have not lost someone close...		
19.	I feel lonely a great deal of the time ever since s/he died...		
Number of 'Never' answers		X 0	0
Number of 'Rarely' answers		X 1	
Number of 'Sometimes' answers		X 2	
Number of 'Often' answers		X 3	
Number of 'Always' answers		X 4	
<b>Total Score</b>			
A total score of 25 or less is probably not complicated grief			
A total score of 26-30, is probable complicated grief			
A total score of 31 or higher is definite complicated grief			

## Risk Factors

In a comprehensive review of 40 published studies, researchers identified a number of factors often present in complicated grief sufferers.<sup>13</sup> Some of these factors are present in childhood and adolescence while others are related to the circumstances surrounding the death of the loved one.

People who report adversities (e.g., death of a parent, abuse) during childhood suffer more distress during grieving. Separation anxiety during childhood, which is the extreme emotional reaction when a caregiver leaves, places people at greater risk of complicated grief as an adult. Excessive dependency on a spouse or significant other is a strong predictor of complicated grief.

An insecure attachment style, either anxious or avoidant, is a risk factor. Someone with an anxious insecure attachment style has a perpetual worry others will not be available for support. A person with avoidant insecure attachment is highly independent, relies on him- or herself for support, and is emotionally distant. People with a secure, supportive spouse but also an insecure attachment style have particularly severe grief reactions.

The most common risk factors for complicated grief include<sup>14</sup>:

- Older age (>60)
- Female gender
- Childhood trauma
- Lower socioeconomic status (especially when the death causes economic hardship)
- Non-Caucasian race/ethnicity
- Pre-existing anxiety disorder or depressive disorder
- The death was of a spouse or child, or someone who was chronically ill
- The deceased was young
- The death was unexpected
- The death was unusual or due to violence

- Limited information is available about the death

Approximately half of people who develop complicated grief also have major depressive disorder and between 30 and 50% have post-traumatic stress disorder.<sup>15</sup> One in five people with complicated grief has generalized anxiety disorder and one in ten has panic disorder.<sup>11</sup> Often these psychiatric illnesses are present in the same people at the same time (i.e. PTSD, depression, and complicated grief occurring in the same person).

## The Consequences of Complicated Grief

Complicated grief directly and negatively affects the sufferer's quality of life. Many people with complicated grief increase their use of or abuse of tobacco, alcohol, and drugs. People with complicated grief are more likely to have medical illnesses and those illnesses are more severe than in people with normal grief. There is also an increased death rate among complicated grief sufferers.

Between 40 and 60% of complicated grief sufferers contemplate, attempt, and/or complete suicide, which is more than twice as common as in those grieving "normally."<sup>16</sup> Having complicated grief increases suicidality eleven-fold.<sup>16</sup> Approximately 38% of people with complicated grief engage in self-destructive behavior and 13% attempt suicide at least once.<sup>17</sup>

## Goals of Complicated Grief Treatment

It is not the goal of complicated grief treatment to have the sufferer simply "get over" a loss, nor is the goal to forget about the deceased or ignore the fact a meaningful loss has occurred. It is unlikely that someone who suffers from complicated grief will no longer experience sadness, loss, or other symptoms of grief, even with treatment.<sup>14</sup> These goals are unrealistic, unhelpful, and may create false expectations and feelings of failure when

the goals cannot be met.

Instead, the goals of complicated grief treatment are:

- To decrease the frequency, duration, and intensity of grief symptoms
- To allow the patient to experience negative emotions and release them
- To prompt the patient to consider and savor positive emotions
- To instill in the patient a healthy, enduring connection with the deceased and decrease rumination on the deceased (e.g., excessive handling of mementos)
- To help the patient to accept the finality of the loss and its consequences
- To encourage the patient to stop avoiding positive social interactions
- To foster satisfying activities and relationships

## **First-line Treatment**

### *Patient Education*

Once the diagnosis of complicated grief is made, the most important first step is to educate the patient (and support system, if possible) about complicated grief.<sup>10,18</sup> Those who suffer from complicated grief and the people who care about the sufferer should understand while complicated grief is abnormal, is not the sufferer's fault. This step is especially important when the patient's support system has pulled away from the patient out of frustration, which is common. Everyone involved should understand complicated grief is a treatable condition. Moreover, the sufferer may have other, treatable psychological conditions such as depression or PTSD. Depending on the severity of the condition, patients may need to be monitored as frequently as once per week,

especially if suicidality is a factor.

Psychotherapy is the principal treatment for complicated grief. The final part of education and initial management is to ensure the person with complicated grief is referred to a psychotherapist.

### *Cognitive Behavioral Therapy*

Cognitive Behavioral Therapy (CBT) has emerged as the main non-drug intervention in psychology and psychiatry and not just in the treatment of complicated grief. This is due in large part to the broad and consistent success of CBT in the treatment of several psychological conditions, its highly structured format, and its acceptability to patients. In other words, CBT is well studied, broadly accepted, and usually delivers benefits.

Psychotherapy, specific for complicated grief, is currently the best treatment for this disorder.<sup>14,15,19,20,21</sup> Psychotherapy that is not specifically focused on complicated grief is much less effective. Complicated grief-specific CBT consistently outperforms other active psychotherapeutic treatments in clinical trials. About 50 to 70% of those treated with complicated grief-specific CBT benefit from the treatment<sup>15,21,22</sup>, and of those patients who do respond, many achieve long-lasting results.

CBT is a psychotherapeutic treatment based on the principle that psychological disorders and symptoms are the result of unhelpful thoughts. Further, unhelpful thoughts contribute to and sustain emotional struggles and undesirable behaviors. People automatically apply these unhelpful thoughts to themselves, others, and external circumstances.<sup>23</sup> In essence, thoughts give rise to emotions and behaviors and unhelpful thoughts lead to painful emotions and undesirable behaviors. CBT attempts to change a person's unhelpful thoughts into helpful thoughts, which should give rise to healthy emotions and behaviors.

The broad goals of CBT are:

1. To identify the patient's unhelpful thoughts
2. To encourage the patient to consider if these thoughts are helpful or unhelpful
3. To correct distorted thoughts

The specific goals of CBT in the treatment of complicated grief are:

1. To encourage patients to think about the loss of the loved one in a more helpful way
2. To reduce feelings of anguish, anxiety, guilt, or anger
3. To restore a satisfying life without the presence of the deceased

A course of complicated grief-specific CBT generally consists of 16 to 25 sessions, once per week.<sup>20,24</sup>

### **A Typical Complicated Grief-Specific CBT Program**

Sessions 1-3 – Getting Started

- Additional education about complicated grief
- An overview of therapy
- Taking the patient's history
- Identifying goals
- Establishing/nurturing a support system

Sessions 4-9 – Core Revisiting Sequence

- Dealing with loss
- Restoring (or establishing) a satisfying life

Sessions 10 – Review

- Review progress
- Reformulate or finalize goals

Sessions 11-16 – Closing Sequence

- Solidifying psychological health with a focus on current and future life plans

- Relapse prevention
- “Graduation”

### *Group CBT*

Weekly group therapy is a psychotherapeutic treatment where 5-9 patients meet with a regular therapist to discuss issues related to complicated grief. Group therapy may be added to individual CBT. Group therapy has been shown to be particularly helpful in older individuals with complicated grief.<sup>25</sup> In addition to education and guided discussion amongst the patients, therapists may employ several structured activities with the group including “revisiting the story of the death,” “identifying and working on personal goals,” “inviting a significant other to attend a session,” “having an imaginary conversation with the deceased,” and “bringing in pictures and memorabilia.” One major advantage of the group format is patients are able to compare and contrast their experiences with other patients and receive feedback from the therapist and the group members.<sup>25</sup>

### **Second-line and Supplemental Treatment**

#### *Behavioral Activation*

If CBT fails to achieve positive results or the sufferer desires an alternative treatment, behavioral activation is another treatment approach that has been moderately successful for treated complicated grief. Behavioral activation is a psychotherapeutic approach that focuses on behaviors and external factors rather than unhelpful thoughts. Patient improvement rates have been as high as 70%.<sup>26</sup>

The usual course of behavioral activation treatment is 24, weekly sessions. In this treatment approach, the therapist will identify external events that started the grief process. In complicated grief, this is usually obvious: the death of a loved one. Next, the therapist identifies unhelpful behaviors the patient is using

for short-term relief. Examples include spending excessive amounts of time rubbing an item of clothing from the deceased or avoiding friends of the deceased to avoid remembering. Indeed, the main goals of behavioral activation are to overcome the sufferer's inertia and avoidance behaviors.

### *Antidepressants*

Antidepressants are rarely used to treat complicated grief, probably because few studies have been published on the subject. The available trials have been small, but generally support that notion that antidepressants could be helpful in complicated grief.<sup>27</sup> While the scientific support for antidepressant use in complicated grief is scarce, tricyclic antidepressants and selective serotonin reuptake inhibitors (SSRIs) have been modestly effective in small trials. The tricyclic antidepressants tested to date were desipramine and nortriptyline and the SSRIs tested were escitalopram (Lexapro) and paroxetine (Paxil).<sup>27</sup> While antidepressants should not be considered a sole treatment for complicated grief, increasing numbers of therapists and researchers have suggested that adding an SSRI to psychotherapy could improve outcomes. Antidepressants are likely to be even more effective when the person with complicated grief also has major depression, PTSD, or other mental health condition that could benefit from SSRI treatment.

### **Other Therapeutic Interventions**

There are many therapeutic options for complicated grief beyond CBT, behavioral activation, and antidepressant drugs. Some of these treatment modalities have been more rigorously studied than others, but there is at least modest evidence to support each one. Patients usually opt for one of these treatment modalities because CBT and behavioral activation have failed or they are looking for additional/supplemental therapy beyond first and second line treatments.

### *Interpersonal Psychotherapy*

Interpersonal psychotherapy overlaps with CBT and is sometimes incorporated into a complicated grief-CBT protocol.<sup>15,21,24</sup> Interpersonal psychotherapy draws attention to the link between the patient's mood and disturbing life events that either trigger or follow from the onset of the mood disorder. In the case of complicated grief, the major trigger is the loss of a loved one, but other triggers may be considered. Interpersonal psychotherapy focuses on repairing difficult interpersonal relationships and establishing healthy relationships as poor relationships tend to sustain and worsen depression and grief symptoms.<sup>28</sup>

Interpersonal psychotherapy is particularly helpful for patients who have turned inward, blame themselves, and lost sight of their place in their family, community, etc. It may be useful when a person has both major depression and complicated grief. Unlike CBT, standard interpersonal psychotherapy may not need a specific complicated grief component to be successful.<sup>29</sup>

Interpersonal psychotherapy is administered over 8 to 16 weekly sessions. Treatment progresses in three phases.<sup>30</sup> In the initial phase, the therapist permits the patient to occupy the sick role, which absolves the patient from self-defeating thoughts that arise during complicated grief. In other words, the therapist frees the patient from any guilt they feel about their abnormal grieving, which would otherwise interfere with treatment. The patient then makes an interpersonal inventory, cataloging every familial and social relationship. In the final part of the initial phase, the therapist and patient identify a current, unresolved interpersonal problem (in this case, complicated grief).

The middle phase of interpersonal psychotherapy is the intervention phase. For complicated grief, the clinician identifies and draws connections between grief symptoms and the deceased.

The therapist asks detailed questions about the circumstances of the relationship before death, surrounding the death, and the mourning process. The termination phase is similar to graduation in that the clinician praises the patient's accomplishments and establishes a path for ongoing success.

### *Narrative Therapy/Meaning Making Therapy*

During narrative therapy, also called meaning making therapy, clinicians challenge patients with complicated grief to deconstruct the stories of their lives and rebuild their presumptions and beliefs about these stories to construct a more helpful version.<sup>31,32</sup> Presumably, self-conception, relationships, and life experiences become meaningful as clients tell their stories. Moreover, patients are permitted to give a new, authentic, and satisfying meaning to their narrative. The grief process, itself, can be considered a reconstruction of meaning in a world without the lost love one.<sup>33</sup>

Unlike the psychotherapies discussed thus far, narrative therapy is unstructured and may not be restricted to a certain number of weekly sessions. On the other hand, one small clinical trial showed narrative therapy significantly reduced symptoms of depression and complicated grief after two months of treatment.<sup>34</sup>

### *Psychodynamic Psychotherapy*

In psychodynamic therapy, the therapist uses a person's behavior to identify and change unconscious processes that underlie the behavior. Psychodynamic therapy is sometimes called insight-oriented therapy because the patient gathers insights about his or her unconscious processes and gains self-awareness. Modern psychodynamic therapy generally follows a "brief" or "short term" protocol in which the patient and therapist work on a single issue (e.g., complicated grief). The brief protocol averages about 18 sessions with a range of 3 to 80

sessions.<sup>35</sup> The psychodynamic therapist helps the complicated grief sufferer come to terms with unresolved conflicts and symptoms that arise from past dysfunctional relationships. The Task Force on Promotion and Dissemination of Psychological Procedures rates psychodynamic therapy as "possibly efficacious" in the treatment of complicated grief.<sup>36</sup>

### *Family Therapy*

The death of a family member permanently changes the dynamics of the family. When a family experiences a loss in a healthy manner, they provide each other with emotional, financial, and spiritual support as needed. Supportive families have high cohesion and lack significant conflicts. When conflicts do arise, functional families are able to successfully manage those conflicts without long-term divisions. Interestingly, supportive families also have low levels of psychological illness and psychosocial problems.<sup>37</sup> This usually allows all members of the family to adapt and adjust to the loss of the family member.

In complicated grief, the family unit may fail to support one or more family members, straining the entire family. There is frequent conflict without successful resolution or no attempt at resolution, isolation of certain family members, and a general lack of cohesion. Not surprisingly, dysfunctional families have high rates of psychological illness including depression and complicated grief.

The goal of family therapy in complicated grief is to make dysfunctional families more functional and supportive of one another.<sup>38</sup> Therapists work to improve family communication styles, family cohesiveness, and their ability to tolerate differences. Since supportive families rarely become dysfunctional at the point of loss, family-focused grief therapy ideally begins during chronic illness or palliative care, prior to the loss of a loved one.<sup>37</sup> Family therapy may

be particularly beneficial for suicidal patients or those who are grieving for someone who committed suicide.<sup>39</sup> Family therapy is probably not well suited to supportive, highly functional families, even if one or more family members experience complicated grief after the loss of a loved one.

### **Art Therapy**

During art therapy, a professional art therapist uses various media to help patients improve self-awareness and their orientation to reality, reduce symptoms of depression and anxiety, and increase self-esteem. Patients are encouraged to express themselves through art and, perhaps, through discussion of the art they create. Not only is the process of expressing oneself through art beneficial, but the content of the art can also serve as a springboard for its own communication that goes beyond words. Art therapy is a unique mental health therapy because the patient does not need to use words. Art therapy may be particularly helpful for treating complicated grief in children and adults who have become nonverbal (e.g., aphasia, mutism).<sup>40,41</sup> Very little research has been done on the efficacy of art therapy in complicated grief.

### **Music Therapy**

A professional trained in music therapy may use any number of musical endeavors to help patients with complicated grief. Therapy may include listening to music, dancing and singing, or even creating music with instruments. The goals of music therapy are to provide an expressive outlet, foster patient engagement in psychological treatment, and offer emotional support through music. Music therapy is effective as a supplemental treatment for various conditions including Alzheimer's disease, autism spectrum disorder, pain management, and unhealthy reactions to traumatic events (e.g., military personnel who have experienced combat). Music therapy is less well studied in the

treatment of complicated grief; however, at least one small study showed it could be effective.<sup>42</sup>

### **Support Groups**

Most people who progressed through normal grief processes are helped by family, friends, clergy members, and other people within their respective support systems.<sup>43</sup> In fact, there is no evidence to support the notion that normal grief requires specific treatment for mental health providers.<sup>43</sup> Mutual support groups, or groups of individuals who have experienced similar forms of loss, can benefit people during the grieving process. These do not necessarily need to be led or attended by mental health professionals; instead, support is obtained from hearing the accounts of other members of the group and receiving support from those who can empathize and sympathize.

The role of support groups in complicated grief is less clear. It is generally considered ineffective for people who are experiencing complicated grief to simply rely on friends, family and support groups without formalized mental health treatment. Nonetheless, people who are experiencing complicated grief may benefit from informal support groups in addition to individual and, perhaps, group psychotherapy provided by a licensed medical health professional.

### **Choosing the Right Treatment Provider**

People who suffer from complicated grief should select a provider who is capable of providing psychotherapy. Three types of mental health professionals are licensed and qualified to provide psychotherapy.

**Psychiatrists** are physicians. They have completed medical school, obtained an MD or DO degree, and completed residency training in psychiatry. These mental health professionals are able to prescribe antidepressants, if necessary. However, it is increasingly difficult to find psychiatrists

who provide psychotherapy. Most have chosen to instead focus on medicine management and pharmaceutical treatments rather than “talk therapy.” Therefore, complicated grief sufferers who want to consult a psychiatrist should first determine if they provide psychotherapy.

**Psychologists** are mental health professionals who have obtained Masters or doctoral degrees in psychology. Psychologists who have also completed clinical fellowships and obtained licensure can treat patients with mental health conditions. Two main types of psychologists can provide psychotherapy for complicated grief, clinical psychologists and counseling psychologists. Clinical psychologists hold either a PhD in psychology or a Doctor of Psychology (PsyD) degree. In a few states, clinical psychologists are able to prescribe certain medications, such as antidepressants. Counseling psychologists may hold a PhD in psychology or a Master’s degree. These mental health professionals have a different license than clinical psychologists and cannot legally prescribe medications in any US state.

**Clinical social workers** who wish to treat patients must obtain either a PhD or Masters of Social Work degree (MSW) and hold a license to perform clinical therapy. Social workers do not have the legal authority to prescribe medications. A grief counselor may be a clinical psychologist, counseling psychologist, or licensed social worker, but school psychologists and other well-meaning lay individuals may act as grief counselors. It is important to note a “grief counselor” does not necessarily hold any special credential. Most people experiencing normal grief can be helped through the grieving process by a grief counselor, regardless of whether that grief counselor is licensed to practice psychotherapy or not.<sup>43</sup>

However, if the person’s grief becomes complicated grief, they should seek out someone who is licensed to provide mental health therapy--

a psychiatrist, licensed psychologist, or clinical social worker. Relying on an unlicensed grief counselor for treatment of complicated grief is unlikely to be helpful.

The best course of action is for the grieving person to surround themselves with people who are able to identify abnormal grieving and have the courage to discuss the topic. Palliative care physicians, hospice care nurses, and social workers who work in end-of-life care settings (e.g., hospice, retirement homes, long-term care facilities) have the training required to detect complicated grief.

Unfortunately, there is a general lack of awareness of complicated grief outside of these settings. Family and friends may recognize a person is acting strangely after the loss of a loved one, but most are unlikely to realize the person is suffering from complicated grief. In fact, most primary care physicians would not necessarily consider asking questions about grieving in the course of a normal medical visit.

As such, patients and those who care about them should actively inquire about grief counseling and bereavement services. Hospices are an excellent resource for information. Primary care physicians may be able to direct patients for grief counseling and complicated grief treatment, but it will likely be the patient’s responsibility to bring up the subject during an appointment. Patients and family members may decide to seek out a mental health professional directly. In these cases, it is probably best to select a licensed provider such as a psychologist or social worker, and choose one who has experience in bereavement services and complicated grief treatment.

Since cognitive behavioral therapy is the first-line treatment for complicated grief it is more important to find a mental health provider who specializes in CBT that it is to choose between psychiatry, psychology, and clinical social work. For example, a psychiatrist who does not routinely

perform psychotherapy is not a good choice for someone suffering from complicated grief. On the other hand, a person who has complicated grief and a mood disorder, such as depression, may want to consult a psychiatrist who does perform CBT. This mental health professional could provide psychotherapy and prescribe antidepressants as needed. Clinical psychologists and clinical social workers usually have many more training hours devoted to psychotherapy than psychiatrists, mainly because psychiatrists spend a significant amount of training learning about medication management and treating psychiatric illnesses with drugs. Therefore, most people with complicated grief should probably seek out a clinical psychologist or clinical social worker, ideally one who specializes in bereavement and complicated grief.

Here are some web-sites that may help in locating a therapist who can assist with complicated grief issues: When you search in a directory of therapists search under the specialty “grief”

[www.therapists.psychologytoday.com](http://www.therapists.psychologytoday.com)

[www.locator.apa.org](http://www.locator.apa.org)

[www.helppro.com/NASW/Common/SearchResults.aspx](http://www.helppro.com/NASW/Common/SearchResults.aspx)

[www.complicatedgrief.org](http://www.complicatedgrief.org)

[www.mastersincourse3ling.org/loss-grief-bereavement.html](http://www.mastersincourse3ling.org/loss-grief-bereavement.html)

### **Complicated Grief and End of Life Care**

Improvements in healthcare and public safety over the past several decades have changed the manner in which people spend their final days. People are living longer and fewer are dying suddenly from things like heart attack or stroke. More people are dying from chronic illnesses such as dementia or cancer. This extra life is both a blessing and a curse. People are able to spend more time with their loved ones, but when the loved one’s health is poor, much of that relationship is devoted to caring for the sick person. This process can take a considerable

toll on caregivers leading to depression, poor life satisfaction, and poor physical health.<sup>44</sup> Indeed, caring for someone who is chronically ill is a risk factor for complicated grief.

One unexpected benefit of caring for someone who is chronically ill is that caregivers have the time to consider end-of-life issues before the loved one passes. One important issue that demands attention is how the caregiver will adapt once the loved one dies. The caregiver has the chance to consult with therapists before their loved one’s death.

Since many chronically ill patients leave the end of their lives in hospice, it is not surprising that hospice providers have been among the leading proponents of grief and bereavement therapy for caregivers. Most hospices routinely screen caregivers for complicated grief and depression and access to bereavement therapy.<sup>45</sup> Treating depression before the death of the loved one and providing psychotherapy and skills training appears to reduce the rate of complicated grief.<sup>46</sup>

People at increased risk for complicated grief, specifically those older than 60 years of age, those in a lower socioeconomic bracket, women, African-Americans, and Hispanics may specifically benefit from complicated grief screening and treatment. In fact, complicated grief is approximately twice as common in African-Americans as it is in whites.<sup>47,48</sup> Unfortunately, African-Americans are far less likely to use hospice services than whites are<sup>49</sup> despite the fact that the services are often covered under most public health insurance plans and is covered by Medicare.<sup>50,51</sup>

Perhaps most importantly, hospice services are uniquely equipped to provide chronic supportive care for people at the end-of-life, which significantly reduces the burden on caregivers. In other words, the hospice provides for the physical, psychological, emotional, and sometimes spiritual needs of the patient leaving

the caregivers to enjoy their last days with the patient without these substantial burdens.

## **Paying for Psychotherapy**

Insurance coverage for mental health conditions varies considerably. Medicare Part B helps cover mental health services including the fees charged by psychiatrists, clinical psychologists, and clinical social workers. Medicaid Alternative Benefit Plans also must cover mental health and substance use disorder services. The Veteran's Administration system may cover some, most, or all of the cost of mental health services depending on the veteran's active service record. Almost all private health insurers offer some form of mental health coverage, but individual plans vary widely.

In all cases, the person seeking treatment should read their health insurance documentation and/or consult their health insurer to learn several important features of their specific health insurance plan. For example, music therapy and art therapy may not be covered at all

- Is there a deductible for mental health services?
- Are there any copayments are required at the time of service?
- Is there a limit to the number of sessions that are covered per calendar year?
- Which mental health providers are considered in-network or out-of-network?
- Are some types of mental health providers not covered at all?

## **Summary**

Grief is a normal human reaction to loss. We now know people respond normally to loss in one of four ways: resilience, chronic grief, depressed improved, and chronic depression. However, approximately 7% of all people experience an abnormal form of grief called complicated grief.

Complicated grief is a chronic process that lasts for 12 months or more in adults. Complicated grief may be felt as a persistent yearning for the deceased, intense sorrow and emotional pain, preoccupation with the deceased and the circumstances surrounding the death. People with complicated grief may have considerable difficulty accepting the person's death, refuse to believe the person is gone and refuse any reminder of the person's death. Complicated grief sufferers may blame themselves or experience bitterness and anger because of the loss. Suicidal thoughts are common in complicated grief sufferers. Sufferers feel alone, detached from other individuals, and feel they have no personal identity apart from the deceased. They often fail to pursue their own goals and interests after the loss, and many times these symptoms and behaviors push family and friends away. Untreated complicated grief can negatively affect physical health as well, increasing the risk for heart disease and other medical conditions.

Risk factors for complicating grief include older age, female gender, non-Caucasian race, and pre-existing mental health issues. Complicated grief is also more likely to occur if the loved one was a spouse or child or died after a chronic illness. Likewise, the grieving person is more likely to develop complicated grief if the death was unusual, due to violence, was unexpected, or occurred under unusual circumstances. African-Americans have particularly high rates of complicated grief, approximately double the rate of whites. Unfortunately, African-Americans seek out mental health professionals and hospice care less often than whites, which places them at even greater risk for hardship.

Psychotherapy is the main treatment for complicated grief, while drug therapy is used only in select patients, usually those with other mental health conditions such as depression. Evidence from clinical trials suggests the most effective psychotherapy for most patients is cognitive behavioral therapy focused on

complicated grief. For those who do not benefit from cognitive behavioral therapy or wish to try a different approach, behavioral activation therapy is highly effective and considered a second line treatment. Group therapy is often used in addition to individual psychotherapy.

Some patients may benefit from other psychological treatments including interpersonal therapy, narrative therapy, psychodynamic psychotherapy, and family therapy. Art therapy and music therapy may be helpful for certain patients, though these interventions should be considered supplemental to psychotherapy.

Complicated grief sufferers have several options for mental health treatment. They may choose between psychiatrists, psychologists, and clinical social workers. Each of these professionals is licensed and capable of providing expert treatment services. Psychiatrists and clinical psychologists to a limited extent are able to prescribe antidepressant medications if needed. Since it is becoming more difficult to find psychiatrists who provide psychotherapy apart from medicine management, complicated grief sufferers may find it easier to consult clinical psychologists, counseling psychologists, or clinical social workers for treatment. The key for patients is to identify the provider who specializes in the treatment of complicated grief and practices the form of psychotherapy (e.g., CBT) that appeals to them.

End-of-life care services including hospice provide a unique opportunity to support caregivers prior to the loss of a loved one. Hospices can help identify people at increased risk for complicated grief (e.g., African-Americans, older individuals, women, people with depression, etc.) and coordinate bereavement services and possibly psychological support. Sadly, people at greatest risk of complicated grief are usually the least likely to use of hospice and end-of-life services.

Most private and all public health insurers provide

coverage for mental health treatments including psychotherapy for complicated grief. People with complicated grief who do not seek treatment tend to get worse with time, drift further away from family and friends, and may develop other psychological and medical problems. Therefore, it is important that people at risk for complicated grief or who show signs of complicated grief seek the help of a licensed mental health provider who is capable of providing psychotherapy.

## References

1. Shear MK, McLaughlin KA, Ghesquiere A, Gruber MJ, Sampson NA, Kessler RC. Complicated grief associated with hurricane Katrina. *Depress Anxiety*. Aug 2011;28(8):648-657. doi:10.1002/da.20865
2. Kübler-Ross E. On death and dying. 1969.
3. Maciejewski PK, Zhang B, Block SD, Prigerson HG. An empirical examination of the stage theory of grief. *JAMA*. Feb 21 2007;297(7):716-723. doi:10.1001/jama.297.7.716
4. Arizmendi BJ, O'Connor MF. What is "normal" in grief? *Aust Crit Care*. May 2015;28(2):58-62; quiz 63. doi:10.1016/j.aucc.2015.01.005
5. Galatzer-Levy IR, Bonanno GA. Beyond normality in the study of bereavement: heterogeneity in depression outcomes following loss in older adults. *Soc Sci Med*. Jun 2012;74(12):1987-1994. doi:10.1016/j.socscimed.2012.02.022
6. 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*. Nov 2002;83(5):1150-1164.
7. Bonanno GA, Wortman CB, Nesse RM. Prospective patterns of resilience and maladjustment during widowhood. *Psychol Aging*. Jun 2004;19(2):260-271. doi:10.1037/0882-7974.19.2.260
8. Bonanno GA. Resilience in the Face of Potential Trauma. *Current Directions in Psychological Science*. June 1, 2005 2005;14(3):135-138. doi:10.1111/j.0963-7214.2005.00347.x
9. Kersting A, Braehler E, Glaesmer H, Wagner B. Prevalence of complicated grief in a representative population-based sample. *J Affect Disord*. Jun 2011;131(1-3):339-343. doi:10.1016/j.jad.2010.11.032
10. Shear MK. Clinical practice. Complicated grief. *N Engl J Med*. Jan 8 2015;372(2):153-160. doi:10.1056/NEJMc1315618
11. Simon NM, Wall MM, Keshaviah A, Dryman MT, LeBlanc NJ, Shear MK. Informing the symptom profile of complicated grief. *Depress Anxiety*. Feb 2011;28(2):118-126. doi:10.1002/da.20775
12. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. 5th ed. Washington, DC: American Psychiatric Association; 2013.

13. Lobb EA, Kristjanson LJ, Aoun SM, Monterosso L, Halkett GK, Davies A. Predictors of complicated grief: a systematic review of empirical studies. *Death Stud.* Sep 2010;34(8):673-698. doi:10.1080/07481187.2010.496686
14. Simon NM. Treating complicated grief. *JAMA.* Jul 24 2013;310(4):416-423. doi:10.1001/jama.2013.8614
15. Shear K, Frank E, Houck PR, Reynolds CF, 3rd. Treatment of complicated grief: a randomized controlled trial. *JAMA.* Jun 1 2005;293(21):2601-2608. doi:10.1001/jama.293.21.2601
16. Latham AE, Prigerson HG. Suicidality and bereavement: complicated grief as psychiatric disorder presenting greatest risk for suicidality. *Suicide Life Threat Behav.* Winter 2004;34(4):350-362. doi:10.1521/suli.34.4.350.53737
17. Szanto K, Shear MK, Houck PR, et al. Indirect self-destructive behavior and overt suicidality in patients with complicated grief. *J Clin Psychiatry.* Feb 2006;67(2):233-239.
18. Guldin MB, Vedsted P, Jensen AB, Olesen F, Zachariae R. Bereavement care in general practice: a cluster-randomized clinical trial. *Fam Pract.* Apr 2013;30(2):134-141. doi:10.1093/fampra/cms053
19. 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.* Feb 2011;31(1):69-78. doi:10.1016/j.cpr.2010.09.005
20. Rosner R, Pfoh G, Kotoucova M. Treatment of complicated grief. *Eur J Psychotraumatol.* 2011;2. doi:10.3402/ejpt.v2i0.7995
21. Shear MK, Wang Y, Skritskaya N, Duan N, Mauro C, Ghesquiere A. Treatment of complicated grief in elderly persons: a randomized clinical trial. *JAMA Psychiatry.* Nov 2014;71(11):1287-1295. doi:10.1001/jamapsychiatry.2014.1242
22. 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.* Apr 2007;75(2):277-284. doi:10.1037/0022-006x.75.2.277
23. Beck AT. Cognitive therapy : nature and relation to behavior therapy. *J Psychother Pract Res.* Fall 1993;2(4):342-356.
24. Wetherell JL. Complicated grief therapy as a new treatment approach. *Dialogues Clin Neurosci.* Jun 2012;14(2):159-166.
25. Supiano KP, Luptak M. Complicated grief in older adults: a randomized controlled trial of complicated grief group therapy. *Gerontologist.* Oct 2014;54(5):840-856. doi:10.1093/geront/gnt076
26. Papa A, Sewell MT, Garrison-Diehn C, Rummel C. A randomized open trial assessing the feasibility of behavioral activation for pathological grief responding. *Behav Ther.* Dec 2013;44(4):639-650. doi:10.1016/j.beth.2013.04.009
27. 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.* Jun 2012;14(2):149-157.
28. Weissman MM, Klerman GL, Paykel ES, Prusoff B, Hanson B. Treatment effects on the social adjustment of depressed patients. *Arch Gen Psychiatry.* Jun 1974;30(6):771-778.
29. Cruz M, Scott J, Houck P, Reynolds CF, 3rd, Frank E, Shear MK. Clinical presentation and treatment outcome of African Americans with complicated grief. *Psychiatr Serv.* May 2007;58(5):700-702. doi:10.1176/appi.ps.58.5.700
30. Weissman MM, Markowitz JC, Klerman G. *Comprehensive guide to interpersonal psychotherapy.* Basic Books; 2008.
31. Roberts AR, Watkins JM. *Social workers' desk reference.* Oxford University Press, USA; 2009.
32. Alves D, Mendes I, Goncalves MM, Neimeyer RA. Innovative moments in grief therapy: reconstructing meaning following perinatal death. *Death Stud.* Oct 2012;36(9):795-818.
33. Neimeyer RA, Burke LA, Mackay MM, van Dyke Stringer JG. *Grief therapy and the reconstruction of meaning: From principles to practice.* Journal of Contemporary Psychotherapy. 2010;40(2):73-83.
34. Barbosa V, Sa M, Carlos Rocha J. Randomised controlled trial of a cognitive narrative intervention for complicated grief in widowhood. *Aging Ment Health.* 2014;18(3):354-362. doi:10.1080/13607863.2013.833164
35. Driessen E, Hegelmaier LM, Abbass AA, et al. The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis update. *Clin Psychol Rev.* 2015;42:1-15.
36. Leichsenring F, Leweke F, Klein S, Steinert C. The empirical status of psychodynamic psychotherapy - an update: Bambi's alive and kicking. *Psychother Psychosom.* 2015;84(3):129-148. doi:10.1159/000376584
37. Kissane DW, McKenzie M, Bloch S, Moskowitz C, McKenzie DP, O'Neill I. Family focused grief therapy: a randomized, controlled trial in palliative care and bereavement. *Am J Psychiatry.* Jul 2006;163(7):1208-1218. doi:10.1176/appi.ajp.163.7.1208
38. Delalibera M, Presa J, Coelho A, Barbosa A, Franco MHP. Family dynamics during the grieving process: a systematic literature review. *Cien Saude Colet.* 2015;20:1119-1134.
39. de Groot M, Neeleman J, van der Meer K, Burger H. The effectiveness of family-based cognitive-behavior grief therapy to prevent complicated grief in relatives of suicide victims: the mediating role of suicide ideation. *Suicide Life Threat Behav.* Oct 2010;40(5):425-437. doi:10.1521/suli.2010.40.5.425
40. Chilcote RL. Art therapy with child tsunami survivors in Sri Lanka. *Art Therapy.* 2007;24(4):156-162.
41. Lister S, Pushkar D, Connolly K. Current bereavement theory: Implications for art therapy practice. *The Arts in Psychotherapy.* 2008;35(4):245-250.
42. Iliya YA. Music therapy as grief therapy for adults with mental illness and complicated grief: a pilot study. *Death Stud.* Jan-Jun 2015;39(1-5):173-184. doi:10.1080/07481187.2014.946623
43. Zisook S, Simon NM, Reynolds CF, 3rd, et al. Bereavement, complicated grief, and DSM, part 2: complicated grief. *J Clin Psychiatry.* Aug 2010;71(8):1097-1098. doi:10.4088/JCP.10ac06391blu
44. Haley WE, LaMonde LA, Han B, Narramore S, Schonwetter R. Family caregiving in hospice: effects on psychological and health functioning among spousal caregivers of hospice patients with lung cancer or dementia. *Hosp J.*

2001;15(4):1-18.

45. Ghesquiere AR, Aldridge MD, Johnson-Hurzeler R, Kaplan D, Bruce ML, Bradley E. Hospice Services for Complicated Grief and Depression: Results from a National Survey. *J Am Geriatr Soc.* Oct 2015;63(10):2173-2180. doi:10.1111/jgs.13656

46. Schulz R, Boerner K, Shear K, Zhang S, Gitlin LN. Predictors of complicated grief among dementia caregivers: a prospective study of bereavement. *Am J Geriatr Psychiatry.* Aug 2006;14(8):650-658. doi:10.1097/01.JGP.0000203178.44894.db

47. Goldsmith B, Morrison RS, Vanderwerker LC, Prigerson HG. Elevated rates of prolonged grief disorder in African Americans. *Death Stud.* 2008;32(4):352-365. doi:10.1080/07481180801929012

48. Ramey SJ, Chin SH. Disparity in hospice utilization by African American patients with cancer. *Am J Hosp Palliat Care.* Aug 2012;29(5):346-354. doi:10.1177/1049909111423804

49. Greiner KA, Perera S, Ahluwalia JS. Hospice usage by minorities in the last year of life: results from the National Mortality Followback Survey. *J Am Geriatr Soc.* Jul 2003;51(7):970-978.

50. Bogasky S, Sheingold S, Stearns SC. Medicare's Hospice Benefit: Analysis of Utilization and Resource Use. *Medicare & Medicaid Research Review.* 2014;4(2):mmrr2014-2004-2002-b2003. doi:10.5600/mmrr.004.02.b03

51. Medicare program; hospice care amendments. Final rule. *Fed Regist.* Nov 22 2005;70(224):70532-70548.

