

The Cutting Edge

IS COMPLICATED GRIEF A POST-LOSS STRESS DISORDER?



Naomi Michele Simon, M.D., M.Sc. is an Associate Professor of Psychiatry, Harvard Medical School, Director of the Center for Anxiety and Traumatic Stress Disorders, Director of the Complicated Grief Program at MGH, Chief Medical Officer of the Red Sox Foundation and Massachusetts General Hospital Home Base Program. Dr. Simon's major clinical and research interests include optimizing initial and next step psychotherapy and medication treatments for anxiety and stress-related disorders, and understanding the presentation and the biological impact of stress, trauma, and loss-related conditions. She has served as a principal investigator or co-investigator on numerous studies aimed at improving our understanding and treatment of

posttraumatic stress disorder, panic disorder, generalized anxiety disorder, social anxiety disorder, and the syndrome of complicated grief. Dr. Simon is a member of the Scientific Council of the Anxiety Disorders Association of America, a Distinguished Fellow of the American Psychiatric Association, and a Member of the American College of Neuropsychopharmacology.

INTRODUCTION

The coming of DSM5 highlights advances in psychiatry and neuroscience that have helped shape how we think about our patients and how to treat them. Research on the brain and emotional processes have improved our understanding of core underlying components of affect, fear responses, and differential reactions to stress, including a greater understanding of the interaction of environmental experiences with psychological and biological risk factors. Yet despite these advances, much controversy remains about what should be called a "diagnosis," and what different symptom clusters or syndromes that develop in response to environmental stressors represent.

This controversy is particularly salient in the case of reactions to bereavement, a universal life experience. It is important not to label uncomplicated acute grief, transient surges of grief at anniversary dates, or forms of lasting but integrated grief as pathological conditions, as grief is part of a natural healing response.^[1] Loss of an important relationship is, however, one of the greatest stressors a person can experience, and carries with it a broad range of psychological as well as practical challenges with which the bereaved person must cope. Given this reality, it would be surprising if there was not a subpopulation of individuals for whom adjustment was more problematic and for whom intervention would be helpful. It would also be surprising if bereavement did not trigger the onset or worsening of psychi-

atric conditions known to be triggered by stressful life experiences.

WHAT IS COMPLICATED GRIEF?

Complicated grief (CG) is a debilitating syndrome that is comprised of symptoms that interfere with adaptation and reengagement in life after bereavement, and that result in persistence of acute grief. Interfering symptoms are often related to specific circumstances surrounding the death, guilt tied to often unfounded beliefs that the individual could have prevented or caused the death, unresolved conflicts around the time of the loss, excessive cognitive and/or behavioral avoidance, or difficulty with emotion processing. In support of CG as a syndrome, we demonstrated that CG clustered as a single factor when examined in a group of 782 bereaved individuals. Factor analytic approaches based on the *Inventory of Complicated Grief*^[2] in 288 clinically confirmed primary treatment seeking CG cases helped inform our proposal for DSM5.^[3] Although the most common symptom was

*Correspondence to: Naomi Michele Simon, M.D., M.Sc., Center for Anxiety and Traumatic Stress Disorders, Massachusetts General Hospital, One Bowdoin Square, 6th Floor, Boston, MA 02114. E-mail: nsimon@partners.org

DOI 10.1002/da.21979

Published online in Wiley Online Library (wileyonlinelibrary.com).

TABLE 1. Typical CG symptoms

1. Persistent intense yearning or longing for the person who died.
2. Frequent intense feelings of loneliness.
3. Feeling that life is empty or meaningless without the person who died.
4. Wish to die in order to find the person or because life is unbearable without them.
5. Thoughts or images of the person regularly intrude on usual activities or interfere with functioning.
6. Frequent troubling rumination about something related to the loss.
7. Recurrent feeling of disbelief or inability to fully comprehend the finality of the loss.
8. Persistent feeling of being shocked, stunned, dazed, or emotionally numb since the death.
9. Recurrent feelings of anger or bitterness related to the death.
10. Persistent difficulty trusting or caring about other people.
11. Frequently experiencing pain or other symptoms that the deceased person had, or hearing the voice, or seeing the deceased person.
12. Intense emotional or physiological reactivity to reminders of the loss.
13. Excessive avoidance of reminders of the loss.
14. Excessive proximity seeking, frequent impulse to see, touch, hear, or smell things to feel close to the person who died.

longing (88%), employing at least one symptom from the yearning and preoccupation with the deceased cluster as a core factor with at least one from two other clusters yielded a sensitivity of 93.8% and a specificity of 98.7%.^[4] Other clusters included shock and disbelief, anger and bitterness, estrangement from others, avoidance and proximity seeking behavioral changes, and hallucinations of the deceased.

In contrast to CG, acute grief is a natural time limited and often culturally influenced response to bereavement. Distress can be intense with associated shock, disbelief, sadness, longing, emotional lability, fear, and/or insomnia. Yet, for the vast majority of people, grief lessens in intensity over time and while some grief and longing may remain or resurface at times such as special anniversary dates, the person is able to adapt and find joy and meaning without the deceased. It is a minority of people (conditional prevalence estimate of 6.7%^[5]) for whom there are complications that interfere with the progress of grief, which therefore remains intense. Although CG is not yet a formal diagnosis, there has been agreement on many core symptoms (See Table 1 for typical symptoms), and recent criteria sets for DSM5 have been proposed.^[3,6,7] CG symptoms at least 6 months after a loss include traumatic distress, separation distress, cognitive symptoms such as guilt and caregiver self-blame, heightened emotionality, and behavioral changes such as proximity seeking and avoidance.^[3,4,6] Horowitz and colleagues first called for CG as a diagnostic entity that would fall most appropriately in a category of stress response disorders such as Posttraumatic Stress Disorder (PTSD) and adjustment disorders,^[8] and included symptom clusters of post-loss related avoidance, intrusions, and failure to adapt, as was similarly argued by Langner and Maercker nearly a decade later.^[9]

HOW ARE CG AND PTSD CONCEPTUALIZED AS DISTINCT STRESSOR RELATED SYNDROMES?

PTSD was first designated as a psychiatric disorder in DSM III, and a great body of research has now helped shape our understanding of the disorder^[7] as well as facilitated the development of targeted treatment. PTSD differs from other psychiatric disorders in being triggered by a clearly identifiable environmental event that is expected to trigger a time-limited psychological response in a majority of people. Death of a loved one is also a clearly identifiable event that is expected to trigger a response in most people. Bereavement has been shown to trigger posttraumatic stress disorder and in some studies (e.g.^[10]) is the most common criterion A event. Notwithstanding the similarities, the response to loss differs in some important ways from the response to trauma. It is clear that the syndrome variously called complicated grief, traumatic grief, prolonged grief, or persistent complex bereavement disorder is distinct from PTSD. However, given that both are clearly disorders that arise in response to a clearly defined stressful event, it would make sense to group them together as stressor related conditions. To underscore this commonality, CG might better be named post-loss stress disorder.

Along these lines, CG experts have moved away from the briefly proposed name, "traumatic grief," to prevent confusion, as the loss does not need to be sudden or violent to lead to CG. In contrast, bereaved caretakers for children, spouses, or parents with known terminal illnesses nonetheless develop CG, and in actuality caretakers may face additional challenges after the death when trying to integrate the loss and substantially shift to new activities, relationships, and meaning without the deceased. The name complicated grief instead carries with it the clinically intuitive heuristic that the normal grief process is off track and there are complications.

Examining how this syndrome of grief-related complications is similar or different from responses to trauma resulting in PTSD is a useful model to inform complicated grief as a psychiatric syndrome. Although features of CG overlap in part with core components of PTSD psychopathology such as guilt, anger, avoidance, and preoccupation with the event, there are differences. For example, yearning and proximity seeking is not seen in PTSD, and unless the death was violent, although anxiety may be present, fear is not commonly a core emotion in CG. Further, an important aspect of grief as a stressor is the impact of loss on attachment. Attachment is a basic psychological and biologically driven component of core relationships, and the loss of a close attachment figure serves as a major stressor to this attachment system, leading to a need to readjust both practically with changed life circumstances, and emotionally.^[11]

Separation distress is thus a core component of complicated grief that is not core to the construct of PTSD.^[3,6]

DO OTHER ASPECTS OF THE RESPONSE TO TRAUMA AND PTSD DEVELOPMENT INFORM COMPLICATED GRIEF?

In both PTSD and CG, risk factors include specific aspects of the event in combination with preexisting risk factors. For example, the relationship to the deceased and type of death appear to be important, but as with trauma and PTSD, not all individuals exposed to the same type of loss develop CG. Both PTSD and CG are also defined by their trajectory of persistent symptoms. After exposure to a significant trauma such as rape,^[12] very high rates of distress and some core PTSD symptoms are present in a majority of people, yet only a minority develop PTSD over time, which can be thought of as a failure of symptom resolution or adaptation of the initial stress response. In DSM-IV, PTSD is diagnosed after just 1 month, despite data supporting that many individuals will continue to improve in the coming months. Prospective longitudinal studies have similarly demonstrated that while the majority of bereaved individuals achieve a less intense or distressing “integrated” grief over time, a minority have a trajectory that does not lessen with time,^[8,13] supporting that CG represents a lack of adaptation to a stressor after 6 or 12 months, or often years.

HOW DOES MODELING LOSS AS A STRESSOR INFORM THE OVERLAP AND COMORBIDITY OF COMPLICATED GRIEF WITH PTSD AND DEPRESSION?

Life stress and traumatic experiences are also well recognized scientifically as a trigger of Major Depression (MDD), with prospective studies demonstrating that MDD and PTSD may develop alone or together after a trauma (e.g.^[14]). Thus, if loss is a severe stressor, it would follow that CG may be considered a post-loss stress syndrome that would be likely to have overlapping symptoms and comorbidity with other conditions triggered by life stressors, including both PTSD and depression. Further, there is some experimental evidence that emotion regulation deficits may be a component of maladaptive responses to bereavement and thus CG development.^[15] Preexisting mood and anxiety disorders and factors such as a history of maltreatment in childhood seem to serve as risk factors for CG, and we have shown nearly a quarter of bereaved individuals with MDD or bipolar disorder have concomitant CG.^[16,17] Nonetheless, despite relatively high rates of comorbid MDD (55%) and PTSD (49%) among 206 treatment seeking individuals with a primary diagnosis of CG, a significant proportion (25%)

did not meet criteria for any other Axis I disorder.^[18] The distinctness of CG features from depression and PTSD has been further supported by multiple factor analytic studies (e.g. see^[19]). Thus, CG as a stressor related condition, similar to MDD and PTSD, has high rates of overlap but also distinctiveness from its nearest neighbors.

POSTTRAUMATIC GROWTH THEORIES OFFER A HYPOTHESIS RELEVANT TO BOTH TRAUMA AND LOSS

Although much research has established PTSD as a complex biological and psychological disorder, our understanding of the impact of stress and trauma on psychological growth is in its infancy, with only recent attention to the concept of posttraumatic growth. Posttraumatic growth theory hypothesizes that trauma can result in both traumatic distress, as well as greater life satisfaction and meaning. It is hypothesized that trauma may challenge an individual’s core beliefs about the world. These challenges are processed cognitively through intrusive automatic ruminations of the event, and when not interfered with by “complications” such as emotion regulation difficulties, also include more deliberate thinking processes that allow cognitive adaptation and meaning making to adjust to a new, post-event life narrative.^[20] This process is not unlike what is required after an important loss; the death of a child has been used as a classic example where such a process is required to occur, and when it does not, greater psychological and traumatic distress is present. With CG, processing and adapting to the loss becomes “stuck” and intervention may be necessary to enable processing the finality of the loss and related emotional distress, and thus enable the bereaved individual to adapt and move forward in a redefined, meaningful life without the deceased.

SUMMARY: COMPLICATED GRIEF AS A POST-LOSS STRESS DISORDER

The death of an important attachment figure serves as a major life stressor to which most people adapt after a period of acute grief, not unlike early responses to trauma that resolve for the majority. Although CG is not yet a formal diagnosis in DSM5, growing evidence suggests that a significant loss can result in a range of stress-related symptoms including stress to core attachment systems and separation distress that is distinct from PTSD, persists, and causes substantial distress and impairment without lessening over many months and years, consistent with the notion that the grief process is “complicated” or “stuck.” Similar to PTSD, CG has a high rate of comorbidity with related conditions triggered by environmental stressors yet also has unique features.

Further, factors that may interfere with the processing of a traumatic stress overlap as risk factors for both PTSD and CG. Thus, while more research is needed, available evidence supports the notion that CG may be conceptualized as a post-loss stress disorder.

REFERENCES

1. Shear MK. Getting straight about grief. *Depress Anxiety* 2012;29:461–464.
2. Prigerson HG, Maciejewski PK, Reynolds CF, III, et al. Inventory of complicated grief: a scale to measure maladaptive symptoms of loss. *Psychiatry Res* 1995;59:65–79.
3. Shear MK, Simon N, Wall M, et al. Complicated grief and related bereavement issues for DSM-5. *Depress Anxiety* 2011;28:103–117.
4. Simon NM, Wall MM, Keshaviah A, Dryman MT, LeBlanc NJ, Shear MK. Informing the symptom profile of complicated grief. *Depress Anxiety* 2011;28:118–126.
5. Kersting A, Brähler E, Glaesmer H, Wagner B. Prevalence of complicated grief in a representative population-based sample. *J Affect Disord* 2011 Jun;131(1–3):339–343.
6. Prigerson HG, Horowitz MJ, Jacobs SC, et al. Prolonged grief disorder: psychometric validation of criteria proposed for DSM-V and ICD-11. *PLoS Med* 2009;6:e1000121.
7. DSM-5 Development. American Psychiatric Association; 2012. Available at: <http://www.dsm5.org>. Retrieved June 18, 2012.
8. Horowitz MJ, Siegel B, Holen A, Bonanno GA. Diagnostic criteria for complicated grief disorder. *Am J Psychiatry* 1997;154:904–910.
9. Langner R, Maercker A. Complicated grief as a stress response disorder: evaluating diagnostic criteria in a German sample. *J Psychosom Res* 2005;58:235–242.
10. Breslau N, Kessler RC, Chilcoat HD, Schultz LR, Davis GC, Andreski P. Trauma and posttraumatic stress disorder in the community: the 1996 Detroit area survey of trauma. *Arch Gen Psychiatry* 1998;55:626–632.
11. Shear K, Shair H. Attachment, loss, and complicated grief. *Dev Psychobiol* 2005;47:253–267.
12. Rothbaum BO, Foa EB, Riggs DS, Murdock T. A prospective examination of post-traumatic stress disorder in rape victims. *J Trauma Stress* 1992;5:455–475.
13. Bonanno GA, Wortman CB, Nesse RM. Prospective patterns of resilience and maladjustment during widowhood. *Psychol Aging* 2004;19:260–271.
14. Shalev AY, Freedman S, Peri T, et al. Prospective study of post-traumatic stress disorder and depression following trauma. *Am J Psychiatry* 1998;155:630–637.
15. Gupta S, Bonanno GA. Complicated grief and deficits in emotional expressive flexibility. *J Abnorm Psychol* 2011;120:635–643.
16. Sung SC, Dryman MT, Marks E, et al. Complicated grief among individuals with major depression: prevalence, comorbidity, and associated features. *J Affect Disord* 2011;134:453–458.
17. Simon NM, Pollack MH, Fischmann D, et al. Complicated grief and its correlates in patients with bipolar disorder. *J Clin Psychiatry* 2005;66:1105–1110.
18. Simon NM, Shear KM, Thompson EH, et al. The prevalence and correlates of psychiatric comorbidity in individuals with complicated grief. *Compr Psychiatry* 2007;48:395–399.
19. Golden A-MJ, Dalgleish T. Is prolonged grief distinct from bereavement-related posttraumatic stress? *Psychiatry Res* 2010;178:336–341.
20. Triplett KN, Tedeschi RG, Cann A, Calhoun LG, Reeve CL. Posttraumatic growth, meaning in life, and life satisfaction in response to trauma. *Psychol Trauma*. In Press.