COMPLICATED GRIEF: A KNOWLEDGE SYNTHESIS FOR PRIMARY CARE
NURSE PRACTITIONERS

by

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Thank you, Adam, Mom, Ashley and Samantha for supporting me through these past two years. You always made me believe that I could accomplish anything. I could not have done this without you!
DEDICATION

I would like to dedicate this project to my Dad who, in a unique and unforeseen way, inspired me to write this paper.
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INTRODUCTION

Approximately 2.5 million people die each year in the United States, and it is estimated that each death leaves behind an average of five bereaved individuals (Frank, Houck, Reynolds, & Shear, 2005). Ten to twenty percent of bereaved individuals develop a condition known as complicated grief. Therefore, over 1 million people each year are expected to suffer from complicated grief in the United States. Complicated grief is often debilitating and is associated with negative health outcomes (Frank et al., 2005). However, identifying and treating patients with complicated grief is not clear. This is evident in the fact that complicated grief is not included in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) despite clinical and research evidence that suggest that complicated grief has unique symptoms that differ from other DSM-IV diagnoses.

Primary care providers have a major role in treating psychological disorders. It is estimated that from 20 to 50 percent of primary care visits are instigated due to an emotional component (Clark, Hiller, Leahy, Marley, & Pratt, 2006). Primary care providers are in a strategic position to treat grief because of their intimate and holistic knowledge of patients and their families and because they are trained in the management of physical and emotional symptoms. Therefore, it is necessary for primary care providers to be adept at identifying and treating disorders such as complicated grief.

Grief is a normal and necessary process that one must experience after a loss of a loved one. However, when a person does not progress through the “normal” grief process, mental and physical health problems may develop into more serious disorders
(Clark et al, 2006). Although complicated grief is not yet defined in the Diagnostic and Statistical Manual (DSM) of the American Psychological Association (now in volume IV), complicated grief is a clinical problem that must be addressed. The lack of a clear definition distinguishing complicated grief from other disorders has hindered practitioners’ ability to address the specific needs of these patients. Thus, the goal of this project is to enhance understanding of complicated grief, particular for primary care nurses who are likely to be confronted with this health problem.

Purpose of Project

Helping patients cope with the loss of a loved one in a healthy and effective manner is an important role of primary care providers. The loss of a loved one is among life’s most traumatic experiences, and the grief related to the loss is associated with an increased risk for morbidity and mortality (Zhang, El-Jawahri, & Prigerson, 2006). Depression, anxiety, substance abuse, hallucinations, physical illness and death are some of the associated effects of bereavement that have been reported in the literature (Cruess, Lichtenthal, & Prigerson, 2004). However, providers are confused as how to evaluate and manage grief processes due to the lack of standardization of care on this topic. There is an abundance of literature related to this subject and yet there is need for a coherent description of the problem in a format useful to practitioners.

The purpose of this project is to synthesize three areas of literature on grief -- clinical, conceptual, and empirical -- to provide a clear and coherent description of the latest knowledge on complicated grief in adults. This description may then be used to inform clinicians about complicated grief in terms of its etiology, manifestations, risk
factors, outcomes, and recommended treatment approaches in their evaluation of and intervention with bereaved individuals suffering from complicated grief.

Background and Significance

For over twenty years now complicated grief has been described in the literature. There have been many different terms used to describe complicated grief, but it was seen more frequently and consistently by 1993. One of the most widely accepted terms to describe the disorder was traumatic grief. This became a confusing definition after the 9/11 attacks due to the implication that it was a form of post traumatic stress disorder (PTSD). Therefore, since 2001, the most popular term is complicated grief (Aoun, Lobb, Kristjanson, & Monterosso, 2007).

Many researchers and clinicians initially believed that complicated grief was a result of other disorders, including major depression, adjustment disorders and anxiety-related disorders. A more recent consideration is that complicated grief only partially shares symptoms of depression, PTSD, and anxiety. Although there are similarities between all these disorders, the contemporary attitude is that there is a sufficient uniqueness to complicated grief that calls for it to be distinguished as a separate entity. Recently, researchers have attempted to define complicated grief through empiric validation (Aoun et al, 2007).

The DSM-III, developed in 1987, was the first edition to include uncomplicated bereavement. This description suggested that depression associated with bereavement was a normal reaction to loss. Given the lack of attention to complicated forms of grief, clinicians have been forced to assess and treat pathological grief symptoms based on a
variety of diagnoses, including depression, uncomplicated bereavement, PTSD, and adjustment disorders. However, it became apparent that the attitude towards grief was changing. In the DSM-IV, developed in 2000, PTSD could be diagnosed if a person had experienced a death of a loved one. In this edition, uncomplicated bereavement was removed and instead bereavement was listed under a code for “Other Conditions That May Be a Focus of Clinical Attention (Cruess et al, 2004).” This was considered to be progress in the field of bereavement. Since that time there has been increasing focus on the inclusion of complicated bereavement in the DSM. Much literature has been generated on this topic.

The literature synthesis for this paper is organized into three major areas based upon three dominant patterns of knowing in nursing: Conceptual, empirical, and clinical (Schultz & Meleis, 1988). Conceptual sources of knowledge about complicated grief include current conceptualizations and descriptions of grief and theoretical frameworks used to explain grief. Empirical sources refer primarily to research-based literature involving studies on bereavement and grief. Clinical sources of knowledge on complicated grief derive primarily from clinically-based journals as well as from the practice-based knowledge and personal and ethical patterns of knowing in nursing (Carper, 1978).
Conceptual Knowledge

**Definitions**

*Bereavement, Loss, Mourning and Grief*

*Bereavement* refers to the occurrence of loss of a loved one. This is the objective situation of having lost someone significant. The time that a person spends in bereavement depends on how attached the person was to the person who has died and how much time was spent on anticipating the loss. Bereavement grants a unique position on the bereaved person; this includes responsibilities and particular privileges. Responsibilities include the burying of the deceased, funerals, memorial services, and disposing of the deceased possessions. Privileges include taking time away from work and other expected roles that are expected to be filled under normal circumstances (Coyle & Ferrell, 2006).

*Loss* is a general term that denotes the absence of something which could include objects, qualities or persons. The loss has different implications depending on the intensity of the relationship to the person. Therefore, more significance should be placed on the individual rather than the actual loss due to differences in the meaning of the relationship (Coyle & Ferrell, 2006).

*Mourning* had different meanings depending on social and cultural practices. Many experts will define mourning as “the social expressions or acts expressive of grief that are shaped by the practices of a given society or cultural group.” Often times, mourning and grief are described interchangeably (Hansson, Schut, Stroebe & Stroebe, 2001). Mourning also includes the process of acknowledging the loss externally and incorporating the loss into the bereaved person’s life (Coyle & Ferrell, 2006).
Grief, on the other hand, is a multifaceted response to loss. Grief is the reaction to bereavement. The focus of grief is usually on the emotional response, but it truly encompasses the physical, cognitive, behavioral, spiritual, social and philosophical aspects of loss. Grief is a highly personal and subjective experience (Coyle & Ferrell, 2006). There is much variability in how a person responds to the grief process including the duration, the intensity, and the way in which they express their grief. However, most people experience intense symptoms that gradually lessen over time. Most bereaved individuals will not require professional help or medications because grief is considered to be a normal reaction to the death of a loved one (Hansson et al, 2001). There are affective, behavioral, cognitive, and physiologic manifestations of grief (see Table 1).

**TABLE 1. Common Manifestations During Bereavement**

<table>
<thead>
<tr>
<th>Affective</th>
<th>Behavioral</th>
<th>Cognitive</th>
<th>Physiologic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Agitation</td>
<td>Preoccupation</td>
<td>Loss of appetite</td>
</tr>
<tr>
<td>Despair</td>
<td>Fatigue</td>
<td>with thoughts of</td>
<td>Sleep disturbances</td>
</tr>
<tr>
<td>Dejection</td>
<td>Crying</td>
<td>the deceased</td>
<td>Energy loss</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Social</td>
<td>Lowered self-esteem</td>
<td>Exhaustion</td>
</tr>
<tr>
<td>Guilt</td>
<td>Withdrawal</td>
<td>Self reproach</td>
<td>Somatic</td>
</tr>
<tr>
<td>Anger</td>
<td></td>
<td>Helplessness</td>
<td>complaints</td>
</tr>
<tr>
<td>Hostility</td>
<td></td>
<td>Hopelessness</td>
<td>Susceptibility to</td>
</tr>
<tr>
<td>Loneliness</td>
<td></td>
<td>Problems with</td>
<td>Disease/illness</td>
</tr>
<tr>
<td>Yearning</td>
<td></td>
<td>memory and</td>
<td>Headaches</td>
</tr>
<tr>
<td>Relief</td>
<td></td>
<td>concentration</td>
<td>Dizziness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Idealization of</td>
<td>Muscular aches</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the deceased</td>
<td>Tremors/shakes</td>
</tr>
</tbody>
</table>

(Coyle & Ferrell, 2006; Hansson, Schut, Stroebe, & Stroebe, 2001)

Approximately 80 to 90 percent of bereaved individuals experience normal or uncomplicated grief (Zhang, El-Jawahri, & Prigerson, 2006). Although grief is
considered a natural process, it is not suggested that grief is an undemanding experience. Most often grief is extremely painful and disruptive, but as a person progresses, the loss becomes accepted (Zhang et al, 2006). There is not a limit to the amount of time that grief can persist. Adjustment from the loss can take months to years and is variable between individuals and across cultures (Stroebe, Schut, & Stroebe, 2007). When these feelings and experiences do not diminish over time, complicated grief occurs.

**Complicated Grief**

Complicated grief has been described in the literature for approximately 20 years. Consequently, there have been many terms used to describe the same condition. Complicated grief has been termed pathological grief, abnormal grief, atypical grief, traumatic grief and pathologic mourning (Cruess et al, 2004). For the purposes of this paper complicated grief (CG) will be the only term used.

Complicated grief is still not considered a specific disorder in the DSM-IV and there is no universally accepted definition. Nevertheless, an illustration of the disorder is necessary here in order to fully understand the underlying implications. The description of complicated grief here is compiled from recent articles.

Defining complicated grief has been a very difficult process over the past 20 years for several reasons. First, differentiating between normal and complicated grief has been challenging because there is no obvious cutoff point from when one ends and the other begins. Complicated grief is not a single syndrome but a combination of many different symptoms. In addition, it is difficult to distinguish complicated grief from other disorders, such as depression, anxiety disorders and PTSD (Hansson et al, 2006).
The person who is suffering from complicated grief will often exhibit many of the following symptoms: unrelenting and disturbing incredulity about the death and resistance to accepting the reality; intense yearning or longing for the loved one; pangs of extreme, painful emotions; preoccupying thoughts of the person including disturbing, invasive thoughts about the death; avoidance of activities that serve as reminders of the deceased; little or no interest or engagement in ongoing life; and hopelessness about the future (Aoun et al, 2007; Bonanno & Kaltman, 2003; El-Jawahi et al, 2006; Shair & Shear, 2005). The most important premise underlying the definition of complicated grief is that the severity and duration of the symptoms determine if a bereaved person is experiencing complicated grief.

In essence, the bereaved person with complicated grief disorder is caught in a state of chronic mourning. The person psychologically rejects the reality of the loss and is disinclined to adapt to life without the loved one. Complicated grief has again and again been shown to increase the risk for suicidal thoughts and behaviors (Zhang et al, 2006).

The manifestations discussed above are extremely important because they can cause severe health consequences. Individuals who are grieving are at risk for developing depression, anxiety and other psychiatric disorders. Bereaved persons visit with doctors more often, use more medication, and are hospitalized more often. In addition, complicated grief is associated with an elevated systolic blood pressure, cardiac disorders, malignancies, sleep disturbances, and changes in eating habits (Cruess et al, 2004).
Theoretical Frameworks on the Process of Grief

Over the past century there has been significant work done to better understand bereavement and grief. Earlier theories and ideas have subsequently influenced contemporary models of bereavement. Therefore, it is essential to review all major theories in order to understand the current themes of grief.

*Stage Theory of Grief Resolution*

Bowlby and Parkes were the first to propose a stage theory of grief that included four stages: shock-numbness, yearning-searching, disorganization-despair, and reorganization (Maciejewski, Zhang, Block, & Prigerson, 2007). Kubler-Ross adapted the previous theory and described the stage theory of grief resolution. This has become a widely excepted theory for both professionals and laypersons. She describes that grief involves a systematic progression through stages. The stages include: shock or disbelief, separation distress or yearning, angry protest, despair or depressed mood and ultimate acceptance of the loss (Kubler-Ross, 1969).

This theory, however, has only been tested empirically in one study. Interestingly enough, a survey conducted in 1997 by Downe-Wamboldt and Tamyn acknowledged that medical education routinely relied on teaching the stage theory of grief resolution as opposed to other more empirically validated theories on grief and bereavement. In addition, The National Cancer Institute has a web site on loss that describes these phases of grief (Bonanno, 2007).

A 2007 study by Maciejewski and colleagues performed an empirical examination of the stage theory of grief that revealed that in the event of a natural death the stages of
grief are experienced. Nevertheless, major bereavement researchers dispute the evidence (Silver & Wortman, 2007). They found that grief is highly variable and is not possible for bereaved persons to progress through an orderly sequence of defined stages. Additionally, they find that this belief can have negative consequences due to the fact that bereaved persons may feel that they are not progressing or coping appropriately (Wortman, 2007).

_Grief Work Perspective_

The grief work perspective is one of the major theoretical foundations in bereavement research. It is formulated from Freudian theory based on his paper written in 1917, “Morning and Melancholy.” In this theory, when a loved one dies, the bereaved person struggles to sever ties from the deceased. The function of grief is to detach from the deceased through a process of grief work. Therefore, one must perceive the death as a reality to avoid complications of grief. By perceiving this reality, individuals will go through a period of intense anguish or depression (Silver & Wortman, 1989).

Complicated grief occurs when there is ambivalence towards the deceased which, for this reason, prevents transference of the attachment to new relationships. The five major ideas of grief work include: distress and depression are inevitable, failure to experience this distress is pathological, the bereaved must work through the loss, there is a belief that recovery will be achieved, and finally there is a state of resolution (Stroebe, 2001).

Although this has been the major theoretical framework seen in bereavement research and many other theorists have derived their theory from the grief work hypothesis, recent literature has criticized this theory for many reasons. The main
criticism is due to the fact that there is lack of empirical evidence. Also, the grief work theory has not been shown to be universal (Stroebe, 2001). Different cultures respond in different ways to grief, and no research proves that different mechanisms of coping are superior to others (Stroebe, 2001). The grief work theory does not extrapolate on maladaptive or dysfunctional processes. This theory assumes that the bereaved will return to normal functioning. In addition, there is a premise that the bereaved do not always need to confront grief and avoidance may not necessarily indicate that the grief experience is pathological (Stroebe, 2001). This theory cannot often be utilized when studying complicated grief due to its lack of focus on the complicated side of grief.

**Attachment Theory**

Attachment theory was developed by John Bowlby and Mary Ainsworth (Berghaus, 2002). The origination of this theory can be tracked to the 1940’s, but it was not until the 1980’s when the theory became more widely recognized and accepted into conventional psychology and popular culture. This theory is heavily influenced by the grief work theory. The attachment theory explores the impact of childhood attachments or relationships and how it affects the individual in adulthood.

Bowlby (Berghaus, 2002) discussed three phase of the separation response, including protest, despair and finally detachment. The foundation of attachment theory originated from studying infant-mother relationships (Berghaus, 2002). The theorists sought to describe the biological aspect of grief versus the psychological characteristic of grief. The premise of this theory is that forming attachments is a necessary part of human development because it creates a sense of security and safety. Grief, therefore, is a
normal biological process that occurs in response to separation and loss (Behavioral Neurotherapy Clinic, 2007). The biological response of grief is to recover from the separation from the deceased, but when this does not take place anxiety occurs.

It is postulated that childhood attachments affect adult attachments. For example, if a child is rejected by his mother than the child has an insecure attachment to the primary caregiver. Later in life, if this person loses a significant person he may have an unhealthy grieving process due to his past childhood experiences. On the other hand, a person who had normal and healthy attachments to the primary caregiver will be able to grieve in a “normal” manner. The bereaved person attempts to detach from the deceased, but instead of severing the bonds, the attachment is redirected in order for the bereaved to adjust to the physical absence of the deceased. In other words, the quality of the attachment affects how successfully a person will achieve separation during childhood and subsequently in adulthood (Stroebe & Stroebe, 2007). In Bowlby’s most recent work, he places an importance on continuing the attachment with the deceased due to enhancing the stability of one’s identity. The relationship is, of course, changed and reorganized but the relationship persists (Bonanno et al, 1999).

The core premise of complicated grief arises from the inability to break the bond with the deceased, making attachment theory a highly relevant conceptual theory within which to interpret the separation distress that follows intimate loss (Aoun et al, 2007). However, it is thought that people who experience a loss who had an insecure attachment to the deceased may not seek to continue the attachment (Fields & Friedrichs, 2004). It is
necessary for further research and exploration to be conducted in considering the usefulness of attachment theory in adult complicated grief.

_Cognitive Stress Theory_

Stress theories are generalized to address any stressor in life and are therefore not unique to bereavement. However, these theories do have application in understanding bereavement because the loss of a loved one is considered to be one of life’s most stressful events (Aoun et al, 2007). The cognitive stress theory influences other theories in the field of bereavement and more specifically in the study of complicated grief. Consequently, a brief synopsis of the cognitive stress theory will be described.

The cognitive stress theory provides a framework for describing the impact of difficult life events to its implications on health. Unlike the grief work perspective, this theory describes bereavement as an experience of multiple stressors. It also differs from the grief work perspective in that the loss of a loved one is not always severely difficult; rather the difficulty of the loss is subjective to each individual (Schut & Stroebe, 1999).

The bereaved person performs an appraisal of the event. This appraisal determines how challenging the loss of the loved one is experienced. The subsequent appraisal determines the possible options of coping mechanisms available to prevent impairment. The coping mechanisms implemented during this process either causes the person to attend to the stressor or retreat from the source of the stress. Consequently, avoidance is not necessarily seen as maladaptive, but can actually help the person through the grief process (Bonanno et al, 1999).
The dual process model was created in 1999 by Stroebe and Schut as a response to the lack of new theories in bereavement studies during a time when grief work was become less popular. This theory provides the means to illustrate ways in which people came to terms with loss of a loved one (Schut et al, 1999).

The two main categories of this theory involve loss-orientation and restoration orientation coping mechanisms. Loss-orientation is the actual coping with the loss itself, similar to the grief work model. This is the time when yearning, reminiscing, and crying about the loved one occurs. Restoration-orientation describes the time when the bereaved person is focusing on all other stressors that do not directly involve the deceased. This is the time in which the person deals with the stressors of change that is related to the loss. For example, the bereaved person needs to master new tasks, create a new identity, and reorganize life. These changes can include learning to cook, selling a house and socializing. The dual process model is not a stage model, but rather an oscillation between the two ways of coping. See Figure 1. The bereaved is not always confronting the loss, but at times is avoiding feelings and memories about the loss. This oscillation provides brief periods of respite from grieving itself, which is crucial for a healthy adjustment over time. The caveat is that the avoidance of the situation is not prolonged or extreme. Unrelenting grieving would have an adverse effect to mental and physical health (Schut et al, 1999).
In other words, the bereaved individual oscillates between the two processes. The first being confrontation of the loss and avoidance of stressors to directly deal with the loss. The person would then confront the secondary stressors that may include dealing with finances and avoid dealing with the loss. Adaptive grieving involves confrontation and avoidance of the two components.

When addressing complicated grief with this model, researchers believe that complicated grief occurs because there is considered to be a “disturbance of oscillation.” This implies that the bereaved person is not moving back and forth from the two coping mechanisms. Spending too much time and effort in either loss-oriented or restoration-oriented mechanisms could cause manifestations of complicated grief. The person suffering from complicated grief is either confronting the loss or avoiding the loss in

(Schut et al, 1999)
extremes (Schut et al, 1999). The dual process model is one of the only models created to study complicated grief at this time.

Conclusions on Conceptual Knowledge

It is imperative that future research focuses on creating a universal framework and a definitive definition of complicated grief in order for further understanding of appropriately identifying and treating patients with complicated grief. However, it is apparent, after examining the major theories of bereavement, that there is a multiplicity of frameworks that having guided exploration into grief. This diversity, along with the ambiguity of defining complicated grief, has impeded the research and understanding of complicated grief.

From the perspective of a clinician, the dual process model provides a unique and applicable theory for evaluating grieving patients. A practitioner has the ability to assess whether a patient is oscillating adequately between the two mechanisms of coping. The practitioner can then determine whether the patient needs to spend more time in the other method of coping. In addition, this model serves as a good teaching tool. Practitioners can use this model to illustrate that one can move back and forth from the actual grieving to the avoidance and that each entity is imperative in order to grief in a healthy manner. This may comfort patients who feel that they need to continually focus on the death and the loss.
Empirical Knowledge

**Diagnostic Criteria**

Within the literature there are two major criteria proposed in order to diagnose complicated grief. Both have empirical support, although neither has been truly recognized universally and only time will tell which will be adopted in the future. The main goal of illustrating these two criteria is to educate clinicians on the descriptions present in the literature. This will serve to assist practitioners in identifying patients presenting with symptoms that may warrant further assessment and, perhaps, treatment.

The major researchers involved in developing diagnostic criteria for complicated grief are Horowitz and his colleagues at the University of California and Holly Prigerson and her colleagues at Yale University (Aoun et al, 2007). In 1997, Horowitz and his colleagues investigated a new diagnosis related to prolonged and tumultuous grief reactions that differed from the DSM-IV criteria for major depressive disorder. They developed definitions of thirty symptoms that had been observed clinically in previous interviews of bereaved persons. The researchers then developed a plan to examine whether any arrangement of those symptoms would provide criteria for a possible diagnosis (Horowitz, Siegel, Holen, Bonanno, Milbrath, & Stinson, 1997). They found that complicated grief disorder was established by a smaller set of symptoms. The person who fits the symptomotology did not have common characteristics with symptoms found in the diagnosis of major depressive disorder. The criteria that resulted from this investigation are shown below in Table 2.
TABLE 2. Criteria for Complicated Grief Disorder.

<table>
<thead>
<tr>
<th>A. Event Criterion/ Prolonged Response Criterion</th>
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<tbody>
<tr>
<td>Bereavement (Loss of spouse, other relative or intimate partner) at least 14 months ago (to avoid anniversary).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Signs and Symptoms Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last month any three of the following seven of the following, with a severity that interferes with daily functioning:</td>
</tr>
</tbody>
</table>

Intrusive symptoms:
1. Unbidden memories or intrusive fantasies related to the lost relationship
2. Strong spells or pangs of severe emotion related to the lost relationship.
3. Distressing strong yearnings or wishes that the deceased were there.

Signs of Avoidance and Failure to Adapt
4. Feeling of being far too much alone or personally empty
5. Excessively staying away from people, places or activities that remind the subject of the deceased.
6. Unusual levels of sleep interference.
7. Loss of interest in work, social, caretaking, or recreational activities to a maladaptive degree.

(Horowitz, Siegel, Holen, Bonanno, Milbrath & Stinson (1997)

Prigerson & Jacobs (2001) have also created diagnostic criteria for complicated grief.
The researchers developed these criteria from their “Inventory of complicated grief,” which they developed in 1995. The criteria were created from a consensus conference, where the researchers believed that separation distress and bereavement from death should both be incorporated. See Table 3. In addition, the criteria included traumatization, functional impairment and the length of symptoms being present for two months from the time of onset. However, in 2006 the timeframe was changed to a length of 6 months of experiencing symptoms (Prigerson & Macijewski, 2005).
TABLE 3. Criteria for Complicated Grief Proposed for DSM-V

<table>
<thead>
<tr>
<th>Criterion A:</th>
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<tbody>
<tr>
<td>Yearning, pining, longing for the deceased.</td>
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<tr>
<td>Yearning must be experienced at least daily over the past month or to a distressing or disruptive degree.</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Criterion B.</th>
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</thead>
<tbody>
<tr>
<td>In the past month, the person must experience four of the following eight symptoms as marked, overwhelming, or extreme.</td>
</tr>
<tr>
<td>1. Trouble accepting the death</td>
</tr>
<tr>
<td>2. Inability trusting others since the death</td>
</tr>
<tr>
<td>3. Excessive bitterness or anger about the death</td>
</tr>
<tr>
<td>4. Feeling uneasy about moving on with one’s life (e.g., difficulty forming new relationships)</td>
</tr>
<tr>
<td>5. Feeling emotionally numb or detached from others since the death</td>
</tr>
<tr>
<td>6. Feeling life is empty or meaningless without the deceased</td>
</tr>
<tr>
<td>7. Feeling the future holds no meaning or prospect for fulfillment without the deceased.</td>
</tr>
<tr>
<td>8. Feeling agitated, jumpy or on edge since the death</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Criterion C.</th>
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<tr>
<td>The above symptom disturbance causes marked dysfunction in social, occupational, or other important domains.</td>
</tr>
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</table>

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<tr>
<th>Criterion D.</th>
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<tbody>
<tr>
<td>The above symptom disturbance must last at least 6 months.</td>
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</tbody>
</table>

(Prigerson & Maciejewski (2005))

It is essential to distinguish the differences between these criteria. Prigerson makes separation distress (preoccupation with thoughts of the deceased) and functional impairment essential criteria, evident through criterion A and C. She also includes loneliness, anger, emotional numbness, and disbelief, included in criterion B. Finally Prigerson’s criteria require a 6 month period of symptoms (Goodkin, Lee, Molina, Zheng, Frasca, O’Mellan, Asthana, Shapshak, & Khamis, 2006). In contrast, Horowitz requires a much longer time frame of 14 months from bereavement to diagnosis and includes sleep disturbances and avoidance reminders in the proposed criteria (Goodkin et al, 2006).

Forstmeir & Maerker (2006) conducted a study to compare the two diagnostic systems of Prigerson et al (2005) and Horowitz et al (1997). They found that there were
significant differences between the two criteria. In this study, they found contrasting prevalence rates of complicated grief between the two sets of criteria. Horowitz’s criteria make a diagnosis of complicated grief at a much higher rate than Prigerson’s. The reasons for these differences may be due to the fact that Prigerson requires fulfillment of the disturbance criterion. In addition, Prigerson’s criteria require four out of eight symptoms to be present versus Horowitz’s which requires three out of seven symptoms. This implies that persons must be more impaired to receive a diagnosis of complicated grief when utilizing Prigerson’s criteria (Forstmeir et al, 2006).

After reviewing the two major proposed diagnostic criteria, many questions arise about how to diagnose complicated grief. How much impairment should be present for a patient to receive a diagnosis and how long should these symptoms be present? In order for clinicians to truly understand complicated grief, future efforts must be made for the integration of these two sets of criteria.

Distinguishing Complicated Grief from Other Disorders

Practitioners need to be knowledgeable about other disorders that could be mistaken for complicated grief. There are many similarities between the disorders but treatment methods differ. In addition, persons with complicated grief can have other diseases concurrently.

Complicated grief and PTSD share some common symptoms, but these disorders are not synonymous. The precipitating event that occurs in patients with PTSD is a traumatic event, whereas in complicated grief, the precipitating event is the loss of a relationship. However, in some cases this loss could be itself traumatic. The event that
occurs in PTSD is not considered a universal experience, but the loss of a loved one is considered to be a normal, expected experience. Persons with PTSD will have intrusive thoughts about the memories of the traumatic death causing negative and distressing memories. In addition PTSD patients will generally avoid reminders of the occurrence.

In complicated grief, however, intrusive thoughts occur but are more often positive and comforting. These thoughts often consume the patient to the point that the person cannot progress or adapt to the life without the deceased. People suffering from complicated grief avoid reminders of the absences of the deceased, but instead seek reminders of the presence of the deceased (Cruess et al, 2004)). There is an increased focus on reconnecting to the deceased. These patients will often express feelings and attempt to talk about their feelings related to the loss, whereas PTSD patients withdrawal and avoid talking about the event (Zhang et al, 2006). Complicated grief occurs because of the separation distress and PTSD occurs because of the fear of a threatening event (Cruess et al, 2004).

Major depressive disorder is often confused and inappropriately diagnosed in patients with complicated grief (Cruess et al, 2004). As with PTSD, there are similarities between depression and complicated grief. Additionally, depression and complicated grief often coexist. Bereavement-related depression can be diagnosed two months post loss and diagnostic criteria include: guilt about actions that were taken or not taken at the time of death, preoccupations with worthlessness, psychomotor retardation, functional impairment, and hallucinations other than hearing voices or seeing the deceased person occasionally (Zisook & Kendler, 2007). Researchers have found that a close relationship
to the deceased often predispose patients to complicated grief (Cruess et al, 2004). In contrast, a conflicted relationship with the deceased often predicts depression post loss. Intrusive thoughts, avoidance of the loss and decreased abilities to adapt to the loss are unique to complicated grief (Cruess et al, 2004). Over time bereavement-related depressive symptoms often decrease whereas the grieving symptoms persist in complicated grief. It is also apparent that these disorders are distinct because complicated griever will not often respond to traditional antidepressive therapies (Zhang et al, 2006).

There is evidence that complicated grief can be distinguished from depression and PTSD. Studies demonstrate that although complicated grief is frequently comorbid with other psychiatric disorders, a diagnosis based solely on the DSM-IV disorders of major depressive disorder and PTSD risks missing many cases of CG. Several studies have verified that complicated grief is distinct from depressive symptoms. Zisook and Schuchter (1991) found that 24% of their sample met criteria for bereavement-related depression and 10% met criteria for PTSD two months post loss. In another study, 10.7% of the subjects met criteria for complicated grief, 5.7% for PTSD and 9% for depression (Barry, Karl, & Prigerson, 2002). Finally, another study showed that 16 out of 135 participants could be diagnosed with complicated grief, but of that 16, only 6 had a comorbid disease of depression (Zisook & Schuchter, 1991). Although depression can occur with complicated grief, complicated grief can occur in the absence of depressive symptoms (Ogrodniczuk, Piper, Joyce, Weidman, McCallum, Azim, & Rosie, 2003).

Table 4 summarizes the similarities and differences between complicated grief and other DSM-IV disorders. The top section illustrates the similarities between
complicated grief and depression and PTSD. In contrast, the lower section of the table describes the differences between complicated grief and depression and PTSD.

TABLE 4. Similarities and Differences between Complicated Grief and DSM-IV Disorders

<table>
<thead>
<tr>
<th>Similarities Between Complicated Grief and DSM-IV Disorders</th>
<th>Posttraumatic Stress Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Major Depression</strong></td>
<td><strong>Complicated Grief</strong></td>
</tr>
<tr>
<td>• Sadness</td>
<td>• Sadness related to missing the deceased</td>
</tr>
<tr>
<td>• Loss of interest</td>
<td>• Interest in memories of deceased maintained</td>
</tr>
<tr>
<td>• Lost of self-esteem</td>
<td>• Guilt focused on interactions with the deceased</td>
</tr>
<tr>
<td>• Guilt</td>
<td>• Preoccupation with positive thoughts of the deceased</td>
</tr>
<tr>
<td></td>
<td>• Intrusive images of the person dying</td>
</tr>
<tr>
<td></td>
<td>• Avoidance of situation and people related to reminders of the loss.</td>
</tr>
<tr>
<td><strong>Differences Between Complicated Grief and DSM-IV Disorders</strong></td>
<td><strong>Posttraumatic Stress Disorder</strong></td>
</tr>
<tr>
<td><strong>Major Depression</strong></td>
<td><strong>Complicated Grief</strong></td>
</tr>
<tr>
<td>• Pervasive sad mood</td>
<td>• Triggered by physical threat</td>
</tr>
<tr>
<td>• Loss of interest or pleasure</td>
<td>• Primary emotion is fear</td>
</tr>
<tr>
<td>• Pervasive sense of guilt</td>
<td>• Nightmares are very common</td>
</tr>
<tr>
<td>• Rumination about past failures/misdeeds</td>
<td>• Painful reminders linked to the traumatic event: usually specific to the event.</td>
</tr>
</tbody>
</table>

(Frank et al, 2005)
Health Outcomes of Complicated Grief

Research has shown that bereavement can cause various poor physical and mental health outcomes. However, complicated grief has been shown to cause even more severe physical and health problems. It is important to determine what impact complicated grief has on the lives of the people it affects.

Prigerson et al (1997) found persons suffering from complicated grief had higher incidences of cancer, hypertension, heart disease, changes in eating habits, tobacco abuse, and suicidal ideations. A subsequent study confirmed that persons with complicated grief had an increase risk of suicide (Letham & Prigerson, 2004).

A 2003 study compared mental and physical health problems with complicated and uncomplicated bereaved people. The results showed that persons with complicated grief were discovered to have decreased mental health, an increase in unhealthy symptoms, decreased sense of well-being, and decreased daily functioning (Ott, 2003).

In 2005 a study was done to investigate the sleep quality in complicated grief (Germain, Carroff, Buysse, & Shear, 2005). Poor sleep quality is considered to be a risk factor for psychiatric problems. The researchers found that complicated grief was associated with poor sleep quality. These findings may be related to changes in social rhythms and low activity levels (Germain et al, 2006). In addition, there was a higher rate of insomnia in the bereaved sample when compared with the non-bereaved group in a 2005 study (Hardison, Neimeyer, & Lichstein, 2005).

These studies provide an important component for which all primary care practitioners should be aware. The knowledge of the adverse outcomes demonstrates that
complicated grief is not a benign condition, and patients suffering from complicated grief should be monitored closely for adverse health outcomes and potential suicide.

Risk Factors for Complicated Grief

Risk factors play an important role in identifying and treating any disorder. Research has discovered that complicated grief can be associated with certain risk factors. These risk factors can predispose a person to complicated grief after the death of a loved one. Identifying risk factors can assist practitioners in the prevention and evaluation of complicated grief. Bereavement researchers use the term “risk factor” to define the situational, interpersonal and intrapersonal components that have the potential to increase vulnerability to the array of bereavement outcomes (Stroebe et al, 2007).

Attachment is an important component of complicated grief. Silverman, Jacobs, & Prigerson (2001) found that persons who experienced child abuse or neglect or a death of a parent during childhood had a higher risk of developing complicated grief after a loss during adulthood. Insecure attachments in childhood may increase a person’s susceptibility to separation anxiety, thus increasing the risk for developing complicated grief later in life. In addition, children who did not have strong parental support may leave them vulnerable to other psychological problems due to the likelihood of having to suffer other challenges in life (Silverman et al, 2001). A 2006 study has also concluded that separation anxiety during childhood is associated with complicated grief (Vanderwerker, Jacobs, Parkes, & Prigerson, 2006).

Anecdotally, researchers and laypeople have thought that having a difficult or strained relationship with the loved one predisposed the bereaved person to grief-related
problems. However, newer research is showing that this is not the case. In fact, there appears to be an inverse relationship. While a strong marital relationship is associated with a positive effect of health and well-being, the loss of that positive relationship is linked with complicated bereavement and other health-related problems (Prigerson, Maciejewski, & Rosenheck, 2000). Researchers are illustrating that excessive dependency on their spouse is a predictor for complicated grief (Bonanno, Wortman, Lehman, Tweed, Harring, Sonnega, Carr & Nesse, 2002). Yearning, one of the core components in complicated grief, is increased in those who had strong marital attachments (Carr, House, Kessler, Nesse, Sonnega & Wortman et al, 2002). Thus, those who had supportive, confiding, and positive interactions with their spouse tended to have higher levels of complicated bereavement than those who have conflicting relationships with their spouse (Van Doorn, Kasl, Beery, Jacobs & Prigerson, 1998). In addition, a 2005 study found that bereaved college students showed a higher prevalence of complicated grief when the loss was of someone whom they had a close relationship. This may indicate that closeness, despite being in a marital or conjugal relationship, can be a risk factor for complicated grief (Hardison, Neimeyer & Lichsteine, 2005).

A 2005 study showed that insomnia was a risk factor for complicated grief in bereaved college students. Individuals who suffered from insomnia preloss in the bereaved group reported more complicated grief symptoms compared with their non-insomniac counterparts (Hardison et al, 2005). The persons who suffered a loss due to violent deaths of a loved one had higher incidences of insomnia and had a higher risk for complicated grief. The researchers postulate that this may be due to the fact that these
subjects had more intrusive thoughts and disturbing dreams about the deceased prior to bedtime (Hardison et al, 2005).

There are inconsistent results on the impact of a sudden, unexpected death or a traumatic death as a risk factor for complicated grief. Other research suggests that those who are unprepared for the death of a loved one have higher chances of developing complicated grief. Sanders (1983) showed that a sudden loss can cause more severe health consequences. In contrast, another study of bereaved persons perception of how peaceful or violent the death was or how much the person suffered was not associated with complicated grief (Barry et al, 2002). In another study prolonged forewarning increased anxiety, while sudden death was associated with higher levels of yearning in women but not in men (Carr, House, Wortman, Nesse, & Kessler, 2001). Although there are inconsistencies in the research on sudden and/or traumatic deaths as risk factors for complicated grief, practitioners should be aware of the potential for causing bereavement-related consequences.

In Wiles, Jarrett, Payne & Field (2002) three major risk factors were noted by general practitioners. These risk factors were: the nature of the death (traumatic deaths increasing the risk), the support from friends or family available to the bereaved person and, finally, the reaction to the death. In this study the practitioners were conscious of identifying mental health problems, such as substance abuse, anxiety and depression. In addition, these practitioners identified medical error or negligence as a cause of death as a risk factor for complicated grief. Despite the fact that these practitioners identified risk factors, there were few counseling referrals because most practitioners felt that there was
a natural progression through grief and that symptoms decreased over time. It was found that they did not know about the new models of grief and the potential for long-term complications (Wiles et al, 2002).

The other study sought to determine potential risk factors for caregivers of seriously ill patients in developing complicated grief. The researchers found that lack of social support, history of alcohol or substance abuse, poor coping skills, history of mental illness, loved one was a child, and concurrent crisis are all risk factors for complicated grief (Ellifritt, Nelson & Walsh, 2003). Table 5 summarizes the risk factors for complicated bereavement.

<table>
<thead>
<tr>
<th>TABLE 5. Risk Factors for Developing Complicated Bereavement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect/Abuse during childhood</td>
</tr>
<tr>
<td>Childhood separation anxiety</td>
</tr>
<tr>
<td>Loss of a parent during childhood</td>
</tr>
<tr>
<td>Strong/Close relationship with the deceased</td>
</tr>
<tr>
<td>Insomnia</td>
</tr>
<tr>
<td>Limited support</td>
</tr>
<tr>
<td>Unexpected death</td>
</tr>
<tr>
<td>Previous history of mental illness</td>
</tr>
<tr>
<td>Previous history of alcohol or substance abuse</td>
</tr>
<tr>
<td>Lack of preparedness</td>
</tr>
<tr>
<td>Concurrent Crisis or loss</td>
</tr>
</tbody>
</table>

Treatment for Complicated Grief

Nurse practitioners have many assets to assist patients. One such asset is that of primary intervention. Because practitioners are proactive in their approach, it is important to discuss the pre-complication interventions available.

Because lack of being prepared for the loss of a loved one is a major risk factor for developing complicated grief, practitioners can, at times, assist patients in preparing
for the death. The practitioner should be honest and empathetic about an impending death. This approach provides an opportunity for saying their “goodbyes” and cognitively and emotionally prepare for the death. Hebert, Dang, & Schulz. (2006) found that caregivers who felt unprepared for the death of their loved one had more than double the chance of developing depression and complicated grief.

Early hospice and palliative care referral may also assist with preparing the individual for a loss, thus reducing the risk for complicated grief. Christakis and Iwashyna (2003) found that bereaved individuals had better survival if their loved one was enrolled in hospice. Additionally, timely hospice participation reduced the risk of depression during the first six months of bereavement in another study (Bradley, Prigerson & Carlson, 2004).

Within the past decade, treatment approaches have been explored in the research. Although some treatments have proven to be efficacious in complicated grief, there is no one universally accepted treatment method. The hope is that future research will build upon previous studies to create treatment plans that address this condition.

**Pharmacotherapy**

Zygmont, Prigerson, Houck, Miller, Shear, Jacobs, & Reynolds (1998) studied the effects of paroxetine and nortriptyline for the treatment of complicated grief. Both medications appear to decrease the depressive symptoms equally but neither had a strong effect on the grief symptoms (Zygmont et al, 1998).

Other researchers explored whether interpersonal therapy (IPT) and/or nortriptyline could decrease symptoms of bereavement-related depression. IPT was done
for 50 minutes each week. Nortriptyline or placebo was taken daily and monitored by checking blood levels to ensure therapeutic levels. Combination nortriptyline with IPT showed a marked improvement in depressive symptoms. However, no changes in any combination of medical therapy and IPT occurred in the bereavement symptoms (Reynolds, Miller, Pasternak, Frank, Perel, Cornes, Houck, Mazumdar, Dew, & Kupfer, 1999).

A 2001 study considered buproion sustained released as treatment for general bereavement, not specifically complicated bereavement. The results showed that there was improvement in depression and grief intensity. However, further research is necessary to evaluate whether people who suffer from complicated grief respond to this medication (Zisook, Shuchter, Pedrelli, Sable, & Deaciuc, 2001).

A prospective study done in 2007 examined the effect of escitalopram on complicated grief. Four female patients, all with a comorbidity of complicated grief and depression, were used in this study. In addition, three of the four patients suffered from PTSD. During the 10-week study, all patients tolerated a titration of escitalopram to 20mg/day. The results showed that there was a reduction in complicated grief symptoms. Major limitations of this study include the small sample size. Larger randomized controlled studies are needed, but initial results indicate that selective serotonin reuptake inhibitors may play a role in the treatment of complicated grief (Simon, Thompson, Pollack, & Shear, 2007).
Therapy

A study done in 2007 studied cognitive behavior therapy to prevent complicated grief among relatives and spouses bereaved by suicide. The researchers determined that a family based cognitive behavior grief counseling program did not improve complicated grief reactions, suicidal ideation or depression. However, there was a decrease in thoughts of guilt and blame for the death of the loved one (Groot, Keijers, Neeleman, Kerkhof, Nolen & Burger, 2007).

Traumatic grief treatment, now known as complicated grief treatment (CGT), was developed in 2001 (Shear, Frank, Foa, Cherry, Reynolds, Vander Bilt, & Masters, 2001). It consists of treatment that targets depression through interpersonal therapy (IPT) and PTSD symptoms through cognitive behavioral therapy. The goals of the treatment are to encourage the development of relationships with others and to assist the patient in engaging in daily activities. These processes serve to facilitate the creation of positive memories of the decreased and to reduce grief symptoms. The IPT is used to support the patient in developing relationships with other people. Grief reduction is addressed by re-experiencing the death of the loved one and addressing situations that the person attempts to avoid. The findings showed that there was an improvement in symptoms when compared to interpersonal therapy alone (Frank et al, 2005).

In 2006, a randomized controlled trial was performed to test the CGT. The dual process model of coping is the framework used in this treatment. The treatment includes loss-focused cognitive-behavioral therapy and restoration focused IPT techniques. Again, the cognitive-behavioral techniques assist the bereaved person to confront situations in
which were previously avoided and to imagine the death. Imaginable conversations with
the deceased and recalling memories are important components. The IPT works on
restoring relationships and building rapport with others. The results of the study show
that there is a better response to CGT when compared to IPT. However, the response
rates were weaker than desired; only 51% of the subjects responded to CGT. It is
apparent that more work is needed in this field (Frank et al, 2005).

In 2006 an internet-based intervention program was tested for complicated grief.
The intervention is based on Horowitz’s stress response theory (Wagner, Knaevelsrud &
Maercker, 2006). This program consisted of a 5-week intervention that included biweekly
45 minute writing assignments and cognitive-behavioral therapy via email
correspondence with an assigned therapist (Wagner et al, 2006). These patients showed a
reduction in symptoms at post treatment, 3-month follow up and 1.5-year follow-up
(Wagner et al, 2006; Wagner & Maerker, 2007). The main symptoms that were decreased
included: intrusion, avoidance, and failure to adapt (Wagner et al, 2006). By the 1.5 year
follow-up patients showed a decrease in physical health symptoms (Wagner et al, 2007).

A 2007 study compared treatment effects of cognitive-behavioral therapy,
including cognitive restructure and exposure therapy, to conventional supportive therapy.
The treatment included a total of twelve, 45-minute sessions. The cognitive restructuring
method taught patients how to identify and change negative cognitions. Exposure therapy
consisted of instructing the patient on how to confront the loss by telling the story of the
loss, writing memories and thoughts of the places and situation that were being avoided,
and finally to confront the reality of the loss. Supportive therapy included identifying
difficulties experienced in the patient’s life. The therapist did not address the cognitions and did not encourage exposure in supportive therapy. The cognitive-behavioral approach was more successful than the supportive therapy. In fact, starting with exposure therapy and then initiating cognitive restructuring showed more clinical improvement (Van den Hout, & Bout, 2007).

After evaluating all of the available treatment options for complicated grief it is apparent that more research need to be conducted to guide future interventions. The complicated grief treatment appears to be the most promising by combining cognitive-behavioral and interpersonal therapies. Additionally, medical therapy with selective serotonin reuptake inhibitors (SSRIs) specifically escitalopram, may prove to be another mode of treatment. As with treatments for many mental health disorders, combinations of therapy and pharmacotherapy may prove to be the key when treating complicated grief.

Clinical Knowledge

Primary care providers are guided by evidence-based practice. However, this is not the only manner in which they practice advanced nursing. Knowledge and skills gained from clinical experiences shapes how providers assess, diagnose and treat patients.

Because loss and death is a certain occurrence in everyone’s life, primary care providers will come into contact with patients who are grieving. Providers are expected to have a vast amount of knowledge of many different physical and mental disorders. Although there is ambivalence about the primary care provider’s role in providing
support to bereaved patients, it is necessary that all these providers have basic knowledge about how to assess for bereavement and its complications.

Through a comprehensive literature search only one clinical article was found directly discussing complicated grief. Perhaps this is due to the fact that complicated grief is not considered a true disorder as defined by the DSM-IV. Conceivably, if and when, this disorder is officially defined clinical research will take place.

Zeitlin (2001) discusses anticipatory grief, normal grief, complicated grief, grief in the terminally ill and children, and interventions for grief. She recommends making a bereavement call or sending a bereavement card to the family to offer condolences and support. In addition, she recommends offering a follow-up appointment after the death to assess the person’s health. She suggests that the practitioner assists the patient in expressing his/her feelings and encourage the bereaved to create a steady routine. The practitioner should caution the patient to avoid making huge lifestyle changes or decisions at shortly after the loss. Finally the practitioner should educate the patient about the bereavement process and encourage involvement in bereavement support groups, often offered by local hospices (Zeitlin, 2001).

Zeitlin gives a brief overview of complicated grief and illustrates the health consequences and risk factors associated with the disorder. Although not all risk factors listed have been empirically validated, her personal clinical experiences may have contributed to the information listed in the article. These risk factors include: previous history of psychiatric disorders, a history of multiple, recent losses and deaths by suicide, AIDS, murder or other unexpected deaths. Another important component to this clinical
article is the suggestion that bereaved individuals often present to the clinic with somatic complaints. These appointments serve as opportunities to evaluate for complicated grieving. She recommends psychiatric evaluation for these patients (Zeitlin, 2001).

Although there are few clinical articles dealing specifically with complicated grief, there are articles generated for general practitioners on how to identify and act in response to general grief.

A 2001 article in *Advance for Nurse Practitioners* (Valentino, 2000) discusses how to recognize and respond to grief so as to guide practitioners in daily practice. Valentino recommends that practitioners be aware of their own feelings about death and grief, despite the discomfort of this. She infers that the plan of action and treatment goals will be different for those patients who are grieving. The author describes common physical and mental manifestations of grief. In addition, Valentino suggests four interventions to assist grieving patients (see table 6).

<table>
<thead>
<tr>
<th>TABLE 6: Interventions to Assist Grieving Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask every patient directly: “Have you recently lost a loved one?”</td>
</tr>
<tr>
<td>Document bereavement in the patient’s chart so all members of the health care team are aware of it.</td>
</tr>
<tr>
<td>Provide support to bereaved patients in the form of education, referral to community resources and providing a sounding board.</td>
</tr>
<tr>
<td>Explore your own feelings about death and become educated about the grief process.</td>
</tr>
</tbody>
</table>

(Valentino, 2000)

A 2002 study done by Main and colleagues was done to improve the management of bereavement in general practice. These recommendations were made from a survey completed by bereaved individuals in a general practice clinic in Britain. Based on the responses from the bereaved patients five recommendations were made. The first
recommendation is to send a letter of sympathy and support. Secondly, the authors recommend a visit to the individual either by a nurse or the practitioner. Next, a specific bereavement consultation should be offered to the individual. The chart should be labeled to remind the practitioner about the bereavement. Finally, a record of deaths should be kept to permit the staff to offer sympathy when appropriate (Main, 2000).

All of the recent empirical research is an encouraging commencement for future clinical research that will ultimately guide primary care practitioners in becoming knowledgeable about grief processes, including complicated bereavement.

Conclusion

Complicated grief, although not considered a disorder by the DSM, has been shown in the literature to exist and pose many problems for the people who suffer from this disorder. Because loss is a certainty in everyone’s life, grief and its outcomes will be encountered in primary care clinics. Primary care nurse practitioners have the ability and are in the ideal position to respond to their patient’s bereavement needs.

The purpose of this project was to examine the current state of knowledge about complicated grief, to inform primary care clinicians about the definitions, conceptual framework, and empirical and clinical data available concerning complicated grief. The long term goal is that this will assist practitioners in identifying and intervening when complicated grief occurs.

The adverse health outcomes associated with complicated grief should inspire practitioners to address this disorder, just like a nurse practitioner would with hypertension or diabetes. The conceptual framework provides knowledge about how the
grieving process occurs, how it affects the bereaved person and finally how complications can ensue. The information about risk factors should help practitioners identify those patients at risk for developing complicated grief, thereby mobilizing the practitioner to follow the patient closely.

The lack of a true definition and uncertainty in the conceptual framework has created a sense of ambiguity for health care providers on how to address this disorder. The information synthesized in this paper provides the primary care nurse practitioner with knowledge in the following areas:

1. Accepted definitions used in bereavement literature, including: bereavement, loss, mourning, grief and complicated grief.

2. Common manifestations that can occur during bereavement.

3. An understanding of the general theories that have guided bereavement research and practice. These include: the stage theory of grief, the grief work perspective, attachment theory, cognitive stress theory and the dual process model. Secondly, the dual process model is a particularly helpful model for use by practitioners to guide how they educate, manage and treat patients during the bereavement process.

4. A description of the distinction between complicated grief and the DSM-IV disorders of major depression and post traumatic stress disorder.

5. Adverse health outcomes associated with both general bereavement and complicated grief.
6. Risk factors for developing complicated grief, which are useful in monitoring patients at risk.

7. Empirical support for approaches to preloss care and interventions that could potentially initiate positive sequelae for the bereaved person.

8. Current and classic literature sources that can be used to provide quality health care through evidence-based practice.

Because Primary care nurse practitioners are trained to approach patients in a holistic and empathetic manner, they will often provide the first opportunity for healing in bereaved patients. Although there is uncertainty about the actual diagnostic criteria for complicated grief, this paper provides information needed for practitioners to provide appropriate referral for bereaved persons who experience 6 or more months of symptoms that impair their functional ability and are different from other DSM disorders. Practitioners do harm if an assessment of grief is not done due to the consequences of grief on life. Therefore, it is essential that a proactive approach is taken with each grieving patients. Providing education, assessment, referral and an empathetic ear may initiate the healing process for the bereaved person.
REFERENCES


