# *Grief and mourning gone awry: pathway and course of complicated grief*

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*Complicated grief is a recently recognized condition that occurs in about 7% of bereaved people. People with this condition are caught up in rumination about the circumstances of the death, worry about its consequences, or excessive avoidance of reminders of the loss. Unable to comprehend the finality and consequences of the loss, they resort to excessive avoidance of reminders of the loss as they are tossed helplessly on waves of intense emotion. People with complicated grief need help, and clinicians need to know how to recognize the symptoms and how to provide help. This paper provides a framework to help clinicans understand bereavement, grief, and mourning. Evidence-based diagnostic criteria are provided to help clinicians recognize complicated grief, and differentiate it from depression as well as anxiety disorder. We provide an overview of risk factors and basic assumptions and principles that can guide treatment.*

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## Introduction

I have never climbed Mt. Everest, but I sometimes think it would be easier than navigating the pathway through grief. Loss of a loved one is a natural, universally experienced life event, and at the same time, among life's most challenging experiences. We expect people to react strongly to bereavement, and engage in rituals and compassionate behaviors to support those closest to the deceased. Yet, in spite of the shared experience and strong social support, most bereaved people feel more alone than at any time in their lives. Given the isolation, the intensity, and the unfamiliar experience that is grief, many people turn to physicians or other health care professionals for help. Clinicians can help, but only if they understand the signs and symptoms of a normal grief experience and how the pathway through grief can go awry. The purpose of this paper is to provide a guide to understanding complicated grief.

More than 2.5 million people die every year in the United States, and 60 million worldwide, each leaving behind a variable number of close attachments, roughly estimated as 1 to 5 per person.[1] Especially for those closest to the deceased, an intensely emotional and disruptive period often follows the loss, gradually attenuating as the reality of the death is comprehended and accepted and its consequences appreciated. The experience of a loved one's death is highly stressful, both because of the loss and also because of confrontation with mortality. Additionally, a myriad of stressors emerge as a consequence of requirements to attend to a range of things not usually on the agenda. Coping with these is necessary for restoration of ongoing life.

A deceased loved one thus bequeaths an array of emotional and practical problems that a bereaved person must solve. Given the scope and magnitude of the impact of losing a loved one, it is notable that relatively few negative long-term consequences usually occur. Most people meet the coping demands, with the help of supportive companions, and find a pathway that leads to restoration of a potentially satisfying and meaningful life.[2] However, an important minority, currently estimated at about 7% of bereaved people,[3] does not cope effectively with bereavement. Instead, they become entangled in grief, caught up in a futile struggle of silent protest, trying to avoid reminders, and being carried helplessly on endless waves of acutely painful emotion. These people are suffering from complicated grief (CG), a syndrome in which healing is impeded and acute grief is intense and prolonged. Clinicians need to recognize symptoms of CG and differentiate this condition from usual acute grief, as well as depression and anxiety disorders. It is useful to have a framework for conceptualizing CG in order to better accomplish the differential diagnosis and to recognize risk factors and understand principles used to treat CG.

## Keeping terminology straight

Using the terms bereavement, grief, and mourning interchangeably is a problem. To do so is not wrong, but it is more useful to allow the terms to denote specific components of the experience of loss. Therefore, in this paper, the term *bereavement* refers to the experience of having lost someone close. *Grief* is the psychobiological response to bereavement whose hallmark is a blend of yearning and sadness, along with thoughts, memories, and images of the deceased person. Insofar as we never stop feeling sad that loved ones are gone, or stop missing them, grief is permanent. However, the acute, all-consuming intensity usually moderates over time, as grief becomes deeper, less intrusive, and integrated into our lives. *Mourning* is the array of psychological processes that are set in motion by bereavement in order to moderate and integrate grief by coming to terms with the loss and reorienting to a world without our loved one in it.

## Different kinds of bereavement

When we look, we can discern a general framework for grief, but its day-to-day manifestations are variable and wide-ranging, influenced by many factors. Important among them is the relationship to the bereaved person and specific circumstances of the death. Several studies suggest that grief is most intense and difficult for people bereaved of a child or a life partner, and these are the people most likely to experience CG. In general, death of a child is the most difficult kind of loss, and bereaved family members are at elevated risk for depression and anxiety for close to a decade after the loss.[4,5] In addition these parents are at risk for a range of physical illnesses.[6-9]

There are two ways to look at elevations in mood and anxiety symptoms that are seen more commonly after certain kinds of loss. Some people say we should consider such symptoms normal because so many people exposed to this devastating life event experience them. However, there is another way to look at this. It is normal to break your leg when you fall off a ladder or to develop a bad sore throat and dangerous antibodies when you are exposed to a streptococcus infection. As clinicians, we don't tell a man with a broken leg not to worry; that his injury is normal. Nor would diagnosis of a strep infection be considered pathologizing a normal reaction. The premise of this paper is that acute grief is a normal reaction to loss that does not require a clinical diagnosis. By contrast, major depression, post-traumatic stress disorder (PTSD), panic disorder, and CG are mental disorders that should be diagnosed. Clinicians need to know how to tell the difference.

Whichever way we view mood and anxiety in the wake of bereavement, it is clear that the person who died makes a difference to the likelihood of experiencing these symptoms. The way a person dies can also be difficult for surviving friends and family. Death that is sudden and unexpected, especially if it is violent and untimely, is especially difficult.[10] Suicide of a loved one, in particular, can challenge a bereaved person.[11] Interestingly, though, the framework of grief is remarkably similar across these differences. The more difficult the death, the more potholes in the road, but the direction and destination of mourning is similar.

## Characteristics of grief

Grief is the usual instinctive psychological response to bereavement. Typical kinds of thoughts, feelings, and behaviors occur, albeit in a pattern and intensity that vary and evolve over time. Acute grief is a blend of yearning and sadness, with accompanying thoughts, memories, and images of the death and the deceased person, and a ten-

dency to be more interested in this inner world than in the activities that populate ordinary life. On the other hand, like the love that spawns it, grief's molecular expression is unique to each relationship.

Grief is usually erratic in its manifestations, intensity, and course. Yet, looked at from a bird's-eye perspective, most bereaved people make their way along a road, albeit bumpy and strewn with potholes, that leads to acceptance of the inevitability of the loss, integration of its reality into ongoing life, and reimagining a future with the possibility of joy and satisfaction. During this journey, acute grief, intensely painful and dominant, becomes integrated, muted, and in the background. CG is the syndrome that occurs when this transformation does not occur.

## Grief is not a form of depression

Some people conflate the terms grief and depression. They are not the same. Both infuse our lives with sadness, and both cause disruption, but the similarity ends there. Depression is a mental disorder. Grief is not. Bereaved people are sad because they miss a person they love, a person who added light and color and warmth to their world. They feel like the light has been turned off and they aren't sure how to turn it on again. Depressed people are sad because they see themselves and/or the world as fundamentally flawed, inadequate, or worthless. They feel like the world has no light or color or warmth. There is no light to turn on.

Depression inhibits the capacity to experience positive emotions. Grief does not. Positive emotions occur as frequently as negative ones as early as a week after a loved one dies. Depression biases thinking in a negative direction. Grief does not. Depression interferes with the capacity to care about other people and to understand their good intentions. Grief turns a person inward, but the desire to be with others and appreciation for the efforts of others is preserved. Both depression and grief take one out of ongoing life, but the reason for withdrawal is very different. In the words of author and scientist Kay Redfield Jamison:

> I did not, after Richard died, lose my sense of who I was as a person, or how to navigate the basics of life, as one does in depression. I lost a man who had been the most important person in my life and around whom my future spun. I lost many of my dreams, but not the ability to dream. The loss of Richard was devastating, but it was not deadly.
> *(Nothing Was the Same)*

It is very important that depression and grief not be confounded, because depression requires treatment and grief requires reassurance and support. We do someone a disservice by diagnosing depression if they are experiencing acute grief. Correspondingly, we do someone a disservice by calling it grief when a person is depressed. Moreover, depression-related inhibition of positive emotions,[12] bias toward negative thinking,[13] and interference with relationships can all impede successful mourning and predispose to complicated grief.

## Characteristics of successful mourning

Mourning is the process by which bereaved people seek and find ways to turn the light on in the world again. From a clinical perspective, mourning is an array of psychological processes that can be roughly grouped as emotion regulation and learning processes. When successful, mourning leads people to feel deeply connected to deceased loved ones while also able to imagine a satisfying future without them. After mourning successfully, a bereaved person is re-engaged in daily life, reconnected to others, and able to experience hope for a future with potential for joy and satisfaction. Grief has been transformed and integrated. A successful mourning process entails effective emotion regulation and assimilation of new learning in long-term memory.

Our loved ones exist in long-term memory, but there are different kinds of memory. Episodic, semantic, and implicit memory[14-18] are inter-related but serve different functions, entail different brain systems, and have different properties. Close attachments are mapped in each of these systems, so each must be updated when a loved one dies. To update explicit memory means learning new stories and facts. To update semantic memory means learning new meanings and rules, and to update implicit memory means extinguishing conditioned reward responses and learning new motor patterns and other procedural responses that are permanently out of awareness. Given this multifaceted goal, it makes sense that mourning is a complex process that is often lengthy and arduous. We must repeatedly engage with information about the death and its myriad consequences in order to adequately assimilate it and amend existing information about the deceased in each memory system.

One of the challenges of mourning is that the required learning is both intensely emotional and deeply aversive. Awareness of mortality registers in a specific area of our

brains and almost always registers as a threat. We naturally resist thinking of our own death and even more so that of our loved ones. We must overcome this resistance in order to confront and assimilate the information that a loved one is gone. When we do confront the reality, we are often assailed by tidal waves of negative emotion. Grief can overwhelm our usual emotion regulation capacity, forcing us to resort to escape and avoidance to get some respite.

John Bowlby introduced attachment theory to the mental health field. He described the process of mourning from the perspective of a biobehavioral understanding of attachment relationships. He noted that emotion regulation is typically accomplished only gradually following bereavement, and suggested that it takes considerable time to revise an existing mental model. He further observed that during this process our minds naturally, and mercifully, oscillate between confronting and avoiding (ie, defensively excluding) the painful reality.[19] Yet defensive exclusion is inadequate in the long term. When used exclusively, avoidance hinders the learning process. Moreover, defensive exclusion leaves the sufferer ever vulnerable to the sudden unexpected occurrence of painful reminders of the loss.

It is necessary to find a way to reappraise triggers of negative emotion so that the continued presence of the loss is no longer insistent and disruptive. A collection of emotion regulation strategies, both implicit, eg, extinction of conditioned reward; revision of other procedural memories, and explicit, eg, reflection, reappraisal, distraction, and problem solving, are usually employed as a part of the mourning process. Information about the finality and consequences of the loss is assimilated into long-term memory, both explicit and implicit, leaving a residue of feelings and thoughts about the deceased person that are usually bittersweet and in the background.

## What is complicated grief?

CG is a chronic impairing form of grief brought about by interference with the healing process. We use the term "complicated" in the medical sense to refer to a superimposed process that alters grief and modifies its course for the worse. Think about a physical wound that produces an inflammatory response as part of the healing process. A wound complication, for example an infection, increases the inflammation and delays healing. You can think of bereavement as analogous to an injury and grief as analogous to the painful inflammatory response and complicated grief as analogous to a superimposed infection. The result is delayed healing and increased pain which occurs because aspects of a person's response to the circumstances or consequences of the death derail the mourning process, interfering with learning, and preventing the natural healing process from progressing. *Box 1* describes the clinical picture of a patient with CG.

## Diagnosis of complicated grief

CG is not in *DSM-IV*, so there are no standard, official criteria. However there is considerable evidence that CG is a specific syndrome, different from normal grief and from other mood and anxiety disorders. The clinical picture can be understood as comprised of prolonged and intense acute grief symptoms accompanied by an array of complicating thoughts, feelings, and behaviors. Symptoms of acute grief include intense yearning or longing for the person who died, intrusive or preoccupying thoughts or images of the deceased person, a sense of loss of meaning or purpose in a life without the deceased, and a cluster of other symptoms that interfere with activities or relationships with significant others.

Complicating thoughts include incessant questioning, worrying, or ruminating over some aspect of the circumstances or consequences of the loss. Rather than reflecting upon the reality and implications of the death, a person with CG may be caught up in counterfactual thinking, reviewing and perseverating on the "if only"s. A person with CG may be catastrophizing about the future or worrying incessantly about a range of bad things that may happen because his or her loved one is gone.

Complicating emotional processes are negative valence emotions such as guilt, envy, bitterness, or anger, that are relentlessly activated and excessively painful, without periods of respite from positive emotions. Positive emotions, when they occur, are tinged with guilt. Overly negative emotions can focus the bereaved person's mind on the painful events surrounding the death and increase the likelihood of thinking about negative consequences of the loss. It is difficult to reflect and reappraise when negative emotions are very activated.

Complicating behaviors include excessive avoidance of reminders of the loss, compulsive proximity seeking, or both. For example, people with CG may dramatically

restrict their lives to try to avoid places they went with the deceased or situations the deceased would enjoy. They may avoid being with family or friends because of feeling envious, embarrassed, or anxious because of the death. At the same time, a person with CG may spend long periods of time trying to feel closer to the deceased person through pictures, keepsakes, clothing, or other items associated with the loved one. They may want to see, hear, touch, or smell things that remind them of the deceased loved one.

CG symptoms cause a great deal of distress and usually interfere with functioning and with the ability to find meaning and purpose in life. Many people with CG have suicidal thinking, sometimes at a level that is of concern. In our work, we have found the Inventory of Complicated Grief (Prigerson et al, 1995) to be an excellent screening tool. However, there are currently no formal diagnostic criteria for this condition. Based on data[20] and extensive clinical experience during three large NIMH-funded treatment studies, we proposed a criteria set[21] *(Table I)* that was used in the deliberations by the *DSM-5* workgroup. However, others have proposed alternatives[22] and the *DSM* workgroup is proposing criteria be placed in the appendix (at www.DSM5.com) Additionally, they suggest that a bereavement disorder be considered a form of adjustment disorder, described by the text in *Box 2*.

The main differential diagnostic considerations for CG include normal acute grief and major depression, and, if the death is violent, PTSD. Differential diagnosis can be challenging because symptoms overlap and comorbidity is common with CG, especially among those who are help-seeking. The difference between CG and normal grief is related to the heightened intensity and longer persistence of acute grief symptoms and to the presence of complicating processes, as described above. One of the indicators of CG is that the family and friends of the

**Box 1**

Christy's situation is an example of complicated grief. She lost her husband George and a favorite aunt in quick succession. Her husband had a chronic illness in which he had numerous hospitalizations, usually with positive outcomes. She had come to expect some improvement after a hospital stay, or at least stabilization. So when her elderly aunt developed a serious illness and took a turn for the worse, Christy thought her recently hospitalized husband would be OK without her. Unfortunately this was not to be. Christy was at her aunt's bedside when her husband died. Her immediate reaction was shock and disbelief, accompanied by a flood of remorse that she had not been with George, and a strong feeling that it was unfair that she had to lose him in this way. From the moment she learned of his death until she came for treatment 2 years later, she was overcome by guilt, blaming herself for abandoning her husband in his time of need. She repeatedly told herself that if she had been with George, she would have gotten him back to the hospital and prevented his death. Ruminating over this failing, she was consumed with feelings of yearning to have him back, and unable to function in her usual effective way. Thoughts and memories of George filled her mind, and she found it difficult to care about anything else. Her friends had become harsh, accusing her of wallowing in her grief. She was hurt, but, in a way, she saw their point. As she described it, time was moving on but she was not. It is worth noting that before George's illness, the couple had a strong and very satisfying relationship, in many ways the envy of their friends. By contrast, Christy had a shaky relationship with her mother, who she described as cold and critical. Her father was a nice guy but someone who could not stand up to his wife. He had died when Christy was in her early 20s, shortly after she had married for the first time. Christy always loved her father's sister who seemed like the only adult who was really interested in her.

Christy had not felt supported in her family when she was growing up, and she had a failed marriage before she met George. Still, she had done well in school and was successful in her job as a mid-level manager for a small manufacturing company. When she met George, 3 years after her divorce, he literally swept her off her feet. The couple met at a dance class and were immediately drawn to each other. Both were serious-minded but fun-loving people with many ideas for their shared future. They had a strong group of friends and socialized often. They were together for 9 years before George became ill, which was 5 years before he died. Christy was an exuberant, warm, loving person. Throughout her life, she had weathered her share of disappointment as well or better than most, but George's death and the circumstances under which it occurred had her stymied.

sufferer are eager for them to get help. Often it is a family member or friend who finds the therapist or treatment program. This is a good indication that the grief symptoms are lasting longer than expected in the person's cultural context.

The symptoms of CG have some overlap with those of major depression, just as normal grief has some overlap with depression. CG symptoms are strongly centered on the loss. For example guilt is specifically related to letting the deceased down, whereas guilt in depression is pervasive and multifaceted. A grieving person maintains a sense of self-esteem and self-worth, whereas depressed people have lost faith in themselves. Additionally, grief symptoms not seen in major depression include intense yearning or longing for the deceased, strong wishes to be reunited with the lost loved one, a desire to feel close to the deceased, intrusive or preoccupying thoughts of the deceased, and efforts to avoid reminders of the loss. People with CG feel the world could be made right instantly by the reappearance of the deceased, whereas those with depression have no such illusions.

We know much more about neurobiology of depression than grief, but initial studies show them to be different. Sleep disturbance is associated with REM sleep abnormalities in depression but not in CG.[23] Activation of dopamine circuitry has been seen in CG[24] and not in major depression. Also, importantly, medication treatment has differential effects on depression and grief symptoms.[25] *Table II* outlines similarities and differences between grief and depression.

Depression can co-occur with CG and exacerbate CG symptoms. Inhibition of positive emotions robs the person with CG of a source of emotional nourishment. The negative cognitive bias in depression increases the tendency to ruminate over the circumstances or conse-

**Box 2**

At least 12 months following the death of a close relative or friend, the individual experiences intense yearning/longing for the deceased, intense sorrow, and emotional pain, or preoccupation with the deceased or the circumstances of the death. The person may also display difficulty accepting the death, intense anger over the loss, a diminished sense of self, a feeling that life is empty, or difficulty planning for the future or engaging in activities or relationships. Mourning shows substantial cultural variation; the bereavement reaction must be out of proportion or inconsistent with cultural or religious norms.

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|---|
| The person has been bereaved, ie, experienced the death of a loved one, for at least 6 months |
| At least one of the following symptoms of persistent intense acute grief has been present for a period longer than is expected by others in the person's social or cultural environment:<br>Persistent intense yearning or longing for the person who died<br>Frequent intense feelings of loneliness or like life is empty or meaningless without the person who died<br>Recurrent thoughts that it is unfair, meaningless or unbearable to have to live when a loved one has died, or a recurrent urge to die in order to find or to join the deceased<br>Frequent preoccupying thoughts about the person who died, eg, thoughts or images of the person intrude on usual activities or interfere with functioning |
| At least 2 of the following symptoms are present for at least 1 month:<br>Frequent troubling rumination about circumstances or consequences of the death, eg, concerns about how or why the person died, or about not being able to manage without their loved one, thoughts of having let the deceased person down, etc<br>Recurrent feeling of disbelief or inability to accept the death, like the person can't believe or accept that their loved one is really gone<br>Persistent feeling of being shocked, stunned, dazed, or emotionally numb since the death<br>Recurrent feelings of anger or bitterness related to the death<br>Persistent difficulty trusting or caring about other people or feeling intensely envious of others who haven't experienced a similar loss<br>Frequently experiencing pain or other symptoms that the deceased person had, or hearing the voice or seeing the deceased person<br>Experiencing intense emotional or physiological reactivity to memories of the person who died or to reminders of the loss<br>Change in behavior due to excessive avoidance or the opposite, excessive proximity seeking, eg, refraining from going places, doing things, or having contact with things that are reminders of the loss, or feeling drawn to reminders of the person, such as wanting to see, touch, hear, or smell things to feel close to the person who died. (Note: sometimes people experience both of these seemingly contradictory symptoms.) |
| The duration of symptoms and impairment is at least 1 month |
| The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning, where impairment is not better explained as a culturally appropriate response |

**Table I.** Proposed criteria for complicated grief.[21]

quences of the death. Depression saps energy and fuels avoidance behavior. Depression also interferes with interpersonal relationships, and companionship is an important facilitator of successful mourning. In all of these ways co-occurring depression can worsen CG and interfere with its resolution.

When death is violent, CG also needs to be differentiated from PTSD. When someone experiences the sudden unexpected death of a loved one, they may develop PTSD. However, this needs to be differentiated from CG as there is some overlap in symptoms. People with CG experience intrusive images of the deceased loved one. They often engage in avoidance behavior and feel estranged from others. Many report sleep disturbance or difficulty concentrating. Close confrontation with death inevitably registers as a personal threat. However, fear of personal physical danger is very rare in CG. Instead, bereaved people primarily experience sadness and yearning focused on the sustaining relationship they lost. CG symptoms differ correspondingly from those of PTSD, yet conceptually, CG's closest neighbor is PTSD, not depression, as CG, like PTSD is a specific kind of response to a specific kind of life event. That said, a physical trauma that threatens physical harm and causes heightened fear and hypervigilance, is a very different specific event than a loss.

A physical trauma is contained and limited in space and time such that distance in time and space markedly reduce the threat. By contrast, a loss is never over, and the response to loss is quite different from the response to danger. An important loss, by definition, affects a person's experience of themselves and the world. Most people are deeply and immutably changed after losing a loved one. Experiencing a trauma is very different. Most people who experience trauma do not develop symptoms. Almost everyone who loses a loved one experiences grief.

Coping with trauma entails a period of appraisal of the threat and its possible implications. Expectations of danger and safety in certain circumstances may be revised. Coping with loss requires a major modification of the memory systems that typically contain extensive information about the loved one. The finality and consequences of the loss must be assimilated and life goals and plans redefined without expectations of the loved one being included. Trauma may or may not have such extensive consequences.

Differences in the quality, time course, and implications of loss and trauma are reflected in different symptoms of PTSD and CG. PTSD is characterized by prominent fear and anxiety while sadness and yearning are predominant in CG. Intrusive thoughts and images focus on the traumatic event in PTSD and on the deceased person in CG. People with PTSD avoid situations and places considered to be dangerous, whereas people with is CG seek to avoid strong feelings of missing the deceased. PTSD is associated with hypervigilance to threat whereas physiological dysregulation in CG is related to loss of interpersonal regulators. Like depression, PTSD can co-occur with CG and worsen its symptoms and course.

Occasionally there are other differential diagnostic questions, often related to other anxiety disorders. Many people with CG experience separation anxiety symptoms focused on other important people in their lives. Some experience panic attacks that may be associated with avoidance behavior. Others develop excessive uncontrollable worry about everyday events. Any of these symptoms can be directly related to the loss, but it is also possible that the stress of the loss may trigger an anxiety disorder. Rates of panic disorder with or without agoraphobia, and generalized anxiety disorder are elevated in clinical populations with CG. Similarly, people with CG may feel uncomfortable in social situations because of a feeling of being "odd man out" but sometimes bereavement can trigger an episode of social anxiety disorder. Since any mood or anxiety disorder may be exacerbated by a major stressor, clinicians often need to decide whether symptoms are best explained by one of these prior conditions or by complicated grief, or whether both are present.

| Major depression | Acute grief |
|---|---|
| Pervasive loss of interest or pleasure | Loss of interest or pleasure related to missing loved one |
| Pervasive dysphoric mood across situations | Pangs of emotion triggered by reminders of loss |
| Preoccupation with low self esteem; general sense of guilt or shame | Preoccupation with the deceased; guilt and self blame focused on death |
| General withdrawal from activities and people | Avoidance of activities, situations and people because of the death |
| Intrusive images are not prominent | Intrusive images of the deceased are common |
| Yearning and longing not usually seen | Yearning and longing are frequent |

**Table II.** Difference between grief and depression.

## Risk factors for complicated grief

Risk factors can be grouped as predisposing person-related, relationship-based, or as related to circumstances or consequences of the death. Person-related risk factors include a past history of mood or anxiety disorder, a history of early insecure attachment style, and a past history of multiple trauma or loss. Most people who develop CG have had an exceptionally rewarding and fulfilling relationship with the person who died. Not infrequently this is "earned" attachment security as the person has a history of insecure attachment in childhood. Some types of loss are more likely to result in CG than others. Loss of a child, loss of a close life partner, and suicide or homicide loss are among the most difficult. Additionally, if there are more individual circumstances of the death, such as failure to be present at the time of the death, disagreement or uncertainty with medical care, disappointment in one's own capacity to comfort the deceased, or with others' behavior, these can also become a focus of rumination that derails mourning and increases the risk for developing complicated grief.

Troubling consequences of the death may include any of a range of difficult problems related to the deceased person's possessions or death arrangements, or to hostile or threatening behavior of others. Sometimes a person can become excessively worried about how he or she will manage without her loved one in his or her life, or about what will become of certain other people now that the deceased is gone. These are just examples of ways in which circumstances and consequences of the death can become a focus of rumination or avoidance that interfere with learning about the reality and its consequences.

## Treating complicated grief

We conceptualize CG as a condition in which the normal healing process, entailing emotion regulation and learning, is derailed by complicating thoughts or behaviors. Treatment targets resolving complications and facilitating healing. A group of basic assumptions can inform therapeutic goals and underlie the principles that guide the treatment. These assumptions include the following: human beings possess an instinctive mechanism for healing after loss, that is a component of the attachment system, the goal of which is to evaluate and integrate information related to the death into memory systems used to forecast and plan for the future; emotion regulation plays a role in successful mourning; trusted companions who are empathic, reliable, and responsive help with emotion regulation and serve as natural catalysts for the healing process—we don't grieve well alone; grief complications can occur and need to be addressed in order to free the stalled healing process.

We developed a treatment approach based on these assumptions and tested in a prospective randomized controlled trial.[26,27] Principles of the treatment include the following: *Self-observation and reflection*, which are important tools for both addressing complications and facilitating natural healing. *Companionship* is central to all aspects of treatment. *Natural healing* is facilitated by addressing loss and restoration-related issues in tandem, and by entraining a process of oscillation toward and away from confronting emotional pain facilitates natural healing. *Imagery exercises* are especially useful in fostering learning in both implicit and explicit memory systems. *Positive emotions* are physically and emotionally healthy and foster optimal creativity and problem solving. We used these principles to develop a set of procedures to help people overcome complicated grief. We also found that antidepressant medication appeared to be a helpful adjunct to the treatment and might be a part of the therapeutic armamentarium for complicated grief.

## Summary

Bereavement is one of life's most difficult challenges, yet most people weather its storms, comforted and supported by close companions. A minority of bereaved people find themselves stalled in acute grief that seems to persist without respite, lasting years, or even decades after a particularly difficult loss. CG can be reliably identified and responds best to specific treatment. There is a pressing need for health and mental health professionals to learn to recognize and treat people with this condition. ❑

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## *Cuando el duelo y el luto evolucionan mal: vía y curso del duelo complicado*

*El duelo complicado es una condición reconocida recientemente que ocurre en cerca del 7% de los deudos. Las personas con esta condición quedan atrapadas en una rumiación acerca de las circunstancias de la muerte, la preocupación por sus consecuencias o la evitación excesiva de recuerdos de la pérdida. Al ser incapaces de comprender la finalidad y consecuencias de la pérdida, ellas recurren a una excesiva evitación de recuerdos de la pérdida y del impacto de las oleadas de intensa emoción ante las cuales no pueden hacer nada. Las personas con duelo complicado necesitan ayuda y los clínicos necesitan saber cómo reconocer los síntomas y cómo proporcionarles esta ayuda. Este artículo entrega una estructura para apoyar a los clínicos a comprender las pérdidas, el duelo y el luto. Se entregan los criterios diagnósticos basados en la evidencia para ayudar a los clínicos a reconocer el duelo complicado y diferenciarlo de la depresión y del trastorno ansioso. Se entrega una panorámica de los factores de riesgo y de los supuestos y principios básicos que puedan orientar el tratamiento.*

## *Douleur morale et deuil irrésolu : trajectoire et évolution du deuil compliqué*

*La douleur morale compliquée après la perte d'un être cher est un état récemment reconnu qui survient chez environ 7 % des personnes endeuillées. Les sujets concernés sont pris dans une rumination des circonstances de la mort, du souci de ses conséquences ou un évitement excessif du rappel du décès. Cet évitement vient d'une incapacité à comprendre la finalité et les conséquences de la perte, les personnes étant désespérément secouées par des vagues d'émotion intense. Les sujets souffrant d'un deuil compliqué ont besoin d'aide et les médecins doivent savoir en reconnaître les symptômes et répondre à leur détresse. Les médecins trouveront dans cet article un cadre pour les aider à comprendre la perte, la douleur morale et le deuil. Les critères de diagnostic basé sur les preuves aideront les médecins à reconnaître la douleur morale compliquée et à la différencier de la dépression et des troubles anxieux. Nous analysons les facteurs de risque et les hypothèses de base ainsi que les principes qui peuvent guider le traitement.*


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