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Disturbed grief: prolonged grief disorder and persistent complex bereavement disorder

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[Image: PRIYA SUNDRAM]

Each individual's grief process is unique. The concept of stages of grief occurring in a specific order is a popular, yet inadequate representation of what grieving people go through.[1] Traditional models developed to understand grief therefore often unhelpfully suggest that all bereaved individual do, and even should, follow the same process towards recovery from loss. The newer grief task model[2] offers a more neutral framework to describe normal and disturbed grief. The model proposes that normal grief is the successful achievement of certain "grief tasks," whereas complications in managing these tasks might indicate disturbed grief. There is no recommended or specific order in which to achieve these tasks. Grief tasks include: to accept the reality of the loss; to process the associated pain; to adjust to a world without the deceased; and to find an enduring connection with the deceased in the midst of embarking on a new life. The model also describes challenges faced following losses other than bereavement (Box 'Grief following events other than bereavement'). Doctors from any specialty can identify bereaved patients who are struggling for longer, or more severely than most. Defining when this grief becomes disturbed or pathological is difficult, and has been the subject of recent classification and debate (box 1).

What defines prolonged grief disorder and persistent complex bereavement disorder?

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and international classification of diseases (ICD) offer definitions to support clinicians to identify disturbed grief. DSM (5th edition) has introduced criteria for persistent complex bereavement disorder (PCBD) categorised as one of the "other specified trauma- and stressor-related disorder."[5] The forthcoming 11th edition of the ICD will include prolonged grief disorder (PGD).[6 7] Table 1⇓ shows criteria for PCBD and PGD as described by Prigerson et al,[8] and PGD as proposed for the ICD.[6 7] PCBD can be diagnosed 12 months after loss and PGD at six months. The term PGD is used throughout this article because most of the research drawn upon relates to PGD rather than PCBD, and because PGD is a more commonly used term. Moreover, a recent study showed that, in terms of symptomatology, empirical basis, and psychometric properties (reliability and validity), PCBD and PGD are essentially the same.[9] The information in this article is therefore relevant to both PGD and PCBD.

PGD differs from normal and uncomplicated grief, not in terms of the nature of grief reactions, but rather the distress and disability caused by these reactions and their persistence and pervasiveness.[6 8] That is, symptoms listed in Table 1⇓ occur transiently in many bereaved individuals, but it is only when these reactions are experienced on more days than not, causing severe distress and impairment in important areas of functioning more than six months after loss that a PGD diagnosis is applicable (box 2).

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Supplementary information: Appendix files: Infographic: Identifying abnormal grief

What you need to know

- When confronted with the death of a loved one, most people experience transient rather than persistent distress, and do not develop a mental health condition.
- Bereavement, specifically the sudden, unexpected death of a loved one is associated with an elevated risk for multiple psychiatric disorders.
- Consider prolonged grief disorder (PGD) in people with ongoing separation distress beyond the first six to 12 months of bereavement.
- PGD occurs in approximately 10% of bereaved individuals, with an increased risk following the death of a partner or child and loss to unnatural or violent circumstances, and among people vulnerable to mental health conditions.
- Psychological treatments addressing the pain and consequences associated with the irreversibility of the separation can be effective.
- Emerging evidence provides limited support for pharmacological interventions.

Box 1: Worries about medicalisation of grief

Concerns have been expressed that recognition of PGD as a mental health condition could stigmatise those receiving the diagnosis, or might undermine their coping self efficacy and support from friends and family. However, as supported by research,[3] establishment of the PGD diagnosis confers important advantages as it can be relieving and comforting to those receiving the diagnosis, can facilitate understanding and recognition from the environment, and turn self blame about "being unable to cope" into confidence that treatment might help. Efforts to reduce public stigma associated with mental health problems such as depression and post-traumatic stress disorder have been shown to be effective,[4] emphasising the need for public education about common reactions to the (traumatic) loss of loved ones.

Worries about medicalisation of grief have also been voiced in reaction to the changes in diagnostic criteria for major depression in DSM-5,[5] which allow clinicians to consider a diagnosis of depression in treatment-seeking patients after two weeks following the loss of a loved one. If the criteria for major depression are met, then the clinician should carefully assess whether a conservative watch and wait approach is sufficient or whether suicidal ideation, major role impairment, or a substantial clinical worsening warrant treatment.

Box 2: When to suspect prolonged grief disorder

- When, more than six months after the death of someone close, patients present with persistent, distressing, and disabling grief reactions that are out of proportion to or inconsistent with cultural, religious, or age appropriate norms
- When, more than six months after a loss, patients present with persistent, distressing, and disabling separation distress, difficulties with confronting the reality and irreversibility of their loss, and report a pervasive sense of meaninglessness about life without the deceased loved one

The distress in individuals with PGD might be maintained by negative cognitions and avoidance behaviours, and by sensitivity to loss-related stimuli. For example, following a loved one's death in a road traffic incident, images of a particular car or media coverage of other accidents might trigger images of the accident and associated pain.

How common is PGD?

Few epidemiological studies have examined the prevalence of PGD. Studies based on earlier definitions of PGD indicate that the condition occurs in about 5% of bereaved individuals.[10 11] A recent systematic review and meta-analysis indicates that 10% of bereaved adults are at risk of PGD.[12]

PGD co-existing with other physical and mental health conditions

PGD is associated with an elevated risk of poor physical health, suicidality, reduced quality of life, and functional impairment. It is distinguishable from, but frequently coincides with, major depressive disorder, post-traumatic stress disorder, generalised anxiety disorder, and adult separation anxiety disorder.[8-14] Although no studies have yet monitored the course of PGD as such, there is evidence that in a minority of bereaved individuals, debilitating grief symptoms persist for years.[15-18] In both normal and disturbed grief, it is common for grief reactions to intensify on the birth and death anniversaries of the lost person.

After traumatic bereavement, co-occurrence of PGD with post-traumatic stress disorder and/or major depression among individuals showing signs of severe emotional distress is common. These comorbidities have been observed in the general community,[19] in people seeking treatment,[20] and in older bereaved people.[21] Data to support these associations can also be found in populations where a substantial number of individuals have been affected by trauma—for example, in people directly affected in the Rwandan genocide.[22] In a group of 775 Cambodian people 30 years after losing a loved one during the Khmer Rouge regime, the percentages of people reporting clinically significant levels of depression, post-traumatic stress disorder, and PGD were 32%, 11%, and 14%, respectively, and 12% reported clinical levels of PGD plus post-traumatic stress disorder and/or depression.[23]

Who is most at risk?

There is evidence for elevated risk of PGD among women and people with lower levels of education.[24] Personality traits associated with PGD include insecure attachment and neuroticism.[25] The nature of the relationship with the deceased is important: the death of a partner or child is associated with PGD.[24] Losing a person with whom one had a close and supportive relationship increases the risk.[26-28]

More severe grief is associated with unnatural and violent loss, due to homicide, accidents, criminal attacks, suicide,[29 30] and unexpected death.[31] Elevated risk of persistent distress following unnatural loss has been observed in immigrant ethnic minorities,[32] refugees, and groups affected by conflict.[33]

Longitudinal survey research shows that PGD is associated with negative alterations in beliefs about the self, life, and the future after the loss, and tendencies to assign catastrophic meaning to one's grief reactions. Negative alterations in beliefs are predictive of persistent symptoms over time. PGD is also associated with being inactive or withdrawing from social activity, with phobic avoidance of loss reminders, and with rumination about the causes and consequences of the loss.[34 35] These research findings accord with cognitive behavioural

theories which stress that maladaptive cognitions and avoidant coping cause and maintain PGD.[36 37]

PGD occurs in bereaved children; symptoms, risk factors, and treatment options for PGD in adults and children overlap (box 3).

Can PGD be prevented in those who have been bereaved?

Psychological interventions

Universal or primary prevention in those without risk factors is largely ineffective.[46-48] Indicated or secondary prevention in subgroups with heightened risk for persistent grief are more effective, yielding small to modest effects, particularly among people who self refer, motivated for preventive care, and who report elevated emotional distress.[46-48] Recently, family focused therapy for high risk families of advanced cancer patients, starting during palliative care and continuing into bereavement, was found to reduce statistically significantly the risk that people developed PGD, in comparison with standard care.[49]

Self help

One study examined a writing intervention that was delivered by email (without personalised therapist feedback) to bereaved individuals who had no risk factors. The intervention yielded no statistically significant change in grief symptoms and coincided with high (46%) participant dropout.[50] Another recent study evaluated an online therapist assisted intervention for bereaved care givers of recently deceased cancer patients who reported clinically significant and disabling PGD symptoms at three to six months after loss.[51] This intervention yielded lower dropout (17.3%) and led to statistically and clinically significant reductions in PGD, post-traumatic stress disorder, depression, and anxiety that were maintained over time.

Medication

To our knowledge, no studies have yet examined the effects of preventive drug interventions.

Can PGD be treated?

Psychological interventions

There are still relatively few controlled studies examining psychological treatments for PGD. Recommended psychological therapies, tested in at least two independent and controlled studies, include "complicated grief treatment" (encompassing elements of exposure, cognitive restructuring, and interpersonal therapy)[52-54]; cognitive behavioural therapy (combining exposure and cognitive interventions)[55 56]; and therapist assisted online cognitive behavioural therapy (encompassing exposure, cognitive interventions, and behavioural activation applied using writing assignments) [57 58] (box 4). Table 2⇓ provides a summary of the six controlled studies testing "complicated grief treatment," cognitive behavioural therapy, and internet based therapy.

Promising interventions tested in single controlled studies include behavioural activation,[59] cognitive narrative therapy,[60] and integrated cognitive behavioural therapy.[61] Interpretative and supportive time limited group therapies [62 63] are promising interventions not compared with waiting list or alternative treatment but yielding moderate effects on PGD reduction.

Self help interventions

Apart from the aforementioned studies on internet based therapist assisted cognitive behavioural therapy,[57 58] to our knowledge, no other controlled studies have examined self help interventions for PGD.

Psychological first aid

In situations of traumatic bereavement—for example, in accidents or criminal attacks, first responders and disaster relief workers can provide "psychological first aid."[64] These individuals can establish contact, promote safety and comfort, gather information regarding current needs and concerns, provide practical assistance, and encourage connection with medical and social support resources.[64] Psychological first aid was developed from expert consensus, and is an important area for future research.[65]

Pharmacological interventions

Studies on pharmacotherapy for PGD and depression related to bereavement provide evidence for the efficacy and safety of antidepressant medications, including the selective serotonin reuptake inhibitors citalopram,[53] escitalopram,[66 67] and paroxetine,[68] the tricyclic antidepressants desipramine[69] and nortriptyline,[70 71] and bupropion.[72]Table 3⇓ provides a summary of these studies. In most, pharmacotherapy was used to target depression rather than PGD, and, accordingly, yielded considerably greater reductions in depression symptoms. However, beneficial effects of pharmacotherapy for both depression and PGD might be expected since conditions share underlying mechanisms, including negative cognitions and reduced activity.

In a recent large scale controlled study,[53] citalopram alone or placebo were compared with "complicated grief treatment" combined with citalopram or placebo. Results indicated that citalopram augmented the effects of "complicated grief treatment" on depression but not on PGD, and that citalopram alone did not substantially reduce depression. Antidepressant treatment can be considered as an adjunct to psychotherapy for patients with PGD, and can also be considered for comorbid depression associated with major role impairment, substantial clinical worsening, or suicidality. In such situations, medication should be offered in addition to (rather than instead of) psychosocial interventions and attempts to optimise social support. Benzodiazepine treatment is generally not recommended, since it carries the risk of dependence and can interfere with learning and memory functions that are important for psychological adaptation to loss. In a naturalistic study, benzodiazepines did not improve outcomes.[73]

Who might manage grief and PGD?

Typically, mental health services provide treatment focused on cure and care for mental health conditions related to bereavement, whereas less specialist grief counselling primarily entails emotional support for non-clinical, normative responses to loss.

Self directed and non-specialist management—Individuals grieving the loss of a loved one following an anticipated, natural death do not normally need professional help. They might seek support, advice, and information from general practitioners and grief counsellors. The development of guidelines can improve the identification and treatment of PGD in primary care; a recent study in Denmark indicated that general practitioners had

Box 3: PGD in children

- Criteria for persistent complex bereavement disorder in DSM-5 for children are similar to those for adults, except that the condition can already be classified at six months after loss (12 months in adults).
- The estimated prevalence of PGD in children is between 5% and 10%.[38] PGD symptoms are associated with impairments in functioning and depression. The symptoms of longing and yearning for the deceased, inability to accept the death, shock, disbelief, loneliness, and a changed world view endorsed in the second half year of bereavement have been found to predict a disturbed course of grief.[39] However, symptoms can manifest differently in children than in adults—for example, in an obsession with death during play.[5]
- Meta-analyses show that interventions can reduce the severity of grief reactions in children without PGD symptoms with small to moderate effects,[40] and with relatively greater effects in children with symptoms. Interventions that include confrontation with the most distressing aspects of the loss are particularly helpful (as opposed to interventions including no confrontation).
- Treatments found to be effective in single controlled studies are the group based Family Bereavement Program (found effective in reducing immediate and long term emotional problems in children confronted with parental loss[41 42]) and trauma and grief component therapy developed for adolescents (effective in reducing grief, depression, and anxiety symptoms[43]).
- Cognitive behavioural interventions show a reduction in PGD in uncontrolled studies.[44 45]

Box 4: Psychological interventions for prolonged grief disorder

Exposure interventions

Designed to minimise avoidance of situations, thoughts, and memories associated with the loss. Aimed to encourage verbalisation and exploration of the implications of the separation. This is done by detailed recounting or writing about the loss, exposure to situations, objects, or places associated with the loss, and imaginal exposure to memories of circumstances surrounding the loss, which is particularly indicated when these circumstances were unnatural or traumatic (eg, homicide, suicide, or accident).

Cognitive interventions

Designed to identify and modify negative cognitions that block confrontation with, elaboration of, and adjustment to the loss. Maladaptive cognitions include negative cognitions about the self, life's meaning, and the future, and catastrophic misinterpretations of grief reactions, and—specifically after unnatural loss—the world's safety, predictability, and controllability, and self blame and blame of others.

Behavioural activation

Designed to enable active adjustment to the loss, encourage continuation of meaningful roles and activities, and to reduce depressive avoidance and rumination by gradually increasing engagement in activities that accord with valued social, recreational, and educational or occupational goals and help restore a satisfying life.

problems diagnosing mental health conditions that were related to bereavement.[74]

Referral for specialist assessment—Consider referral to mental health care services, when grief symptoms persist for more than six to 12 months and lead to impaired functioning, or earlier when depression or symptoms of post-traumatic stress disorder are associated with major role impairment, a substantial clinical worsening, or suicidal ideation. Consider an approach that is sensitive to the patient's culture, and give special attention to grieving rituals that fit the culture of that person and which might not have taken place sufficiently.[75] Specialised mental healthcare organisations can provide culturally sensitive psychological therapy for grief to meet the needs of more vulnerable groups, including migrants and refugees.

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Grief following events other than bereavement

- Family members and friends of missing persons might experience intense and persistent emotional reactions that can include symptoms of PGD, post-traumatic stress disorder, and depression.[76] Mental health professionals might label the situation as one of ambiguous loss,[77] externalise the cause to alleviate guilt, and normalise emotional reactions. Healthcare professionals need to refrain from exerting pressure on patients to move on or achieve closure.
- Migration and acculturation might be associated with "cultural bereavement" caused by disruptions in cultural identity. Cultural bereavement can manifest as preoccupation with memories of family in homeland, visitations from ghosts or spirits in dreams, feelings of guilt, and anxiety and anger in response to separation from the homeland.[78]
- Non-bereavement losses such as mental and physical illness and disability have been associated with elevated distress other than PGD.[79] Elevated PGD symptoms have been observed following non-bereavement loss that is related to disasters,[80] job loss, and divorce.[81]
- Resource loss can precipitate depression or exacerbate pre-existing emotional distress, but this does not involve interpersonal attachment reactions characteristic of grief after the death of a loved one.

Patient perspectives

One woman whose daughter died wrote about her experiences with grief

"On July 18, 2012, our 14 year old daughter J was diagnosed with leukaemia and haemophagocytic lymphohistiocytosis, a disease that strikes one in 1.2 million people. She died within 12 weeks of getting these diagnoses. Our world collapsed. Three months before, she was shining and had such a lust for life and now we had to bury her. What I feel since then is indescribable. An intense pain. The pain of me missing J is not even the worst. It is the pain of her not being able to enjoy life. That pain is inhuman. Our whole family is broken. My son not only lost his sister but also his parents. He no longer has the parents that he used to have.

Our future is gone. J was involved in all plans we had. Everything is changed. With her death a part of me died. I feel like a zombie. I am angry at everybody. Angry at old people getting old. Angry at people that, other than J, recover from their illnesses. I often wonder if things would have gone differently, if we would have done things differently. The feeling that I might bring her back, if only I'd find a solution how.

All kinds of things elicit strong feelings. Seeing girls of J's age hanging around town. Hearing songs that were played at J's funeral. We no longer celebrate birthdays and skip public holidays. These are all family days, and we are no longer a family. I visit the grave every day. That's the only thing I can do for her: make sure her grave looks wonderful. She deserves that. Life goes on, but for us it will always be October 8, 2012. The day J died. The days after that have passed, but how? I don't know. I live my life with blinkers on. This cannot have happened, this has not happened. This is someone else's story. Every now and then, I realise it's my story and I collapse.

We are also living in fear. If our son has fever, we fear for the worst. When doctors say there is only a small chance that something is badly wrong, we don't believe that. The chance of getting haemophagocytic lymphohistiocytosis is only one in 1.2 million and that happened too. We have lost all confidence.

We did it without help for six months. After searching for help for some months we found psychological help. Now, three and a half years later, we still have sessions. My psychologist and I watched a video of our final holiday with J. This has helped me a lot. The sessions with the psychologist and talking with J's doctors have convinced me that there is nothing I could have done to prevent this from happening. The intense pain will always remain and my head will always be full. That's why the sessions with the psychologist are important.

Another patient commented on this article, writing: "As a parent and a patient who is still wrestling emotionally and mentally with the unnatural and incomprehensible circumstance of my son's death, and also as someone who is still struggling with largely unresolved traumas of my past as a refugee, this article has shed a new light and insights in understanding these traumatic events in my life better and maybe a new way forward in dealing with them. Although your article is meant for clinicians and other mental health professionals, it also applies to me as a patient who is still going through complex issues of my own in trying to understand, communicating and seeking clarification and counselling on them. By differentiating grief so vividly, your article has acted as a road map for me, and probably it will help me to navigate through these issues with a better understanding and also provide me with new tools to communicate. And, maybe as a result of your article, I will also be able to outline and explain my inner world or struggles a bit more accurately to others while seeking help and possibly a proper diagnosis."

A third patient was asked to describe her experience of PGD. She wrote: "How to live with the loss of a loved one, in my case my son? It is a pain that I cannot describe. Actually, it is a very nasty feeling, with all kinds of emotions occurring at the same time. As if my heart has become empty. The pain is so intense that it sometimes seems to turn me mad. I struggle to find the right words. Seven years after the loss of my son, I'm still fighting hard to get over it. I keep feeling incomplete. This has marked me for the rest of my life."

Tips for non-specialists

- Grief is a normal reaction when you lose someone close. Over time, coping with the consequences of loss should become easier.
- Some people are more likely to experience difficulties in recovery, such as those who have lost a child or partner, suffered loss to a violent cause (eg, homicide, road traffic incident), and were already socially or emotionally vulnerable before the loss.
- People can experience a variety of feelings, including yearning, sadness, anger, fear, and guilt, as well as difficulties in accepting the loss, and might believe that life is meaningless since the loss. These symptoms can come and go.
- Nobody's experience is the same. During the process of grieving a person might experience difficulty in thinking about the consequences of the loss, handling the associated pain, maintaining positive views on life and the future, and adjusting their plans. These experiences do not necessarily signal disturbed grief.
- Disturbed grief might occur when processing the implications, pain, and reality of the loss continues to be disabling and distressing beyond the second half year of bereavement.
- There is some uncertainty on whether and which treatments help most. People experiencing distressing and disabling grief reactions six months on from the loss might benefit from psychological interventions, including cognitive behavioural therapy, to foster adaptive thinking and coping. People who lost someone in traumatic circumstances, or those who have other mental health problems might need help sooner. The setup and type of services will vary in different countries and healthcare systems.
- Look online and speak to your doctor if you are having trouble coping or for ideas on what might help.

Sources and selection criteria

A PubMed search using the terms "prolonged grief disorder," "persistent complex bereavement disorder," and "complicated grief" was performed. We examined Cochrane and other relevant systematic reviews, meta-analyses, and treatment trials. We supplemented these with additional searches and our knowledge of the subject.

How patients were involved in this article

One patient provided feedback on this article. He endorsed its content and did not ask for any changes to the article. He described the article as a "road map" and we used this to summarise a box with tips for non-specialists so that clinicians might more readily share a summary of normal and abnormal grief with a patient (Box: 'Tips for non-specialists').

Additional resources

- ASSIST Trauma Care, offering therapeutic help after traumatic bereavement (www.assisttraumacare.org.uk)
- Child Bereavement UK (www.childbereavementuk.org) supporting families and educating professionals facing children who are grieving, dying, or deceased
- Cruse Bereavement Care, providing information and care following loss (www.cruse.org.uk)
- International Society for Traumatic Stress Studies, providing information on the assessment and treatment of PTSD (www.istss.org)
- NHS Choices loss and grief (www.nhs.uk/livewell/emotionalhealth/pages/dealingwithloss.aspx)
- Royal College of Psychiatrists (www.rcpsych.ac.uk/healthadvice/problemsdisorders/bereavement.aspx)
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Tables

Table 1| Symptoms of persistent complex bereavement disorder and prolonged grief disorder

DSM-5 criteria for persistent complex bereavement disorder[5]	Prolonged grief disorder as per Prigerson et al [8]	Prolonged grief disorder proposed for ICD-11[7]
Event		
Person experienced the death of someone close at least 12 months previously	Person experienced the death of someone close at least six months previously	Person experienced the death of someone close at least six months previously
Separation distress		
At least one of the following symptoms frequently and to a clinically significant degree 1. Persistent yearning or longing for the deceased 2. Intense sorrow and emotional pain 3. Preoccupation with deceased person 4. Preoccupation with circumstances of the death	Yearning, longing, or emotional suffering as a result of the desired unfulfilled reunion with the deceased, daily or to a disabling degree	Longing for the deceased or persistent preoccupation
Other symptoms		
At least six of the following symptoms frequently and to a clinically significant degree 1. Difficulty accepting the death 2. Disbelief or numbness 3. Difficulty in reminiscing positively about the deceased 4. Bitterness or anger 5. Maladaptive appraisals about self associated with the loss (eg, self blame) 6. Excessive avoidance of stimuli (places, people, objects) reminding of the loss 7. A desire to die to be with the deceased 8. Difficulty trusting other people 9. Feeling alone or detached from others 10. Feeling that life is empty or meaningless or that one is unable to function without the deceased 11. Confusion about one's role and diminished identity (eg, feeling that part of self died) 12. Difficulties pursuing interests or making plans for the future (eg, friendships, activities)	At least five of the following symptoms daily or to a disabling degree 1. Confusion about one's role and diminished sense of self (eg, feeling that part of self died) 2. Difficulty accepting the loss 3. Avoidance of reminders of the reality of the loss 4. Inability to trust others 5. Bitterness or anger related to the loss 6. Difficulties moving on with life (eg, making new friends, pursuing interests) 7. Numbness (absence of emotion) 8. Feeling that life is empty, meaningless, or unfulfilling 9. Feeling stunned, dazed, or shocked	Longing or preoccupation is accompanied by intense emotional pain (eg, sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self, an inability to experience positive mood, emotional numbness, difficulty in engaging with social or other activities)
Impairment		
Substantial impairment in personal, family, social, educational, occupational, or other important areas of functioning as a result of the symptoms	Substantial impairment in personal, family, social, educational, occupational, or other important areas of functioning as a result of the symptoms	Substantial impairment in personal, family, social, educational, occupational, or other important areas of functioning as a result of the symptoms
Additional criteria		
Reactions are out of proportion or inconsistent with cultural or religious norms. Following death in traumatic circumstances (eg, homicide, suicide, disaster, or accident), responses to reminders of the loss include distressing thoughts, images, or feelings related to traumatic features of the death (eg, the deceased suffering, gruesome injury)	The disturbance is not better accounted for by major depressive disorder, generalised anxiety disorder, or post-traumatic stress disorder	The grief response has persisted for an atypically long period (≥6 months) and clearly exceeds norms for the individual's social, cultural, or religious context

DSM-5: *Diagnostic and Statistical Manual of Mental Disorders* (5th Edition). ICD-11: international classification of diseases (11th edition)

Table 2| Psychological therapy studies

Study	Inclusion	Condition	Number of sessions/content	N	Outcome	
Boelen et al, 2007[55]	ICG >25, >2 months since loss	CT plus ET	12 sessions	23	ICG reduction	25%
		ET plus CT	12 sessions	20	ICG reduction	36%
		Supportive counselling	12 sessions	11	ICG reduction	12%
Bryant et al, 2014[56]	PGD diagnoses, >12 months since loss	Group CT	10 group sessions	39	ICG reduction	42%
		Group CT plus ET	10 (group) plus 4 (individual)	41	ICG reduction	17%
Eisma et al, 2014[57]	ICG >25, >6 months since loss	Internet based exposure	6 writing assignments completed in 6-8 weeks	18	ICG-R reduction	19%
		Internet based activation	6 writing assignments completed in 6-8 weeks	17	ICG-R reduction	19%
		Wait list control		12	ICG-R reduction	–5%
Shear et al, 2005[54]	ICG >30, >6 months since loss	CGT	16 sessions	49	ICG reduction	38%
		IPT	16 sessions	46	ICG reduction	29%
Shear et al, 2016[53]	ICG >30	Citalopram	33.9 mg/day	101	Response on clinical global impression scale	69%
		Placebo medication		99	Response on clinical global impression scale	54%
		CGT plus citalopram	16 sessions plus medication	99	Response on clinical global impression scale	83%
		CGT plus placebo	16 sessions plus medication	96	Response on clinical global impression scale	82%
Wagner et al, 2006[58]	Clinically significant loss related traumatic stress	Internet based exposure	2 weekly writing assignments during 5 weeks	26	Intrusion reduction	47%
					Avoidance reduction	65%
					Malfunctioning reduction	58%
		Wait list control		25	Intrusion reduction	14%
					Avoidance reduction	6%
					Malfunctioning reduction	18%

CGT: complicated grief treatment; CT: cognitive therapy; ET: exposure therapy; ICG: Inventory of Complicated Grief; ICG-R: Revised Inventory of Complicated Grief; IPT: interpersonal psychotherapy

Table 3| **Pharmacotherapy studies**

Study	Drug name	mg/day	Psychotherapy	N	Design	Analysis	Diagnosis	Time since loss	Outcome	
Hensley et al, 2009[66]	Escitalopram	10-20	None	14	Open label	SC	MDE and grief	7-9 months	ICG reduction	29%
									HDRS reduction	58%
Jacobs et al, 1987[69]	Desipramine	75-150	Support	9	Open label	ITT	MDE		Grief reduction	50%
									HDRS reduction	73%
Pasternak et al, 1991[70]	Nortriptyline	49.2	None	13	Open label	SC	MDE, HDRS ≥15	2-25 months	TRIG reduction	9%
									HDRS reduction	67%
Reynolds et al, 1999[71]	Nortriptyline	66	None	25	RCT	ITT	MDE, TRIG ≥45	0-12 months	Response	56%
Reynolds et al, 1999[71]	Nortriptyline	66	IPT	16	RCT	ITT	MDE, TRIG ≥45	0-12 months	Response	69%
Shear et al, 2016[53]	Citalopram	33.9	Support	101	RCT	ITT	ICG ≥30	0.5-58.7 years	Response	69%
Shear et al, 2016[53]	Citalopram	33.9	CGT	99	RCT	ITT	ICG ≥30	0.5-58.7 years	Response	84%
Simon et al, 2007[67]	Escitalopram	10-20	None	4	Case series	ITT	ICG ≥25	2.94 (1.4) years	ICG reduction	76%
									HDRS reduction	75%
Zisook et al, 2001[72]	Bupropion	150-300	Support	22	Open label	ITT	MDE	0-2 months	ICG reduction	18%
									HDRS reduction	54%
Zygmont et al, 1998[68]	Paroxetine	20-50	TGP	15	Open label	SC	ICG ≥20	6-139 months	ICG reduction	48%
									HDRS reduction	51%

CGT: complicated grief treatment; HDRS, Hamilton depression rating scale; ICG: Inventory of Complicated Grief; IPT: interpersonal psychotherapy; ITT: intention to treat; MDE: major depressive episode; RCT: randomised controlled trial; SC: study completers; TGP: traumatic grief psychotherapy; TRIG: Texas Revised Inventory of Grief