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EDITORIAL

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Traumatic loss: Mental health consequences and implications for treatment and prevention

Paul A. Boelen [a,b,c], Miranda Olff[b,d] and Geert E. Smid [b,c,e]

[a]Department of Clinical Psychology, Faculty of Social Sciences, Utrecht University; [b]Arq Psychotrauma Expert Group, Diemen, The Netherlands; [c]Foundation Centrum '45 partner in Arq Psychotrauma Expert Group; [d]Department of Psychiatry, Academic Medical Center, University of Amsterdam, The Netherlands; [e]University of Humanistic Studies, Utrecht, The Netherlands

ABSTRACT

Traumatic loss involves the loss of loved ones in the context of potentially traumatizing circumstances and is a commonly reported traumatic event. It may give rise to disturbed grief, called prolonged grief disorder (PGD) in ICD-11 and persistent complex bereavement disorder (PCBD) in DSM-5, combined with posttraumatic stress disorder (PTSD) and depression. The recent inclusion of grief disorders in both DSM-5 and ICD-11 have spurred research on grief-related psychopathology. This special issue on traumatic loss includes 10 articles and two letters. Topics addressed include diagnostic criteria for PGD, children's perspectives on life after parental intimate partner homicide, and the impact of visiting the site of deaths caused by terror. Early indicators of problematic grief trajectories are addressed, as well as moderators and mediators of disordered grief, including coping strategies, rumination, and meaning-making. Further, a meta-analysis synthesizing research findings on correlates of disturbed grief following traumatic loss is presented. Finally, specialized treatments as Eye Movement Desensitisation and Reprocessing (EMDR) and Cognitive Behavioural Therapy (CBT) for grief are addressed, and predictors of treatment response for CBT for PGD including levels of self-blame and avoidance are scrutinized. As such, the articles included in this special issue increase our understanding of the needs of people confronted with traumatic loss and bring promising findings with regard to diagnosis, prevention, and specialized treatment in children, young people and adults. This article also introduces a hypothetical staging, profiling, and stepped care model which may offer a template to integrate existing and emerging research findings on possible courses and correlates of grief, in order to inform treatment decisions.

KEYWORDS
Traumatic grief; PCBD; PGD; staging; profiling

PALABRAS CLAVES
Duelo Traumático; PCBD; PGD; estadios; perfiles

关键词
创伤性哀伤; PCBD; PGD; 分期; 侧

Pérdida traumática: Consecuencias para la salud mental e implicancias para el tratamiento y la prevención

La pérdida traumática implica la pérdida de seres queridos en el contexto de circunstancias potencialmente traumáticas y es un evento traumático comúnmente reportado. Puede dar lugar a un duelo perturbado, denominado trastorno de duelo prolongado (PGD) en el CIE-11 y trastorno de duelo complejo persistente (PCBD) en el DSM-5, combinado con trastorno de estrés postraumático (TEPT) y depresión. La reciente inclusión de trastornos de duelo tanto en el DSM-5 como en la CIE-11 ha estimulado la investigación en psicopatología relacionada con el duelo. Este número especial sobre la pérdida traumática de la European Journal of Psychotraumatology incluye diez artículos y dos cartas. Los temas abordados incluyen los criterios de diagnóstico de PGD, las perspectivas de los niños sobre la vida después del homicidio de la pareja íntima de los padres y el impacto de visitar el sitio de causas de muertes por terror. Se abordan indicadores tempranos de las trayectorias de duelo problemático, así como los moderadores y mediadores del trastorno de duelo, incluidas las estrategias de afrontamiento, la rumiación y la generación de significados. Además, se presenta un metanálisis que sintetiza los resultados de investigaciones sobre los correlatos del trastorno de duelo después de una pérdida traumática. Finalmente, se abordan tratamientos especializados como Desensibilización y Reprocesamiento por Movimiento Oculares (EMDR) y la Terapia Cognitiva Conductual (TCC) para situaciones de duelo, y se analizan los factores predictivos de la respuesta a tratamiento para la TCC para PGD, incluidos los niveles de auto-culpa y evitación. Así, los artículos incluidos en este número especial aumentan nuestra comprensión de las necesidades de las personas que enfrentan una pérdida traumática y aportan resultados prometedores con respecto al diagnóstico, prevención y tratamiento especializado tanto en niños como en jóvenes, así como en adultos. Este artículo también presenta un modelo hipotético de estadios, perfiles y atención escalonada que puede ofrecer una pauta para integrar los hallazgos de investigación existentes y emergentes sobre posibles cursos y correlatos de duelo, con el fin de guiar las decisiones de tratamiento.

CONTACT Paul A. Boelen p.a.boelen@uu.nl Department of Clinical Psychology, Faculty of Social Sciences, Utrecht University, P.O. Box 80140, Utrecht, 3508 TC the Netherlands

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创伤性丧亲：精神健康后果及其对治疗和预防的启示

创伤性丧亲指在可能的创伤情境中失去亲人，是一种常被提到的创伤事件。它可能引起的哀伤感，在ICD-11中称为延长哀伤障碍（PGD），DSM-5中称为持续性复杂丧亲障碍（PCBD），结合了创伤后应激障碍（PTSD）和抑郁症。在DSM-5和ICD-11中最近都包含了哀伤障碍，刺激了与悲伤相关的精神病理学的研究。《欧洲创伤心理学期刊》 关于创伤性丧失的这期特刊包括十篇论文和两封来信。讨论的主题包括PGD的诊断标准、父母被伴侣谋杀后儿童的生命观、以及访问恐怖袭击致死地点的影响。还讨论了预测有问题的悲伤发展轨迹的早期指标，以及障碍性哀伤的调节变量和中介变量，包括：应对策略，反刍和发现意义。此外还有一项元分析研究，综合了创伤性丧亲后和哀伤相关的变量的研究发现。最后，讨论了专门针对哀伤的眼动脱敏和再加工疗法（EMDR）和认知行为疗法（CBT），并且仔细考察了PGD的CBT治疗反应的预测因子（包括自责和回避的水平）。 因此，本期特刊中的文章促进我们更好理解遭遇创伤性丧亲的人们的需求，并为儿童青少年以及成人的诊断、预防和专业治疗带来了有希望的发现。本文还介绍了一个分期（staging）、侧写（profiling）和阶梯式护理的假设模型，它可以提供一个模板，将现有的和新兴的研究成果整合到潜在的病程发展和相关变量中，以为治疗决策提供信息。

Traumatic loss refers to the loss of loved ones in the context of potentially traumatizing circumstances. Examples are losses due to homicide, suicide, accidents, and natural disasters, and losses resulting from war and terror. In persons reporting exposure to potentially traumatic events, traumatic loss of loved ones is reported most often (Benjet et al., 2016; de Vries & Olff, 2009; Norris, 1992). Many people are resilient in the face of traumatic loss. In a significant minority of people, however, traumatic loss may give rise to psychopathology, including (but not limited to) posttraumatic stress disorder (PTSD), major depressive disorder, and persistent, distressing, and disabling grief. The term 'traumatic grief' may be used as a broader term referring to the emotional distress linked with traumatizing separations. Currently, different terminology is used to diagnose such persistent, distressing, and disabling grief reactions. In the DSM-5 it is labelled 'persistent complex bereavement disorder (PCBD)' (as a condition for further study that can be classified as 'other specified trauma- and stressor-related disorder'; American Psychiatric Association, 2013). ICD-11 included 'prolonged grief disorder (PGD)' (WHO, 2018). Provided that these labels are carefully used, they foster the identification of people suffering severely following loss and enable the delivery of effective treatment (Lichtenthal et al., 2018)

Over the past years, the *European Journal of Psychotraumatology* has published key papers on traumatic loss informing both scientific and clinical practice (see Olff, 2018). Several papers in this journal have set research agendas. Heralding the inclusion of prolonged grief disorder in ICD-11, Maercker and Znoj (2010) called for an emancipation of disordered grief as 'younger sibling' of PTSD. Rosner (2015) specifically highlighted the paucity of grief research in children despite urgent research needs regarding diagnosis and treatment. Boelen (2016) emphasized the need to enhance knowledge on different stages of disturbed grief, and risk factors associated with problematic trajectories of grief, to improve options for stepped care for grief, including effective and efficient preventive and curative interventions.

1. Overview of this special issue

The articles that comprise this special issue go some way towards fulfilling these research needs. They include empirical research and considerate reflections, contributing to our knowledge about the consequences of traumatic loss, in the interest of both early intervention and specialized treatment. Killikelly and Maercker (2017) present the new ICD-11 diagnostic criteria for PGD, based on the WHO's prioritization of clinical utility and ease of use. It has been argued that simplicity of the new ICD-11 diagnostic algorithm may increase the cross-cultural applicability of the new PGD criteria.

Putting children first, Alisic et al. (2017) describe children's perspectives on life after parental intimate partner homicide. They conducted semi-structured interviews with 23 children and young people confronted with this horrible reality. Their findings underscore the highly diverse individual perspectives and sources of distress, that may include conflicts between family members, and lack of continuity in professional support.

Integrating the perspectives of both parents and siblings (age range 15–61), Kristensen, Dyregrov, and Dyregrov (2017) address the vital question whether visiting the site of death after terror can be beneficial for bereaved families. They interviewed 38 relatives bereaved by the 2011 terror attack in Norway. Beneficial consequences include that visiting the site may foster acceptance of the reality of the loss and increase cognitive clarity. Having the opportunity to pay multiple visits appeared to optimize these positive effects.

The remaining articles focus on adults. Djelantik, Smid, Kleber, and Boelen (2018) identified early indicators of problematic grief trajectories following bereavement in a Dutch sample of 166 bereaved individuals. The endorsement of symptoms

'yearning', 'stunned', 'life is empty', and 'bitterness' predicted a problematic grief trajectory. These findings suggest that early screening and interventions should focus on these symptoms.

Three articles examine moderators and mediators of disordered grief following different forms of traumatic loss. Huh, Kim, Lee, and Chae (2017) examined coping strategies moderating the relationship between attachment representations and patterns of disaster-related grief using data from 81 bereaved parents following the loss of their child in the 2014 Sewol ferry accident. Parents with highly avoidant attachment were found to be overwhelmed by shame and guilt when applying problem-focused coping strategies, suggesting that mental health service providers should take individual differences in attachment representations among bereaved parents into account.

Lenferink, Eisma, de Keijser, and Boelen (2017) examined grief rumination as a mediator between self-compassion and emotional distress in 137 relatives of missing persons. They found that the buffering effect of self-compassion on emotional distress could be explained by reduction of ruminative thoughts related to the disappearance. They therefore suggest mindfulness-based interventions to reduce emotional distress associated with the disappearance of a loved one.

Milman et al. (2018) examined whether violent loss increases symptoms of PGD by hindering the bereaved person's ability to make meaning of the death. In a prospective, longitudinal sample of 171 violently bereft persons, sense of peace and continuing bonds served as mediators. Their findings underscore the potential benefits of addressing meaning-making in interventions for disturbed grief.

Heeke, Kampisiou, Niemeyer, and Knaevelsrud (2019) performed a systematic review and meta-analysis of variables associated with elevated PGD following traumatic loss. Based on data of almost 6000 bereaved individuals, there were indications that symptom-levels of PGD were associated with female gender, lower education, rumination, loss of relatively closer relatives, and avoidant attachment – as well as with elevated rates of comorbid depression and PTSD. The authors also pointed at the limitations of extant research, emphasizing the need for more, preferable large scale, longitudinal research.

Finally, two articles examined aspects of specialized care in treatment-seeking patients with PGD following mostly traumatic loss. Cotter, Meysner, and Lee (2017) report on patients bereaved due to miscarriage, medical condition, motor vehicle accident, and suicide who underwent Eye Movement Desensitization and Reprocessing (EMDR) or Cognitive Behavioural Therapy (CBT) for grief. Patients in both groups reported positive changes in their experience of grief following treatment. Patients who completed CBT described the acquisition of emotion regulation tools, whereas those who completed EMDR reported feeling more distant from distressing memories.

Bryant et al. (2019) investigated predictors of treatment response for CBT for PGD in 80 PGD patients who took part in 10 weekly two-hour group CBT sessions plus four individual sessions of either exposure therapy or CBT without exposure. Greater reduction in grief severity posttreatment was predicted by being in the CBT/exposure condition, and higher baseline levels of self-blame and avoidance. These findings add to the growing number of studies showing that CBT is the preferred treatment for disturbed grief (Boelen & Smid, 2017), suggesting that strategies that target excessive self-blame and avoidance are particularly beneficial in grief-focused CBT.

This special issue also includes two letters to the editor. Eisma and Lenferink (2018) responded to the contribution from Killikelly and Maercker (2018), reflecting on the extent to which prior research supports the validity of the ICD-11 criteria. Killikelly and Maercker (2018), in turn, responded to the issues raised by Eisma and Lenferink (2018).

2. Directions for future research: a hypothetical staging, profiling, and stepped care model

The articles included in this special issue add to our understanding of the nature of emotional distress that can be experienced in the face of traumatic death(s), as well as the maintaining mechanisms and treatment options for people experiencing such losses. As such, they add to an ever-growing body of knowledge that helps to distinguish uncomplicated, benign grief that does not require mental health care, from disordered grief accompanied by pervasive suffering for which specialist care is needed. Yet, the advancement of knowledge on epidemiology, diagnosis, prevention, and treatment of psychopathology related to traumatic loss remains a key priority in this field. Gender aspects associated with traumatic loss also need further study, and would be in line with the journal's gender policy (see Olff, 2016). More knowledge is specifically needed about vulnerable groups, including children, the elderly, persons professionally exposed to the risk of losing important others, such as first responders and members of the armed forces, and refugees, fleeing war or under-resourced circumstances.

The question then is how can we integrate existing and emerging knowledge about different manifestations, correlates, and underlying mechanisms of grief in order to advance treatment development? One clue might lie in a sophisticated classification of disturbed grief that recognizes the variations in its manifestation and temporal development. A staging approach might offer a template for such a classification. Staging approaches have a long tradition in medicine

and are increasingly considered in the context of mental disorders (Beekman, Van Os, Van Marle, & Van Harten, 2012; McFarlane, Lawrence-Wood, Van Hooff, Malhi, & Yehuda, 2017; Nieman, 2017; Shear, Bjelland, Beesdo, Gloster, & Wittchen, 2007). A staging approach might be valuable in identifying 'inflection points' in the development of grief reactions over time and to identify early symptoms associated with persistent distress and dysfunction. Furthermore, a staging approach could be combined with clinical profiling, referring to the identification of clinical characteristics (e.g. level of distress, disability, and comorbidity) and specific risk factors and protective factors associated with the course of grief and the development of transient grief toward severely disordered grief.

Table 1 illustrates a hypothetical staging, profiling, and stepped care model, combining early and later (disorder) stages of grief, with examples of possible clinical characteristics, risk and protective factors, and indications for treatment. It is explicitly called *hypothetical* in order to highlight the provisional status of *every aspect* of this model and to invite scholars and clinicians to reflect upon, discuss, test, complete, and/or refute this approach. The early stages include those bereaved individuals with elevated acute symptoms and with some characteristics of PCBD/PGD falling below the threshold for formal PCBD/PGD-caseness. For them, self-help, non-assisted online interventions, or counselling may be appropriate. A further stage (stage 2 in Table 1) includes people with an episode of full-blown PCBD/PGD for whom evidence-based psychotherapies (e.g. cognitive behavioural therapy, complicated grief treatment) would be appropriate. In this hypothetical model, this stage would be separated from stage 3, defined by persistent distressing and disabling symptoms of grief and non-response to monotherapy for which combined treatment could be indicated, and stage 4, characterized by severe, chronic disorder with increasing comorbidity and disability that might require more intensive treatment (e.g. culturally sensitive, day patient treatment; De Heus et al., 2017; Smid et al., 2015).

A staging perspective may offer a template to frame the possible developmental course of disturbed grief over time, to dissect biopsychosocial underpinnings of different stages in the course of disorder development, and to combine the development of grieving responses and treatment needs in a single framework. Another advantage of such an approach is that early signs of disturbance of grief would not have to be labelled using a formal diagnosis; it would allow for a dimensional view on grief that moves away from a

Table 1. Hypothetical staging, profiling, and stepped care model for grief.

Stage	Characteristics	Clinical characteristics	Risk and protective factors	Interventions
0	Confronted with bereavement with signs of acute grief	Distress and disability: Low	Personal: Moderate-high socioeconomic status (SES); Loss: Low-risk (single, timely natural loss); Social context: Supporting	None, community support
1a	Undifferentiated symptoms of grief, sadness, dysphoria, anxiety	Distress and disability: Low–Mild	Personal: Moderate–high SES; some vulnerable personality traits; Loss: Low-risk; Social context: Supporting	Self-help; psycho-education; watchful waiting
1b	Subsyndromal signs of PCBD/PGD	Distress and disability: Mild–Moderate	Personal: Some vulnerable personality traits; Loss: Low-risk with additional stressors or high-risk (sudden, untimely, and/or traumatic loss); Social context: Supporting	Non-assisted online interventions; counselling; social work
2	First episode of full-threshold PCBD/PGD	Distress and disability: Moderate–Severe	Personal: Vulnerable personality, previous loss experiences; Loss: High-risk Social context: Impaired support	Psychotherapy (e.g. cognitive behavioural therapy, complicated grief treatment, brief eclectic psychotherapy, EMDR)
3	Persistent symptoms which may fluctuate with ongoing impairment: (i) Incomplete remission of first episode; (ii) Recurrence and/or persistent impairments; (iii) Multiple relapses or worsening following incomplete treatment response	Distress and disability: Severe (any serious impairment in functioning)	Personal: Vulnerable personality, previous loss experiences, migration, low SES; Loss: High-risk, traumatic, and multiple Social context: Lack of support	Psychotherapy; Day patient treatment; Medication
4	Unremitting PCBD/PGD of increasing chronicity with substantial comorbidity (depressive disorders, posttraumatic stress disorder)	Distress and disability: Very severe (major impairment in several areas)	Personal: Vulnerable personality, previous loss experiences, migration, low SES, childhood adversity Loss: High-risk, traumatic, and multiple Context: Lack of social support, low SES	Day patient/inpatient treatment; Medication

dichotomized view on grief as either uncomplicated/normal or disturbed/prolonged. This approach provides several suggestions for future research directions. Firstly, an important start would be to enhance knowledge about the long-term course of PCBD/PGD in larger groups of people in order to examine if – as such a staging approach implies – PCBD/PGD indeed follows specific long-term courses or trajectories. Secondly, it would be useful to study the epidemiological distribution of, and biopsychosocial variables involved in, different stages and subtypes of disordered grief. Thirdly, research should focus on identifying lacunas in knowledge about effective treatment options for different stages of grief. Currently, there seems to be a particular need to improve options for indicated prevention (methods to effectively identify and help people with early signs of pervasive grief and enhanced risk of progression to a next stage) and severe unremitting grief accompanied by substantial disability and comorbid conditions. Traditionally, comorbid conditions such as PTSD and depressive disorders are prioritized in treatment. However, this may lead to suboptimal or delayed treatment of disordered grief. Comorbid grief in apparent treatment-refractory cases may still be responsive to treatment and lead to substantial overall improvement. Fourthly, further examination of e-health interventions (e.g. Bourla, Mouchabac, El Hage, & Ferreri, 2018; Olff, 2015, 2019) and culturally sensitive approaches to the assessment and treatment of traumatically bereaved individuals (Schnyder et al., 2016; Smid, Groen, de la Rie, Kooper, & Boelen, 2018) are paramount as well. The *European Journal of Psychotraumatology* looks forward to receiving more papers on mental health consequences of traumatic loss, to better meet the needs and further improve the mental health care for people dealing with mental health consequences of traumatic loss.

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ORCID

Paul A. Boelen http://orcid.org/0000-0003-4125-4739
Geert E. Smid http://orcid.org/0000-0002-9616-5234

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