

Complicated Grief: Epidemiology, Clinical Features, Assessment and Diagnosis

Komplike Yas: Epidemiyoloji, Klinik Özellikler, Değerlendirme ve Tanı

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Öz

Kayıp, üzerinde kontrol sahibi olunamayan bireylerin inanç sistemlerinin ve algılayış biçimlerinin değişmesine sebep olan olumsuz bir olaydır. Normal yas kayba karşı verilen normal bir tepki olup, kederden kaynaklanan sıkıntıyı ifade eder. Komplike yas ise, yeni durumun var olan bilişsel yapıya yeterince entegre edilememesi ve yas tutma sürecindeki çarpıtılmış inançlar gibi bireyin iyileşme sürecinde ortaya çıkan komplikasyonlar nedeniyle yas sürecinin alışılmadık şekilde uzadığı bir sendromdur. Komplike yas ölümün gerçekliğini kabul edememe, yoğun özlem duyma, kaçınma davranışı, bedensel sıkıntı, sosyal geri çekilme ve intihar düşüncesiyle karakterize edilebilen ve diğer psikolojik rahatsızlıklardan ayırt edilebilen bir sendromdur. Bu derlemenin amacı normal dışı yas tepkileri ve risk faktörleri hakkında genel bir bakış sağlamak, komplike yas için önerilen tanı ölçütlerini tanıtmak, değerlendirme araçları hakkında bilgi vermek ve komplike yas ile diğer psikiyatrik bozukluklar arasındaki ayrımı göstermektir.

Anahtar sözcükler: Komplike, uzamış, patolojik, travmatik, yas, keder.

Abstract

A loss is an adverse external event which a person has no control over and changes one's belief system and cognitions. Normal grief is a normal reaction to loss and refers to the distress resulting from bereavement. However, complicated grief is a syndrome where normal grief is unusually prolonged because of complications in the natural healing process; namely the insufficient integration of a new situation into pre-existing cognitive structures and distorted beliefs during the grieving process. Complicated Grief is a disorder characterised by an inability to accept the death, intense yearning, avoidance, somatic distress, social withdrawal and suicidal ideation and has a distinct cluster of symptoms which can be distinguished from other psychiatric disorders. The aims of this review are to give an overview of abnormal forms of grief reactions and risk factors, to introduce proposed diagnostic criteria for complicated grief, to inform about the assessment tools, and to demonstrate the distinction between complicated grief and other psychiatric disorders.

Key words: Complicated, prolonged, pathological, traumatic, grief, bereavement.

LOSS of a significant other is one of the most stressful interpersonal event accompanied by a wide range of strong emotions, including shock and disbelief that the loved one is gone, sadness, yearning, and separation distress (Simon 2013). The stress caused by the loss is associated with functional impairment, reduced quality of life, and increa-

sed morbidity and mortality (Papa et al. 2013). Although most bereaved individuals successfully adapt to life after the loss without professional help, approximately one third of them develop pathological grief responses and healing does not occur without clinical intervention (Eisma et al. 2015).

According to statistics, the estimated conditional prevalence for abnormal forms of grief after bereavement is approximately 7%, and in the general population is around 4% (Kersting et al. 2011, Rosner et al. 2011). However, in at-risk populations, the prevalence rate can be much higher. The rate ranges approximately 20% in bereaved dementia caregivers, around 50% in HIV caregivers and the rate can reach 78% in case of violent death or the death of a spouse (Papa et al. 2013).

Although interchangeably used, the following terms normal grief, complicated grief, bereavement, and mourning describe different aspects of experiencing the death of a loved one. To begin with, 'normal grief' is a normal reaction to loss and refers to the distress resulting from bereavement. It can be described as the state that occurs when people 'are deeply saddened by the death of an attachment figure during a period of weeks or months of acute grief'. It is an expectable response to the loss of a loved one and is expected to end within 2 to 6 months (Kristjanson et al. 2006, Bildik 2013). The grieving process often requires redefining goals, plans, responsibilities and roles in order to restore a meaningful and satisfying life (Koon et al. 2016).

Although most bereaved people recover from a loss, a minority of them suffers from severe and disabling grief. 'Complicated grief (CG)' is a form of a normal grief. However, in CG, the progress of adapting and accepting the finality of the loss is complicated and slowed (Sayıl 2003, Simon 2013). Therefore, it is a syndrome where normal grief is unusually prolonged because of complications in the natural healing process; namely the insufficient integration of a new situation into pre-existing cognitive structures and distorted beliefs during the grieving process (Malkinson 2001, Groot et al. 2007, Shear et al. 2015). To continue with, the terms grief and bereavement are used inconsistently to refer either the response to a loss or the state of having lost someone to death. 'Bereavement' is a state or an objective situation of the death of a significant one rather than the reaction to that loss. However, the term grief describes cognitive, emotional, and behavioural responses to the death and refers the distress resulting from bereavement (Shear et al. 2011). 'Mourning', on the other hand, is the process of adapting to a loss and integrating grief. The term mourning describes intrapsychic processes of accommodating the loss and cultural ways of expressing grief. Mourning process includes accepting the finality and consequences of the loss, revising the internalized relationship with deceased, and envisioning the future without the deceased (Shear et al. 2011). The diagnostic term for "complications that arise from grief" has been variably proposed, namely complicated grief, pathological grief, abnormal grief and prolonged grief. In the current review, the term CG will be used to describe these disturbed grief patterns in order to improve readability.

In this paper, the growing literature on CG alternatively called prolonged grief, pathological grief, or traumatic grief was reviewed. The aims of this current review are to give an overview of abnormal forms of grief reactions, to introduce proposed diagnostic criteria for CG, to demonstrate the distinction between CG and other psychiatric disorders, and to inform about the assessment tools and risk factors. The requirement of this research is based on the multi-dimensional and complex nature of grief.

Awareness of this understudied topic may lead to enhancement in the quality of care on behalf of grieved people and to speed up the recovery process. Additionally, an in-depth understanding of CG may guide to researchers to develop more sensitive measurements in order to make a distinction between normal grief, maladaptive grief, and other psychiatric disorders, and also to reduce the risk of misdiagnosis.

Diagnostic Criteria

Previous researches estimate that between 10% and 20% of grieved people are affected by CG regardless of age, nature of death and relationship with the deceased (Miller 2012). Therefore, in recent years, studies have been conducted to provide the empirical data that would establish CG as a differential diagnostic category. CG would be a unique pathological entity distinct from major depressive disorder (MDD), anxiety disorders, post-traumatic stress disorder (PTSD), and normal grief (Kristjanson et al. 2006). In order to highlight unique CG symptoms and to establish a pathological entity distinct from other psychiatric disorders, several criteria have been established.

First, Worden (1991) defined the most common manifestations of CG under four categories: feelings, cognitions, physical responses, and behaviours. The primary emotional states are sadness, guilt, anger, shock, loneliness, fatigue and anxiety. A number of cognitive deteriorations can also be observed, namely disbelief, hallucinations, and preoccupation. Individuals can experience physical sensations, such as over-sensation, depersonalisation, and lack of energy. Furthermore, sleep and appetite disturbance, social withdrawal, and avoidance of certain situations can all be grouped under the fourth category (Worden 1991). A lapse of 6 months from the beginning of the onset of the symptoms to diagnosis was proffered (Maercker et al. 2012, Enez 2017).

Second, the Horowitz group established the first operational diagnostic criteria for CG. The team identified 30 questions relating to possible CG symptoms. The conceptualisation of the criteria was influenced by the stress response theory. According to this theory, CG occurs as a stressful life event. And the Horowitz team suggested that PTSD should be removed from the category 'Anxiety Disorders' and a new category 'Stress Response Syndromes' should be created. The Stress Response Syndromes should include adjustment disorder, PTSD, acute stress disorder, stress-induced psychosomatic disorder, and CG (Maercker et al. 2012).

More recently, new diagnostic criteria labelled 'prolonged grief' were developed by Prigerson and colleagues with the aim of distinguishing between the core symptoms of CG and other trauma related disorders. Separation distress was evaluated as an essential criterion for the diagnosis of CG. A number of cognitive, emotional and behavioural symptoms were also defined. According to the criteria, the diagnosis should not be made until at least 6 months have elapsed since the death (Kristjanson et al. 2006, Maercker et al. 2012, Maercker et al. 2012). The diagnostic criteria for Prolonged Grief Disorder (PGD) are represented in Table 1.

Later, Shear et al. (2011) established new diagnostic criteria for complicated grief disorder (CGD). The group proposed slightly different criteria based on clinical experience. Persistent intense yearning or longing for the loss, suicidal thinking and behaviours, rumination about circumstances or consequences of the death were evaluated as main symptoms for the diagnosis. In similar with the others, to meet the criteria, the symptoms must persist at least 6 months after the death (Shear et al. 2011, Wakefield

2012). Table 2 outlines the proposed diagnostic criteria for Complicated Grief Disorder (CGD)

Currently, there is no differential diagnostic category in the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5). However, due to significant adverse disruptions in health, impairment in social and occupational functioning and deterioration in the quality of life, a distinct category was under consideration in the fifth edition (Kristjanson et al. 2006). Currently, DSM-5 includes criteria for CG in the section on 'Disorders Requiring Further Study' with the name of 'persistent complex bereavement disorder (PCBD)'. PCBD has been defined as persistent yearning or preoccupation with the deceased for at least 12 months after the death (Bryant 2013, Shear et al. 2013, Hospice Support Fund 2017). It is possible the next edition of the DSM will include full diagnostic entity for CG. Table 3 outlines the DSM-5 criteria for diagnosis in adults.

The World Health Organization's International Classification of Diseases-10th Revision (ICD-10) also does not officially recognize CG as a mental disorder. Maladaptive grief reactions are classified as a type of adjustment disorder (Jordan et al. 2014, Shear et al. 2016). The proposed International Classification of Diseases-11th Revision (ICD-11) includes a new diagnosis, termed prolonged grief disorder (PGD). The recommended diagnostic criteria based on an interview study of almost 300 grieved individuals to identify the main distinguishing clinical features of CG (Jordan et al. 2014). PGD is defined as persistent and severe yearning for the deceased, difficulty in engaging with social activities due to the loss, feeling of loss as a part of oneself, difficulty accepting the death, and anger, guilt or blame regarding the death. To meet the criteria, the symptoms must persist at least 6 months after the death (Shear et al. 2011, Jordan et al. 2014). Table 3 outlines the proposed diagnostic criteria for ICD-11 for Prolonged Grief Disorder.

In one hand, manifestations of grief are unique to each person and shaped by the practices of a society and cultural group. On the other hand, despite the considerable variation in the experience of grief, many individuals generally show similar patterns of intense yearning, sadness, pre-occupation, distress, and intrusive thoughts (Zachar 2015). Multiple studies suggest that the most common features of CG are yearning for the deceased and feeling upset by memories of the deceased. Researchers identified the most common symptoms in a survey of almost 300 patients with CG. The symptoms are yearning for the deceased (88% of those surveyed), feeling upset by memories of the deceased (82%), loneliness (81%), feeling life as empty (80%), disbelief (76%) and inability to accept the death (70%) (Hospice Support Fund 2017).

It is expected that within the 6 months after a loss, acceptance of the loss gradually increases and disbelief over the loss gradually decreases. Yearning, anger and depression peak 4, 5, and 6 months respectively. After six months, the intensity of grief reactions continues to diminish, and the individuals settle into acceptance. Therefore, six months cut off point has been offered for diagnosis of CG (Moayedoddin et al. 2015).

Measures in Complicated Grief

With the aim of measuring these grief responses, identifying individuals who may be at risk of CG and to diagnosing CG, a number of measurement tools have been develo-

ped. The instruments were examined for reliability, validity and availability of using the various tools in the clinical context. The instruments are as follows;

1. the Inventory of Complicated Grief (ICG)
2. the Texas Revised Inventory of Grief (TRIG)
3. the Impact of Event Scale (IES)
4. The Prolonged Grief Disorder (PG-13)
5. the Hogan Grief Reaction Checklist (HGRC)
6. the Brief Grief Questionnaire
7. The Grief Evaluation Measure (GEM)

In the previous meta-analysis, two of these tools were found the most widely used ones in researches and clinical practices: the Inventory of Complicated Grief (ICG) and the Texas Revised Inventory of Grief (TRIG) (Allumbaugh et al. 1999). ICG is a validated 19-item instrument which specifically designed to distinguish normal grief reactions from CG, depression and anxiety. The items assess the frequency of emotional, cognitive, and behavioural responses to the death. They are scored on a five-point scale ranging from 0 (never) to 4 (always) and the total score ranges from 0 to 76. A score higher than 25 suggests possible CG and a score higher than 30 indicates CG is very likely (Shear et al. 2016).

TRIG is a 21 items scale designed to measure unresolved or pathological grief. It includes a five point scale of frequency and relates to two points of time: immediately after the death and the time of data collection. The first 8 items subscale measures feelings and actions at the time of the death and the second 13 items subscale measures current feelings. The individual items reflect typical signs of grief, namely continuing emotional distress, rumination, lack of acceptance and painful memories (Maercker et al. 2012, Miller 2012).

In addition to these two instruments, the Impact of Event Scale (IES) consists of 15 items designed to measure loss related intrusion and avoidance symptoms (Range et al. 2000). The Hogan Grief Reaction Checklist (HGRC) is a 61-item instrument structured as a five-point scale with six subscales. The subscales are blame and anger, disorganization, despair, panic behaviour, detachment, and personal growth. HGRC has been primarily used for assessing grief in parents of deceased children (Maercker et al. 2012).

The Prolonged Grief Disorder (PG-13) is the current version of the Inventory of Complicated Grief Scale (ICG-R). PG-13 is a thirteen-item assessment of the nine identified symptoms indicative of CG. Items describe an emotional, cognitive and behavioural state associated with CG (Supiano et al. 2013). The Brief Grief Questionnaire is a five-item self-reported questionnaire that includes questions about the difficulty in accepting the death, disturbing images or thoughts of the death, impaired functioning, avoiding things related to the deceased, and social isolation (Koon et al. 2016).

The Grief Evaluation Measure (GEM) was designed to screen for the development of maladaptive grief response in grieving adults. The instrument assesses the risk factors, including the mourner's medical history, coping resources before and after the death, and circumstances of the death. It provides an in depth evaluation of the bereaved individuals' subjective grief experience and associated symptoms (Kristjanson et al. 2006).

Risk Factors

Despite considerable variation in the experience of grief, many individuals will experience changes in behaviours, cognitions, and the expression of feelings. Additionally, individuals are generally forced to adapt to secondary losses, namely changes in responsibilities and domestic roles, financial losses, and feeling distant from people which may subsequently affect an individual's sense of identity, self-esteem and purpose in life (Penman et al. 2014). Risk factors for CG have been extensively studied. The literature proposes three types of risk factors associated with CG. Situational factors such as place of death; personal factors such as gender; and interpersonal factors such as the availability of emotional and social support from others (Kristjanson et al. 2006).

To begin with, gender has received considerable attention in the literature. Female is more likely to develop maladaptive grief responses. Another factor is the circumstances of the death. People bereaved by traumatic deaths are at greater risk for developing CG symptoms than those bereaved by natural deaths. The grieving individual is more likely to develop CG if the death was unusual, due to violence or suicide, was unexpected, or occurred under unusual circumstances (Hospice Support Fund 2017). Similarly, CG is also more likely to occur if the loved one died after a chronic illness. The death of loved one from a difficult physical ailment in intensive care units is associated with increased risk of pathology in caregivers as compared with deaths occurring at home (Penman et al. 2014). Moreover, CG is associated with low education, older age (>60), low socioeconomic status, and low social support both before and after the death (Ogrodniczuk et al. 2003, Shear et al. 2013). One of the clearest risk factor is a history of anxiety disorders or MDD before the death and a history of prior loss or trauma. CG also tends to occur after loss of a very close relationship with the deceased, such as loss of a spouse or especially a child. The traumatic circumstances of the death, absence of preparation for loss, and difficult interactions with medical staff at the time of the death also appear to be risk factors (Shear et al. 2013).

Other identified risk factors include absent or unhelpful family, ambivalent attachment to the deceased person, dependent or inter-dependent attachment to the deceased person, and insecure attachment styles to parents in childhood (Shear et al. 2002, Jordan et al. 2014). Additionally, consistently reported risk factors include low self-esteem, low trust in others, previous suicidal threats or attempts, and being a caregiver for the deceased (Ogrodniczuk et al. 2003).

Distinctive Features

Although most people eventually adjust to the loss of a loved one, it is associated with an increased risk of psychopathology and bereavement can precipitate or worsen at least one mental disorder. Researchers underline the potentially important consequences of CG in morbidity, mortality, suicide and social-professional dysfunction as well as increased use of alcohol and other substances.

Although the DSM-5 and ICD-10 did not recognize CG as a diagnostic entity, several studies have reported that CG has unique symptoms and can be treated effectively with the interventions which aim to adjust maladaptive grief reactions into more normal grief reaction (Moayedoddin et al. 2015, Shear et al. 2015). Several studies were reported the distinction of CG from other psychiatric disorders in terms of clinical

phenomenology, aetiology, and response to treatment (Kristjanson et al. 2006).

Comparison of MDD and Complicated Grief

The studies show that nearly 40% of grieving individuals met criteria for MDD during the first two months after the death, and almost 20% of them met the criteria a year after. Researchers underline that grief is a major stressor and could produce a depressive state similar to MDD in non-grief contexts (Moayedoddin et al. 2015).

To begin with, a number of symptoms can occur in both MDD and CG, such as sadness, rumination, guilt, sleep disturbance, suicidal thinking and behaviour, and social withdrawal. However, while these symptoms are specific to the loss or circumstances of the loss in CG, they are more generalized and vague in MDD. Moreover, avoidance is a prominent feature of both disorders. In CG, avoidance is limited to the situations or people related to reminders of the loss; on the contrary, MDD includes anhedonia, loss of interest or pleasure in most activities and a more general social withdrawal. Guilt in CG is specifically related to caregiver self-blame pertaining to the deceased, as opposed to the pervasive sense of guilt in MDD. Similarly, sadness is the pervasive mood in depression, whereas it is related to missing the deceased in CG. While low self-esteem and feeling of worthlessness are permanent in MDD, self-criticism is only related to the loss in CG. Moreover, suicidal thoughts in depression arise from the negative emotions and cognitions about oneself, the world, and the future, or being unable to cope with the intense pain. Suicidal ideation in CG is focused on a wish to rejoin the deceased or not wanting to live without the deceased (Robinaugh et al. 2012, Shear et al. 2013, Shear et al. 2016). Self-critical and pessimistic ruminations are generally observed in depression but the context of rumination in CG is related with the preoccupation with thoughts and memories of deceased (Moayedoddin et al. 2015). To continue with the differences between the two, there are prominent symptoms of CG that are not seen in MDD. For example, intense yearning for the deceased and intrusive or preoccupying thoughts of the dead person are often seen in CG but are usually not observed in MDD (Shear et al. 2016). Predominant affect also differs, in CG feelings of emptiness is common. In depression, predominant affect is persistent depressed mood and inability to feel happiness and pleasure (Moayedoddin et al. 2015).

To sum up, the two disorders have some common symptoms but they differ in that symptoms of CG are centred upon the loss of a loved one. It is important to mention that the DSM-5 removed the grieving exclusion from MDD diagnosis and added a footnote to explain differences between Grief Related Major Depression (GRMD) and grief (Moayedoddin et al. 2015).

Comparison of PTSD and Complicated Grief

The prevalence of PTSD among the bereaved individuals is approximately 10% but varies depending upon the nature of the death and the type of loss; the rate is higher following violent deaths, compared with natural causes (Shear et al. 2015). In one hand, CG has some commonalities with the diagnosis of PTSD and both disorders belong to Stress Response Syndromes. On the other hand, confrontation with physical danger is fundamentally different from losing a significant one; therefore CG symptoms differ from PTSD symptoms (Shear et al. 2011, Maercker et al. 2012).

To begin with the similarities, sense of shock, social withdrawal, sleep and appetite disturbance, and impaired concentration are the common features of both disorders. Additionally, both disorders can be characterized by intrusive thoughts and images, and intense yearning. Intrusive thoughts and yearning can be defined as 'permanent memory states'. In PTSD, they involve distressing memories of the traumatic event, whereas, in CG, the permanent memory states are focused upon thoughts of the deceased, and are often positive or even comforting (Maercker et al. 2012, Shear et al. 2016). In PTSD, intrusive thoughts are associated with the event itself and the sense of threat. By contrast, intrusive memories focus on the deceased or the death in CG (Ogrodniczuk et al. 2003). Avoidance is another common symptom of both disorders. However, in PTSD, the aim of avoidance is to prevent recurrence of danger but to prevent painful feelings and thoughts related to the deceased person in CG (Shear et al. 2011). In other words, individuals with PTSD feel threatened; therefore they avoid fear-inducing stimuli to reduce this threat feeling. In CG, the aim of avoidance is averting painful reminders of the loss (Robinaugh et al. 2012, Shear et al. 2016).

To continue with the differences between the two, one distinction is that the hallmark of CG is sadness due to the separation distress over the absence of the deceased, whereas the predominant emotions in PTSD are fear about the traumatic event will happen again or horror about the world is unsafe. Moreover, yearning for the deceased and seeking proximity to the deceased are often observed in CG but are not seen in PTSD (Shear et al. 2016). During pathological grief nightmares are not typically seen. There may be dreams about the death one, which are associated with sadness upon awakening, on contrary, nightmares often occur in PTSD (Shear et al. 2015). Another difference is the duration criteria in order to diagnose the disorder, which is 6 months for CG and 1 month for PTSD. It means that individuals need at least 6 months to distinguish between healthy adaptation and maladjustment of the loss. Lastly, hyperarousal in CG is related to reminders of the deceased, rather than hyper-vigilance to threat (Shear et al. 2011, Maercker et al. 2012).

To sum up briefly, CG has been found to constitute a distinct cluster of symptoms which can be distinguished from MDD and PTSD. However, clinicians should be aware of that they are often co-morbid with CG (Shear et al. 2013). Additionally, CG is not the only complication that may follow from bereavement, MDD and PTSD may develop in response to the death of a loved one (Kristjanson et al. 2006).

Conclusion

In most of the grieving individuals, an alleviation of maladaptive responses to death of a significant one follows a natural healing process. Adaptation to life after the loss and recovery in symptoms can potentially be achieved with minimal support from clinicians. However, a significant minority of them go on to develop CG which is a disorder characterised by an inability to accept the death, intense yearning, avoidance, somatic distress, social withdrawal and suicidal ideation (Miller 2012).

As it was mentioned above, currently, there is no differential diagnostic category either in the DSM-5 or ICD-10 for CG. Due to demonstrated unique symptoms of CG that are different from the other DSM disorders, the inclusion of 'Persistent Complex Bereavement Disorder' as a distinct clinical entity was considered for the fifth edition of DSM. However, the DSM-5 committee argued that there was no consensus

at present for the addition of a diagnostic category because of two main reasons. First, it was specifically stated that the death of a loved one is a common experience and a 'trigger' for MDD or other adjustment disorders. Second, the committee specifically noted bereavement as a 'normal stressor', but that a more severe pathology and the elimination of the grief may label individuals as 'mentally ill' and may inadvertently encourage unnecessary treatment with medication (Pies, 2013, Kenneth, 2013).

There is considerable debate about the inclusion of a new diagnostic entity to describe persistent and maladaptive grief reactions. The first debate is that grieving individuals may be diagnosed too early in their grieving process, and the diagnostic criteria may pathologise normal grief reactions. Accordingly, over diagnosis may lead to unnecessary treatment for normal distress (Kristjanson et al. 2006). Additionally, fears of stigmatisation can also be experienced by those who are diagnosed with CG. Stigma generally appears as a burden for people because psychiatric disorders exist on a continuum with normal functioning. As a result, rather than the first step for treatment, the diagnosis might be perceived as a negative judgment (Shear et al. 2013, Zachar 2015). Moreover, grief shows itself differently between cultures and religions; therefore, one type of diagnostic system should not be applicable to all cultures and religions. Lastly, it was also argued that MDD, PTSD and anxiety disorders can adequately explain the abnormal reactions following bereavement and additional diagnostic criteria are not required (Bryant 2013).

In contrast to these views, several major justifications can be put forward for including a diagnostic entity to describe persistent and maladaptive grief reactions. To begin with, several studies have proved that the hallmark of grief is distinct from PTSD and MDD. As an example, one of the core differences between CG and MDD is the presence of yearning. Yearning for the deceased and seeking proximity to the deceased are often seen in CG but are usually not observed in MDD. Similarly, the primary emotional state in CG is sadness but it is fear and horror in PTSD (Bryant 2012, Shear et al. 2016). There is also a distinction between CG and other existing disorders in terms of response to treatment. According to previous researches, CG is unresponsive to antidepressants or standard psychotherapy; however, the use of CG-targeted psychotherapy is effective for symptom reduction (Shear et al. 2005).

Moreover, in one hand, grief is evaluated as a transcultural phenomenon. Cultural and religious factors play a major role in determining the parameters of grief. On the other hand, the most common manifestations of CG has been defined and demonstrated across a wide range of cultures. Even grief reactions are highly affected by the cultural ingredients; they can be reliably detected with standardized instruments, such as the Texas Revised Inventory of Grief (TRIG) or the Inventory of Complicated Grief (ICG). Therefore a single diagnostic system can be constructed (Shear et al. 2016). Moreover, although most individuals with CG, unfortunately, do not seek professional help, the addition of diagnoses related to the disorder in the DSM and ICD may bring more public attention to CG and may increase the number of individuals seeking help for their symptoms. Lastly, diagnostic criteria are also important for clinicians to familiarize themselves with the syndrome of CG, to recognize and treat maladaptive grief responses effectively (Boelen et al. 2006).

Throughout the current review, as it was demonstrated CG has unique symptoms which are different from existing psychiatric disorders and should be treated using

strategies and techniques that specifically target the syndrome of CG. Clinicians should be aware of that grief reactions are highly affected by the cultural ingredients and assessment of symptoms should assess through these variables.

There is still a need to enhance the knowledge about the determinants involved in the maintenance and development of CG for the early identification of those at risk for the disorder and for the development of effective treatment interventions. Therefore, more researches are needed to raise the public and professional awareness of CG, in order to ensure that individuals suffering from the condition receive required support. More researchers are invited to develop personalized and patient centred approach to grief, considering individual history, nature of loss, and clinical characteristics of the grieving process. Further research is also needed to identify empirical evidence related to children and adolescents. In particular, the criteria used to define CG in child and adolescents and instruments most appropriate for measurement of CG in child and adolescent population.

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