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Recognition and Treatment Modalities for Complicated Grief
in the Bereaving Widowed Elderly

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PERMISSION

Title Recognition and Treatment Modalities for Complicated Grief in the Bereaving
Widowed Elderly

Department Nursing

Degree Master of Science

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Date April 18th, 2012

Abstract

Reactions to spousal bereavement are very individualized; while a large majority of individuals are able to navigate their way through the bereavement process, there are a significant number who can't. Individuals who suffer from complicated grief are thought to be essentially stuck in a chronic and intense state of mourning that lasts longer than six months post loss. As one would expect, adverse health outcomes are a consequence of untreated complicated grief. It is the purpose of this paper to present the reader with evidence that there are effective treatment interventions for complicated grief. Additionally, a second purpose of this paper is to create a pamphlet to be used by clinicians in a variety of health care settings. This pamphlet will provide evidence based research on recognition of complicated grief, risk factors, and effective treatment interventions. The pamphlet will enhance clinicians' awareness of complicated grief, provide treatment options and will reduce the increased morbidity and mortality rates associated with untreated complicated grief.

Key Words: complicated grief, bereavement, treatment, and pamphlet.

Recognition and Treatment Modalities for Complicated Grief in the Bereaving Widowed Elderly

According to the U.S. Census Bureau (n.d.), by the year 2030 the numbers of individuals over the age of 65 will more than double to 80 million. This will make every one in five individuals elderly, making it the fastest growing population. Within this population of individuals, dealing with the death of a loved one is nearly inevitable. It is estimated that nearly 800,000 individuals suffer the loss of a spouse each year (Hensley, Slonimski, Uhlenhuth, & Clayton, 2008). Spousal bereavement is considered one of the most stressful life events that an individual encounters.

Reactions to bereavement can vary from individual to individual and can include feelings of sadness, shock, hallucinations, irritability and numbness (Rozenzweig, Prigerson, Miller & Reynolds, 1997) to mention a few. While many who suffer the loss of a spouse are able to navigate their way through the grieving process and do so without formal treatment, there is a “significant minority where grief is complicated by rumination or excessive avoidance that derails the progress of grief” (Zisook, Simon, Reynolds, Pies, Lebowitz, Young, Madowitz & Shear, 2010, p. 1097). This is also known as complicated grief (CG).

When looking at what distinguishes “normal bereavement” from CG, it is said that CG has distinguishable features that are quite different than those of bereavement. In an article by Shear, Frank, Houck and Reynolds III (2005), an excellent description of the key features associated with CG were found: (1) a sense or feeling of disbelief regarding the death; (2) feelings of anger and bitterness towards the death; (3) intense yearning and longing for the deceased with recurring painful emotions associated with the deceased; and (4) preoccupation with thoughts of the deceased and intrusive thoughts related to the death. It is noted that many of the features of CG are present in individuals who are displaying a “normal bereavement pattern”

but these features diminish over time and acceptance of the death increases (Zhang, El-Jawahri, & Prigerson, 2006). In individuals who suffer from CG, the bereavement pattern is maladaptive; they become stuck in a constant state of mourning (Zhang et al., 2006).

Currently a diagnosis for CG does not exist in the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV. However, it is being considered and under review for the publication of the DSM V. Literature suggests that features of CG are significantly different from disorders that are commonly misdiagnosed in bereaving individuals. Post-traumatic stress disorder (PTSD), anxiety, major depression disorder and bereavement related depression are often the diagnoses that bereaved individuals receive from their providers. This poses a problem in that treatment for each of these disorders varies, as does the efficacy of the treatment. The lack of a diagnosis has led to underdiagnosing and lack of knowledge on efficacious treatment options as well as increased mortality rates.

According to Zisook et al. (2010), there is sufficient evidence that individuals who suffer from CG symptoms need treatment interventions and that without treatment, the grief can become disabling. Further, literature states that morbidity and mortality rates increase after individuals lose their spouses, especially among the elderly. The elderly are a particularly vulnerable population in that the majority have underlying medical issues that are often compromised by the process of aging, which can further hasten the effects of the grieving process.

As clinicians, it will be imperative that one is able to recognize signs and symptoms of CG as well as having the ability to incorporate knowledge of effective treatment modalities in efforts to curtail adverse health conditions that can result from the loss of one's spouse.

Purpose

This independent study will review the literature as it pertains to elderly individuals who have suffered the loss of their spouses, in efforts to be able to recognize signs and symptoms that are specific to CG, as well as effective treatment modalities for CG. The literature review will also include both pharmacological and nonpharmacological interventions that have been utilized in treating CG. The clinical question to be answered is, "Are there effective treatment modalities for elderly individuals who suffer from complicated grief"?

Upon completion of this literature review, an educational pamphlet will be created for health care providers to use in clinical settings to discuss the research findings on recognition and treatment of CG. The information in this pamphlet will be written in such a way that average patients would be able to read with ease. The pamphlet will include the signs and symptoms and effective treatments, as well as community resources that are available for widowed elderly with CG. The pamphlet will be used for educating future patients as well as health care providers and colleagues.

Significance

Approximately 2.5 million people die each year in the United States. Research suggests that this leaves approximately five people for every death to mourn. Given these statistics, it is estimated that more than 1 million of these people are expected to develop CG (Shear et al., 2005). It is known that individuals who suffer from untreated CG are at a heightened risk for developing negative health consequences, or even death. What further complicates this is the fact that many providers are unsure of how to identify and properly treat patients who may be suffering from CG. It has been suggested that the reason for this is that CG is not a diagnosis in

the DSM IV. The DSM V is currently being rewritten and the inclusion of CG is under consideration once again.

Nursing science and nursing practice delivers care through a holistic perspective. Nursing recognizes that each individual is unique, as well as complex. The holistic perspective encompasses the biological, psychological, social and spiritual aspects of each person (Hamric, Spross, & Hanson, 2009). Additionally, each of these pieces interacts with the other throughout one's lifetime. This study has the ability to impact nursing science and practice by providing a pamphlet based on the literature reviewed in this study. The pamphlet could serve as a valuable resource for a variety of health care providers by assisting them in identifying CG, as well as guiding them in setting up individualized treatment plans tailored to their patients. Both pharmacological and non-pharmacological treatments have been listed within the pamphlet and have been shown to be effective in treating CG, as well as community resources that are available. By enhancing knowledge, health care providers will have the ability to recognize an abnormal bereavement pattern such as one seen in CG. Further, by identifying and treating individuals with CG, morbidity and mortality rates may be reduced.

Theoretical Framework

Lenz, Pugh, Milligan, Gift and Suppe's Theory of Unpleasant Symptoms will be used as the theoretical framework to guide the research gained in this paper, as well as to develop a pamphlet that can be used by clinicians in a variety of health care settings. Lenz et al.'s theory of unpleasant symptoms "...was based on the premise that there are commonalities in experiencing different symptoms among different groups and in different situations" (McEwen & Wills, 2011, p. 286). Lenz et al. (1997) discusses the three major components to the theory:

the symptoms that the individual is experiencing, influencing factors that can either produce or affect the symptom experience, and the consequences of the symptom experience.

The symptoms that an individual experiences are the central focus of the model. It is stated that individuals can experience multiple symptoms that are likely to catalyze each other, which can further be applied to the symptoms associated with CG. Lenz et al. (1997) further stated that each symptom is thought to be a multidimensional experience, and that symptoms can be common across clinical populations. The model used by Lenz et al. describes how psychological, physiological, and situational factors intertwine with the various symptoms associated with the illness and therefore influence the outcome experienced by the individual.

Individuals who suffer from CG are in need of effective treatment that is targeted towards alleviating their symptoms and curtailing the ill effects it may have on their overall health status. The intention of this paper is to provide information to develop a pamphlet that will create awareness and enhance knowledge on CG. This pamphlet will serve as a resource for nursing staff, clinicians and patients to have the ability recognize if an individual is suffering from CG and to provide effective treatment interventions that will decrease symptoms and thereby reduce the morbidity and mortality rates associated with untreated CG.

Definitions

There are several terms that require definition and clarification of efforts to provide a sound understanding of the concepts presented. These terms include bereavement, mourning, and grief.

- 1) Bereavement: "...refers to the period after loss during which grief and mourning occur" (Buglass, 2010, p. 44).
- 2) Mourning: "...is the outward and active expression of grief" (Buglass, 2010, p. 44).

- 3) Grief: According to Greenstreet (2004) as cited by Buglass, (2010) “Grief describes an individual’s personal response to loss and has emotional, physical, behavioral, cognitive, social and spiritual dimensions” (p. 44).

Process

The author searched a variety of databases which included CINAHL, PubMed, Scopus, Cochrane, and PsychINFO. Searches were conducted utilizing PubMed and PsychINFO as their “...content is related to psychology and medicine” which specifically addressed the author’s clinical question (Fink, 2010, p. 19).

The search initially began with PubMed and included search terms of “bereavement”, “complicated grief”, “elderly”, “aged”, “treatment”, “therapy”, “antidepressants”, and “grief”. The author also utilized specific drug names such as “citalopram”, “escitalopram”, “Prozac”, etc. The author then reviewed Medical Subject Headings (MeSH) terms to determine the most appropriate search related to the clinical question above. The most appropriate search of MeSH terms were “bereavement” and “aged” which yielded 1589 articles. This was further limited with the search term “therapy” which yielded 41 articles. The author was able to discern whether the article was appropriate to the clinical question by the title of the article and/or by reading the abstract. The author then “mined” articles with hopes of obtaining further studies and references

Scopus was also utilized when “recurring” authors were present. This provided a search that was based upon a specific author. Recurring authors that were searched were Zisook, Shear and Hensley. The mentioned authors have done extensive research on bereavement related disorders.

The search was further explored by using PsychINFO database to find correlations in regards to ill health and untimely death. Search terms that were utilized included DE “Bereavement” OR DE “Grief” and Epidemiology. This search resulted in 118 articles where the author was able to decipher the relevance to the clinical question, “Are there effective treatment modalities for elderly individuals who suffer from complicated grief?” by either the title of the article or the abstract and was able to narrow this number. A total of fifteen articles were included in this review.

The information taken from this literature search will be used to develop a pamphlet for clinicians in a variety of health care settings that will enhance recognition of CG, risk factors as well as effective treatment interventions to be used. The pamphlet will be critiqued and evaluated by the author’s mentors in practice, as well as fellow colleagues and course instructors. Revisions will be made based upon recommendations and the pamphlet will then be presented to the author’s mentors in practice. Copies will be provided to them to dispense or utilize at their discretion.

Review of the Literature

The literature found regarding CG has proved there are efficacious treatment modalities used to diminish symptoms associated with a pathological bereavement pattern. Given the significant consequences surrounding untreated CG in the elderly, there is a need for effective treatment interventions. By providing education on efficacious treatments, morbidity and mortality rates may decrease. Research shows that individuals who suffer from CG are at increased risk for developing cancers, cardiac events, hypertension, ineffective coping with increased tobacco and/or alcohol consumption, and suicide. Enhancing awareness by providing

an educational pamphlet to be utilized in various health care settings would provide recognition and treatment options for those whom suffer from CG.

The following review and critique will examine six clinical trials conducted by Hensley, et al. (2008), Zygmunt, Prigerson, Houck, Miller, Shear, Jacobs, & Reynolds III (1998), Pasternak, Reynolds III, Schlemitzauer, Hock, Buysse, Houck, & Perel (1991), Jacobs, Nelson, & Zisook (1987), Zisook, Shuchter, Pedrelli, Sable & Deaciuc (2001), and Boelen, Keijser, Van den Hout & Van den Bout (2007); six randomized control trials by Cruz, Scott, Houck, Reynolds III, Frank & Shear (2007), Wagner, Knaevelsrud, & Maercker (2006), Wagner, Knaevelsrud, & Maercker (2007), Shear, Frank, Houck, & Reynolds III (2005), and Rosner, Lumbeck, & Geissner (2011); two meta-analyses conducted by Wittouck, Van Autreve, De Jaegere, Portzky, & van Heeringen (2011), and Currier, Neimeyer, & Berman (2008); one cohort sequential study conducted by Ott (2003); and one evidence based guideline by Zhang et al. (2006).

The literature reviewed for this study discussed different treatment modalities that have been shown to be efficacious in treating CG. The studies presented will be divided into pharmacological interventions and non-pharmacological interventions. This will be done in an effort to provide a generalized flow to the review of literature.

Evidence thus far, consistently shows that symptoms of complicated grief are diminished through the use of antidepressants (Hensley et al., 2008; Pasternak et al., 1991; Zygmunt et al., 1998; Jacobs et al., 1987; & Zisook et al., 2001). While many of these studies are greater than ten years old, they should not be disregarded as they are still valuable studies that confirm the effectiveness of using antidepressants in treatment of CG.

In a study conducted by Hensley et al. (2008) in Albuquerque New Mexico, the primary objective was to evaluate whether treating bereavement-related depression with escitalopram

demonstrated an improvement in depression ratings following the death of a close family member. This study had an open-label design. Subjects in this study had an age range from twenty to seventy-six whom had experienced a loss within twelve months. The sample size was thirty (n=30). Of this sample, twenty seven of the subjects were female and three were male. The subjects were classified as either having complicated grief or uncomplicated grief based on using the Inventory of Complicated Grief (ICG) scale. Thirty subjects were started on escitalopram on their second visit and attended scheduled visits over a period of twelve weeks. Outcome measures used the analysis of variance for repeated measures (ANOVA) and it was implemented using the Number Cruncher Statistical System.

The findings in this study showed that escitalopram showed improvement in symptoms of depression, anxiety as well as grief. Escitalopram was generally well tolerated in this sample with few side effects reported. The study included a variety of bereavement losses which further generalized the study as well as the ethnic diversity represented in the community in which the study took place. Although the results of this study regarding effective treatment in CG are promising, there are confounding limitations that one should be aware of.

There are several caveats to this study that should be explored. Given the small sample size and short duration of the study, it did not provide an absolute consensus that escitalopram should be considered effective in treating CG. It was known that antidepressants can take up to three months before a decrease could be seen in depressive symptoms. It should also be noted that in this study, participants were able to receive psychotherapy outside of the study which could further skew the results. Begging the question, "Did the escitalopram decrease their depression symptoms or was it the psychotherapy"? Further, one could argue that a combination of these two therapies created the decreased symptoms and that it was not one or the other.

Pasternak et al. (1991) conducted an open-label clinical trial study to evaluate whether bereavement-related depression in later life responds effectively to nortriptyline. This study was an open-label clinical trial where a sample of thirteen elderly bereaved depressed adults whom were a part of a larger group participating in an investigation of EEG sleep changes that were associated with recent spousal bereavement-related depression. The sample age ranges at the time of entry were 61 to 78 years old. This included five men and eight women. The average timespan from the death of the spouse was 11.9 months, with a range from 2 to 25 months. Interestingly, this study added twenty additional subjects that met the inclusion criteria that they were non-depressed bereaving adults. Analysis of the sample was measured using the depression ratings (HAM-D), the Global Assessment Scale (GAS), the Beck Depression Inventory (BDI), the Texas Revised Inventory of Grief (TRIG) the Interpersonal Support Evaluation List (ISEL) and the Cumulative Illness Rating Scale (CIRS).

Results of this study showed that there was significant improvement in the bereavement related depression symptoms through the use of nortriptyline. Scores of the HAM-D, BDI and the Brief Symptom Inventory (BSI) showed improvement of 67.9%, 68.4% and 54.5% respectively. Nortriptyline was well tolerated by all thirteen subjects as no one had to discontinue use.

In an open-label clinical trial Zygmunt et al. (1998) compared the effectiveness of treating complicated grief symptoms in adults with paroxetine with an ongoing controlled study utilizing nortriptyline and its treatment effects in bereavement related depression by Pasternak et al. (1991). A sample of fifteen bereaved volunteers was recruited including ten from media ads, and five clinically referred to participate in the study. Their mean age was 56.9 years which included eleven women and four men. The losses suffered included eight spousal, five children,

one grandchild, and one parent. The majority of the subjects were Caucasian (14) and one was black. Analysis of the scores occurred at baseline and at week sixteen on the fifteen paroxetine subjects. A comparison of the changes in scores on the HAM-D and ICG utilized a Spearman's rho correlation.

The findings of this study reported that the level of complicated grief symptoms decreased 53% in the subjects whom were treated with paroxetine. The depression ratings also decreased by 54%. This study concluded that both paroxetine and nortriptyline showed comparable results in reducing complicated grief symptoms and depression ratings through the use of the ICG and HAM-D.

The two medications that were compared in this study, paroxetine and nortriptyline, are antidepressants from different classes; selective serotonin reuptake inhibitor (SSRI) and a tricyclic antidepressant (TCA) respectively. This enhances the credibility that antidepressants could be utilized as an effective treatment in CG. However, the lack of a control in this study and the small sample size are limitations that should be noted. Another limitation is that the duration of the study is relatively short and without follow-up. Further research is needed to determine the overall effectiveness of using these medications.

Jacobs et al. (1987) conducted a clinical trial in a moderate sized metropolitan area to evaluate the effectiveness of desipramine on bereavement related depression. This study included a sample size of ten. There were eight widows and two widowers. The subjects' age ranged from 36 to 65, all had suffered the loss of their spouse within 1-2 years. Improvement was measured by using the Hamilton Depression Rating Scale (HDRS), the Clinical Global Impressions (CGI) scale and a Raskin three-area rating of depression. These measurements occurred initially as well as at each visit that occurred every one to two weeks.

After four weeks of treatment with desipramine, 70% had moderate to marked improvement of their depressive symptoms, 20% had minimal improvement. This study was very short in duration, a total of four weeks. After the four weeks of treatment, the subjects were referred back to their primary provider without follow-up within the study. This was a major limitation to the study. Further, the sample size of the study was small and lacked a control group.

Another study regarding pharmacological interventions was conducted by Zisook et al. (2001). This study was an open-label clinical trial based out of San Diego County that set out to evaluate whether bereavement responds effectively to bupropion sustained release. The sample of twenty-two subjects whose ages ranged from 45 to 83 years who had all lost their spouses within the previous six to eight weeks. There were 17 females and five males. Ethnicity was reported as 19 Caucasian, two Hispanic and one African American. Improvement was measured by using the HAM-D, CGI scale, TRIG, and ICG.

Assessments occurred during the initial assessment and at follow-up approximately eight weeks later. Out of the initial sample of 22, there were 14 subjects that completed the study. The initial sample as well as the completer sample showed statistically significant improvement on the HAM-D and CGI scale. Findings of this study showed there was moderate improvement in the grief score and that the depression score showed significant improvement.

Strengths associated with this study were that this study supported literature where SSRIs and tricyclic antidepressants were effective in treating bereavement related depression. Further, bupropion use in the elderly is safe and has minimal side effects. However, the lack of a control group is a major limitation as well as the small sample size. Another caveat is that the inclusion to this study required the loss of the subjects' spouses during the previous six to eight weeks and

the duration of the study only occurred over four months. Normal bereavement patterns typically improve over the first six months. Abnormal bereavement patterns, such as those considered in complicated grief generally aren't assessed until three to six months post loss.

The antidepressants that were studied included escitalopram, nortriptyline, bupropion sustained release, desipramine, and paroxetine. There has not been a study to date, that this author is aware of, that recommends one antidepressant over the other for use in elderly bereaving adults. Further, many of these studies were conducted in the 1980s and 1990s, indicating the need for more current research.

Literature suggests that antidepressants could be considered effective in treating bereavement related depression and may reduce symptoms of complicated grief. There is a need for larger studies as well as ones with a control group. Many of the studies suggest there is an ethical dilemma of including a control group when using pharmaceuticals; the dilemma specifically relates to not treating a group who is suffering from CG.

When looking at nonpharmacological treatment options, literature consistently shows that various forms of Cognitive Behavioral Therapy (CBT) produces a reduction in CG symptoms and overall severity of CG. Studies further suggest that therapy targeted specifically towards bereavement has been shown to be more efficacious over more generalized forms of therapy.

A clinical trial conducted by Boelen et al. (2007) compared the effectiveness of CBT with a nonspecific treatment through supportive counseling in treating CG. The sample was taken from seven outpatient clinics located in the Netherlands. Of this sample, 14 were male and 40 were female (n=54). The types of loss suffered by the subjects ranged from loss of a spouse/partner (n=15), a child (n=12), a parent (n=15) and other losses (n=12). Each of the

subjects was recruited through various referral sources which ranged from self or professional as well as through advertisements in newspapers and the internet.

Inclusion criteria set forth by Boelen et al. (2007) were such that the subject must have experienced a loss greater than two months ago with a score of at least 25 on the ICG.

Additionally, CG was to be their primary problem and reason for seeking therapy. Individuals were excluded from the study if there was current substance abuse/dependence, psychotic symptoms, risk of suicide, severe depression, or those currently receiving other psychotherapy.

Individuals were allocated to three groups through minimization. The first group (n=23) received cognitive restructuring (CR) with an addition of exposure therapy (ET). The second group (n=20) received ET with CR added later during therapy. The third group (n=11) received supportive counseling (n=11). Each subject was measured at three separate intervals which included pre-treatment, mid-treatment, and post-treatment by using a multivariate analysis of variance (MANOVA). An analysis of variance for repeated measures (ANOVA) was conducted following the three measurement intervals on the outcome measures. The treatment effect sizes (ESs) were calculated using Cohen's *d* statistic.

The results of the study concluded that the ES was greatest for the first group who received ET for the first six sessions. ESs from mid-treatment to post-treatment showed that adding ET to CR produced an additional effect over adding CR to ET. Overall, this study concluded that CBT conditions that included CR and ET were more effective than SC alone. Given that this study utilized therapy that targeted symptoms of CG and compared it to a control group who didn't receive such treatment; it further solidifies the efficacy of using a CBT approach. The effectiveness of ET with CR is comparable to a study conducted by Shear et al. (2005).

Shear et al. (2005) conducted a randomized controlled trial that set out to compare the effectiveness of treating CG through interpersonal psychotherapy (IPT) and complicated grief treatment (CGT). The sample from this study was taken from a university-based psychiatric research clinic as well as from a low-income African American community. The subjects were recruited through professional referral, self-referral, and media advertisement, which was very comparable to how Boelen et al. (2007) recruited their sample. Further, both of these studies used the same assessment tool, the ICG.

Shear et al. (2005) discussed the inclusions which were a score of greater than or equal to 30 on the ICG and the loss suffered must have occurred at least six months prior to the study. If subjects were utilizing antidepressants, they had to be at a stable dose for a minimum of three months. Subjects who were current substance abusers or had a history of dependence within the past three months were excluded as well as those with a history of psychotic disorders, bipolar disorder, and suicidal ideation requiring hospitalization, those with concurrent use of psychotherapy, and those who have a pending lawsuit related to the death.

The sample (n=95) included 83 women and 12 men who's ages ranged from 18 to 85 years old. The participants were assigned randomly to one of two groups. The first group was the CGT group (n=49) and the second group was the IPT group (n=46). The demographics of the sample were distributed in a fairly even manner between the two groups, as were the types of losses suffered. The relationships to the deceased included a spouse/partner, parent, child, and other which are comparable to the study conducted by Boelen et al. (2007).

Conchran-Mantel-Haenszel general association analyses were used to compare the responder rates for the two groups and Kaplan-Meier curves were used to explore the time to response. SAS software, version 8.2 was used for all of the analyses. The mean number of IPT

and CGT sessions was 16 and the mean time to complete the sessions was 18.4 weeks and 19.4 weeks respectively.

This study showed better response to CGT versus IPT, however both showed positive responses. Within this study, subjects who were taking stable doses of antidepressants had marginally better response rates versus those who were not taking antidepressants. Unfortunately, this study does not specifically address which antidepressants the subjects were taking. Given that there were better response rates with concomitant use of both pharmacological and nonpharmacological treatment, perhaps this could be a better treatment option. At this time, further research is needed to validate its effectiveness.

A study conducted by Cruz et al. (2007) further explored the aforementioned study conducted by Shear et al. (2005) through a secondary analysis. The aim of the study was to distinguish whether ethnicity played a role in the presentation symptoms of CG or in their treatment outcomes.

The sample for this study was derived from Shear et al. (2005) that including nineteen African Americans and nineteen Caucasian Americans; all of which had CG. The subjects were randomly assigned to receive IPT or CGT. Since this was a secondary analysis of a previous study, the inclusion and exclusion criteria remained the same, as did the treatment and analyses.

The results of the study showed that the African-American and Caucasian-American participants demonstrated no differences in the pre-treatment severity of symptoms or in treatment engagement or response. Further, the authors of this study concluded that one should not expect to see a difference in clinical presentation of CG or in the response to treatment based on one's ethnicity; specifically comparing African Americans and Caucasian Americans.

Given that the sample size was quite small, and only two ethnic groups were compared, this was a considerably vague generalization to make. The study would have more credibility in regards to ethnicity if multiple cultural differences were taken into consideration. This study does however provide insight; it gives way to another avenue that needs further exploration given that the majority of the studies thus far are predominantly Caucasian participants.

Wagner et al. (2006) explored an alternative to the typical face-to-face CBT; they conducted a randomized controlled trial to determine whether an internet-based CBT approach would benefit individuals who suffered from CG. The sample was recruited through advertisements and links that were posted on psychology websites, websites of organizations of bereaved persons, as well as announcements in print media. This study involved participants who were fluent in German.

Participants in this study met the inclusion criteria: symptoms of intrusion, avoidance and maladaptive behavior which were caused by the loss of someone significant in their life. Applicants were excluded if they were receiving concurrent therapy elsewhere, substance abuse, younger than 18 years of age, severely depressed or having suicidal ideation, at risk of psychosis, dissociative tendency, not fluent in German or if the participants loss was less than fourteen months ago.

The sample of 55 participants whose ages ranged from 19 to 68 years old were randomly assigned to two groups; the treatment group (n=29) or the waiting condition group (n=26). The types of losses suffered in this study were consistent with previous studies such as partner, parent, child, friend, or relative (Boelen et al., 2007; Shear et al., 2005; & Cruz et al., 2007). The type of loss in this study however was predominantly the loss of a child.

The design of this study included the treatment group and waiting condition as well as the effect on pre-treatment as opposed to post-treatment. Various scales were utilized to measure the participants' symptoms of CG and measure improvement of these scores; the BSI for anxiety and depression, the Impact Event Scale (IES), and a failure to adapt scale. MANOVAs and ANOVAs were used to test for interaction effects between the two groups. The differences in scores from pre-treatment and post-treatment between the groups were analyzed and effect sizes were calculated using Cohen's *d* for repeated measures.

The results of this study showed very large effect sizes at post-treatment and at the three month follow-up in regards to CG symptoms. Further, this study concluded that the internet-based treatment led to significant reductions in CG symptoms such as intrusion, avoidance, and maladaptive behaviors. It was also reported that participants had a reduction in depression and anxiety.

Interestingly, 83% of the participants in this study reported they felt the contact between themselves and the therapist was "personal" and 85% felt it was "pleasant" to communicate with the therapist exclusively through email. Only 20% felt as though they "missed the face-to-face contact" with the therapist. Perhaps the stigma of "ineffective coping" lends favor to individuals who may otherwise forgo treatment in fear of being labeled. The anonymity may be appealing to such individuals, including those who have incorporated the technology of the internet into their life.

An explorative study conducted by Wagner et al. (2007) sought to further explore the effects of the internet-based CBT intervention in CG (Wagner et al., 2006) on post-traumatic growth and optimism and whether the improvement in symptoms was due to the increase in post-

traumatic growth or optimism. The inclusion and exclusion criteria, participant demographics and relationship to the deceased are described in the previous study (Wagner et al. 2006).

Measurements of this study were assessed at pre-treatment, post-treatment, three month and fifteen month follow-up. Participants were assessed by self-report utilizing various assessment tools. The Post-Traumatic Growth Inventory (PTGI) was revised to a short form (PTGI-SF) to assess perceived outcomes based on personal strength, spiritual change, relating to others, appreciation of life, and the outlook of new possibilities. The Life Orientation Test-Revised (LOT-R) was utilized to assess the participants' individual optimism. Again, the effect sizes were calculated using Cohen's *d* and analyses utilized ANOVAs.

The results of this study indicated that the internet CBT intervention correlated with a substantial increase in post-traumatic growth however there wasn't a correlation in regards to increased optimism. Further, this study contributes to previous literature that CBT is an effective treatment modality for CG and can enhance post-traumatic growth in individuals.

Each of the studies discussed thus far have explored therapy interventions for CG in an outpatient setting. Rosner et al. (2011) were the first to evaluate individuals in an inpatient setting. They conducted a randomized controlled trial that set out to evaluate whether inpatients with CG benefited from additional CG interventions. This study screened all patients for CG who were admitted from January of 2006 to June of 2007. Additionally, this study included individuals who had at least one other diagnoses besides CG. The majority of other studies excluded such individuals.

The sample included subjects whose ages ranged from 17 to 79. Two groups were formed: the complicated grief group ($n= 50$) and the Treatment as Usual (TAU) group ($n=22$). Participants were placed into the respective groups based upon when they were interviewed and

provided they met the inclusion criteria. Inclusion criteria set forth included a positive screening result for CG, willingness to participate and no acute crisis. Participants who were interviewed from January of 2006 to June of 2006 and met the criteria were placed in the TAU group. Participants who were interviewed from July of 2006 to June of 2007 and met the criteria were placed in the complicated grief group. Between the two groups, age, gender and education did not vary.

The treatment interventions varied between the two groups in that the complicated grief group utilized CBT that included grief specific protocols, where the TAU group did not include the grief specific interventions. It should be noted that both groups received TAU therapy. The CG intervention group received nine double sessions twice per week that lasted 4.5 weeks. The TAU consisted of one weekly individual therapy session, two weekly group sessions and one or two weekly sessions that related specifically to the participant's primary diagnosis.

The ICG was the primary outcome measurement tool used in this study. Other scales were used which included the BDI and the Symptom Checklist-90-Revised (SCL-90-R). These were completed at admission and discharge; no follow-up was completed in this study. The sums of scores were computed for each participant and ANOVAs were conducted.

Results from this study showed that treatment of CG in inpatient settings is effective and that treatment specifically tailored to grief symptoms is more effective. Further, this study suggests that it is useful to screen individuals for CG and provide grief-specific interventions for inpatients, as well as those with comorbid disorders. Again, this study had a relatively small sample size and the unequal group sizes could be considered a limitation to the study. The consistency of the scales utilized in assessing CG is beneficial as one is able to make better comparisons of other studies that have been conducted.

In a meta-analysis, Wittouck et al. (2011) sought to determine the short-term and long-term effects of specific grief interventions utilized for adults. This study included only randomized controlled trials that used specific grief interventions to treat or prevent CG. The researchers searched electronic databases of Web of Science and PsycArticles using search terms and Boolean operators: “bereave OR mourning OR grief OR survivor OR widow” (p. 70) and “psychotherapy OR therapy OR intervention OR treatment OR managing OR counseling OR support OR help” (p. 70). The articles that met the inclusion criteria were further mined for other eligible studies. Further, only studies that were published between 1990 and 2007 were utilized in this study. A total of 14 citations met the inclusion criteria and were included in this meta-analysis (n=14).

Wittouck et al. (2011) found through this study that the effectiveness of preventative interventions showed inconsistent support; however it is imperative to note that the study did show that treatment interventions were effective in both short-term and long-term CG symptoms. This study further pointed out that the majority of the participants in the studies analyzed were predominantly female. This finding is consistent with the studies noted previously within this review of literature. Furthermore, even though there was inconsistent support in the effectiveness of preventative interventions, this should not be applied across the board for all individuals. If an individual suffering from bereavement seeks treatment, treatment should not be withheld as it could be beneficial.

Currier et al. (2008) examined the effectiveness of bereavement interventions in a meta-analysis they conducted. This review was based on 61 (n=61) outcome studies where only controlled studies were used. Of the studies that were included in this review, 48 were published peer-reviewed articles and 16 were unpublished dissertations. The comprehensive search was

done by utilizing PsychINFO, PsycARTICLES, Medline and Dissertation Abstracts International using search terms such as bereavement, grief, treatment outcome, intervention, control group and evaluation.

The measures of therapeutic outcomes were converted to a Cohen's *d* and what resulted from this study was that bereavement interventions were shown to be efficacious versus the non-treatment control groups. Further, the mean effect size at post-treatment in individuals who had poor bereavement adaptation was found to be significantly higher than in those studies with a universal population. Within universal populations, ones who didn't specifically display CG symptoms, the interventions failed to produce sizeable results versus the passage of time.

This study included more studies than the meta-analysis conducted by Wittouck et al. (2011); however both contributed to the growing body of literature that states psychotherapeutic interventions are effective in treating CG. Currier et al. (2008) discussed that interventions aren't always needed in a "normal" bereavement pattern and that interventions didn't show improvement within individuals navigating their way through a "normal" bereavement process. Evidence shows that the passage of time is what is needed when CG are not present, furthermore, individuals who suffer from CG indeed benefit from therapeutic interventions.

As one would expect, untreated CG can bring about many negative health consequences. A study conducted by Ott (2003) sought to determine whether CG caused an increase in mental and physical health problems specifically in bereaved spouses. This study was part of a larger study conducted by Howard, Lueger, Maling, & Martinovich (1993) in which the results of from that analysis were integrated with data retrieved one year later from the current study.

The sample of this study included 120 bereaved spouses who had recent deaths of their spouses and had no major "self-reported" mental health diagnoses. The subjects were primarily

Caucasian, 97%, and ranged in ages from 27 to 87. A cohort sequential design was used and subjects were grouped by their bereavement time (3 month intervals), starting at three months and continued up until 36 months bereaved. The actual data that was included was over an 18 month time period. Assessment tools that were utilized included the ICG and the Mental Health Inventory (MHI). The ICG was assessed at the beginning of the study and then again at three and six months later. The MHI was administered five times; at the beginning of the study and then at 2 three month intervals and finally, one year later. Participants were described as those with CG and those without complicated grief (NCG) based on their ICG scores.

The CG and NCG groups were analyzed on "...sociodemographic measures, participation in professional counseling, and attendance at grief support groups" (Ott, 2003, p. 256) by using chi square analysis. ANOVA was used to compare the MHI scores during each time frame for the two respective groups. A Pearson's correlation was calculated to assess the relationship between the MHI scores and CG status.

Ott (2003) discussed four observations that could be made from the data gained in this study: participants in the CG group didn't vary from the NCG group in regards to sociodemographic measures or whether participants engaged in professional counseling or grief support groups. The CG group perceived less social support and increased life stressors than those in the NCG group. The CG group had lower scores on the MHI and higher current symptoms starting six months after the loss of their spouse and remained significantly higher 18 months post-loss as opposed to those in the NCG group, and there was no significant difference in the prevalence of self-reported physical or mental health illnesses between the respective groups.

Only one evidence based guideline for diagnosis and treatment for CG was found. Zhang et al., (2006) provided a guideline to assist clinicians that discussed the difference between normal bereavement patterns as well as patterns associated with CG, differentiating CG from other mental disorders that are associated with bereavement, as well as effective bereavement interventions. Their primary objective for this update on bereavement was to "...provide information to guide clinicians in their evaluations of interventions with bereaved individuals" (Zhang et al. 2006, p. 1189).

As Zhang et al. (2006) points out, individuals who met the criteria for CG benefited the greatest from bereavement interventions. They further discussed the various types of interventions that are listed within this review of literature such as the use of pharmacological interventions as well as psychotherapeutic interventions such as CBT and CGT. These interventions have been shown to be efficacious in treating bereavement related depression and CG symptoms; however it was felt that further research is needed. This is very evident in regards to the need for randomized controlled trials and pharmacological interventions.

Discussion

Interpretation

It is not surprising that clinicians are often at a loss on how to effectively help their patients during times of bereavement. This is especially true when individuals display ineffective bereavement patterns, specifically when they are exhibiting prolonged grief such as those who are experiencing CG. Currently, there is no such diagnosis, which further contributes to the confusion. CG is now being considered for inclusion in the DSM V which could lend to effective treatment interventions. The possibility of CG as a diagnosis in the DSM V has

brought about increased attention, further research, and updates on what is currently known.

Essentially, it has now been put “back on the radar”.

Bereavement is considered a natural part of one’s life experience and, as one ages, these experiences become increasingly more frequent (Zhang et al., 2006). A tendency for clinicians to dismiss CG as “normal bereavement” may further compound the increased risk of mortality and morbidity associated with CG. Furthermore, there has been conflicting evidence on when to assess individuals who appear to be suffering from CG. It is suggested that this diagnosis could be made six months post loss and that individuals whom display an abnormal bereavement pattern is often seen after the six month timeframe.

The literature reviewed for this paper suggests that there are various treatment modalities that are considered effective in managing symptoms associated with CG. Pharmacologically speaking, only a handful of medications have been tested thus far in regards to treating CG. These medications included escitalopram, paroxetine, nortriptyline, bupropion, and desipramine (Hensley et al., 2008; Pasternak et al., 1991; Zygmunt et al., 1998; Jacobs et al., 1987; & Zisook et al., 2001). While each of these medications showed benefit in reducing bereavement related depression, they weren’t comparisons done with control groups. Research suggests that ethical reasons played a role in withholding medication from a group that could benefit from it.

Research suggests that when looking at nonpharmacological interventions, CBT has proved to be an effective form of treatment for CG. Many forms of CBT have been studied and evidence showed that incorporating grief therapy with CBT has proved to enhance overall scores on the ICG of patients with CG. These findings further solidify the assumption that to date, there are effective treatment options for CG, but perhaps the ultimate intervention has yet to be discovered.

By incorporating Lenz et al.'s theory of unpleasant symptoms to design a pamphlet for nurses and clinicians, it allows one to look at how each symptom the individual is experiencing has the ability to catalyze other symptoms and therefore contribute to ill effects on one's health. Treating the cluster of symptoms associated with CG through the use of CBT and or pharmacological interventions can alleviate the overwhelming burden the individual has succumbed to.

Outcome/Dissemination

The information gained in the review of literature was used to create a pamphlet that will aid health care providers to use as a resource for elderly widowed individuals suffering from CG by enhancing awareness of how to identify CG, effective treatment options, and provide community resources available (see Appendix). Once the pamphlet was completed, it was disseminated via email to peers and graduate nursing instructors to determine the effectiveness and clarity. The pamphlet was also critiqued by the author's mentors in practice. In total, six peers, three instructors, three physicians, one geriatric nurse practitioner and one physician's assistant provided feedback on the pamphlet. Many comments were positive with many constructive comments mainly on formatting and word choice for the ease of the reader. The comments were compiled and taken into consideration, revisions were made to the pamphlet, and professional copies were made for delivery.

The completed pamphlet was presented to the author's mentors in practice with an overwhelmingly positive response. Each of the providers reported that they had very limited knowledge in what CG actually is or how to treat it. The common response when asked what their thoughts were on CG was that it is when there is a difficult death or "complicated" circumstances surrounding the death. Providers felt as though they could recall specific

individuals they felt would have benefited from therapy which was tailored more towards alleviating symptoms, such as those mentioned in the pamphlet. The author's mentors felt as though the pamphlet would be an asset for patients who suffer from CG symptoms, as well as a great resource for other health care providers. It was recommended that the pamphlet be distributed among the community pastors and priests as they are often providing home visits during the bereavement period. Additionally, it was recommended to distribute the pamphlet to local funeral homes, as they could include it in their after-care program for bereaved individuals. Additional pamphlets will be printed and distributed as recommended.

Implications for Nursing

Practice

It is estimated that nearly 75% of all deaths occur in individuals 65 years and older; nearly half of these individuals result in widowed females (Zhange et al., 2006). Recent studies have indicated that a lack of a concrete diagnosis in the DSM IV has contributed to under diagnosing and a lack of treatment within this population. This could contribute to a lack of understanding of what CG is and what differences exist in normal bereaving patterns.

The ICG has proved to be an effective tool to use to identify individuals with CG. For individuals who have elevated scores on the ICG, treatment is warranted. It is imperative for clinicians to have an evidence based resource, such as a pamphlet, available to assist in providing knowledge of CG, risk factors, and symptoms as well as effective treatment options. If individuals who suffer from CG are left untreated, they are at a heightened risk of developing hypertension, depression, substance abuse, malnutrition, cardiac issues, and cancers (Zhange et al., 2006).

Education

Clinicians need to be educated on recognition of CG and treatment options that have proved to be effective. Clinicians also need to be aware of individuals who are at risk for developing CG. Education should include what a “normal” bereavement pattern looks like, as well as an “abnormal” bereavement pattern such as seen with CG. It is imperative that clinicians are aware that abnormal bereavement patterns are associated with increased morbidity and mortality. Further, clinicians should be educated on providing treatment interventions after six months post loss for individuals with CG; less than six months could represent a normal bereavement pattern that will likely improve with time.

Policy

In the practice setting, policy will need to be developed for individuals who are identified as having CG. The pamphlet that was created would provide a useful tool that will aid in recognition, risk factors, symptoms and treatment options available. Policy would be needed to utilize the pamphlet as an educational tool for clinicians to incorporate within their practice. Policy should include follow up for individuals to ensure that the treatment intervention that was selected was effective and if not, that a new intervention should be implemented.

Research

This review of literature revealed that there are limited studies in regards to elderly bereaved widows with CG. Again, this could be attributed to the lack of a current diagnosis in the DSM IV. With the consideration of including CG in the DSM V, CG is currently “back on the radar”. The inclusion of CG in the DSM V would likely provide an opportunity and need for further research.

Research showed that pharmacological interventions were useful in treating bereavement related depression; however the studies each lacked a control group. As it is mentioned earlier in this paper, authors of many studies felt as though it would be unethical to withhold treatment to those who clearly have a need. Further studies are needed to assess whether or not combined treatment could be considered efficacious such as CBT in conjunction with an antidepressant.

A large portion of the research conducted thus far has been predominantly female, it would be recommended that research should include or focus on more males. Within the elderly population, it is noted that a large majority are female widows which would suggest that perhaps this population is accurately assessed. Further research should also include various ethnic backgrounds as Caucasians have been the ethnic group predominantly studied.

Summary/Conclusions

After reviewing the literature, it is clear there are effective treatment options available for individuals who suffer from CG; however the lack of a concrete diagnosis contributed to under diagnosing. CG is associated with adverse effects on one's health if left untreated. Given that nearly 75% of all deaths occur in individuals over the age of 65 and half of these result in widowed females, the incidence rates of CG are expected to climb with the baby-boom generation. "Estimates suggest each death leaves an average of five people bereaved, suggesting that more than one million people per year are expected to develop complicated grief in the United States" (Shear et al., 2005).

Literature suggested that the use of CBT and pharmacological options have been shown to be effective treatment interventions for CG, further research needs to be done. Clinicians are often at the forefront in patient care and are looked upon as the ones who "can make it better".

In order to accurately diagnose and treat patients with CG, one needs to have the knowledge and resources available.

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Appendix

Community Resources

Rice Memorial Hospital Grief Center

- Brenda Wiese, Grief Center Coordinator
- 320-231-4714

Woodland Centers

- 1-800-992-1716

Lutheran Social Services

- 320-235-3411

Center for Grief, Loss, & Transition

- 651-641-0177
- www.griefloss.org

Area Clinics

Affiliated Community Medical Center

- 320-231-5000

Family Practice Medical Center

- 320-235-7232

Other Resources

Faith's Lodge

- 715-266-8200

Center for Loss

- www.centerforloss.com

"Healing is a matter of time, but it is also a matter of opportunity..."
Hippocrates

"Although the world is full of suffering, it is also full of the overcoming of it..."
Helen Keller

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Hope...



Complicated
Grief

What is Complicated Grief?

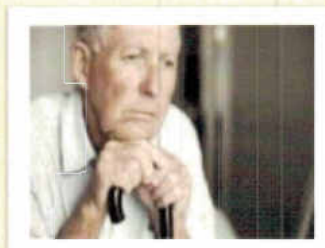
- Intense longing and yearning for the individual who has died.
- Recurrent distressing thoughts and emotions about the deceased that is unrelenting.
- Inability to concentrate on things aside from the loss.
- A sense or feeling of disbelief regarding the death.
- Feelings of anger and bitterness towards the death.
- These characteristics typically last longer than 6 months and interfere with one's daily functioning.

What is Normal Grief?

- In normal grief, emotions such as disbelief, depressed mood and yearning lessen with the passage of time; typically by 6 months after the loss.

If Complicated Grief is Left Untreated, What Can Happen?

- Increased morbidity and mortality
- Cancers
- Heart problems
- High blood pressure
- Increased tobacco and/or alcohol consumption
- Depression
- Suicide



Approaches to Treatment

Medications:

- Antidepressants have been shown to be effective in treating grief related depression as well as reducing symptoms associated with complicated grief.
- Lexapro, Pamelor, Wellbutrin, Norpramin, and Paulane medications studied thus far.

Therapy:

- Cognitive Behavior Therapy (CBT) has shown to be effective.
- Incorporating Grief Therapy in conjunction with CBT has shown to be even more beneficial in relieving symptoms of complicated grief.
- Support groups.