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GERIATRIC DISORDERS (W MCDONALD, SECTION EDITOR)

Bereavement: Course, Consequences, and Care

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Abstract This paper discusses each of several potential consequences of bereavement. First, we describe ordinary grief, followed by a discussion of grief gone awry, or complicated grief (CG). Then, we cover other potential adverse outcomes of bereavement, each of which may contribute to, but are not identical with, CG: general medical comorbidity, mood disorders, post-traumatic stress disorder, anxiety, and substance use.

Keywords Bereavement · Grief · Mourning · Complicated grief · Persistent complex bereavement disorder · Major depressive disorder · Major depressive episode · Post-traumatic stress disorder

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Introduction

The loss of something we hold dearly, whether it is of a loved one, or of a personally meaningful possession, can be a profoundly painful and disruptive experience. Loss sets off a cascade of homeostatic mechanisms aimed at helping the individual recoup the loss, when possible, or adapt to it, when

not. Loss also can be viewed as a stressor, which in certain circumstances, may trigger pathological responses. This manuscript will focus on one particular type of loss, the death of a loved one, also known as bereavement.

Considered one of life's most challenging losses, bereavement shares many features of other, non-bereavement types of loss. However, bereavement also has some unique features: it is almost always painful and disruptive, generally datable, and always irreversible. A universal response to bereavement, grief begins in an initial, "acute grief" form, a bitter but generally transient phenomenon which moves to "integrated grief," a less burdensome, but timeless, form of grief (see Fig. 1). However, for some individuals, in certain circumstances, the transition from the initial, acute grief response to integrated grief does not occur. Instead of healing, grief's symptoms are accompanied by complicating processes leading them to remain intense, protracted, and debilitating—a condition we call "complicated grief" (CG).

However, CG isn't the only potential problematic consequence of the death of a loved one. Like other losses, bereavement may spark a number of pathological responses: leading to new onset or worsening of general medical conditions; precipitating, intensifying or prolonging major depressive disorders (MDD); triggering mania, posttraumatic stress disorder (PTSD) or anxiety disorders; and possibly exacerbating problems with substance use and abuse, among others [1••]. This paper discusses each of these potential consequences of bereavement. First, we describe ordinary grief, followed by a discussion of grief gone awry, or CG. Then, we review other potential consequences of loss, each of which may contribute to, but are not identical with CG: general medical comorbidity, MDD, mania, PTSD, anxiety, and substance use.

"Ordinary" Grief

Grief, the response to the death of a loved one, is a universal, instinctual, and adaptive human experience. Loss of a loved one affects the bereaved, not only emotionally, but also physically, socially, cognitively, and spiritually. Some say grief is the price we pay for love — a price most of us consider well worth the cost. Recently, Katherine Shear, MD noted that grief is the form love takes when someone we love dies (personal correspondence).

Theorists have sometimes argued that there are stages of grief, akin to the stages of death and dying [2]. However, research has failed to support this idea. Rather, all bereaved persons grieve on their own terms, with uniquely individualized experiences, symptoms, trajectories, and time courses [3–5]. For some, grief is hardly noticeable; while for others, it can be a devastating experience, an emotional tsunami ripping apart a person's sense of meaning and belonging.

Normal grief also fluctuates over time within any given bereavement episode. Typically, emotions wax and wane in an oscillating manner as the mourning process unfolds. This has led some to describe grief as occurring in fits and starts [5]. We conceptualize grief as consisting of two forms: acute and integrated [6]. Acute grief is a preoccupying experience in which the bereaved can have feelings of disbelief; consuming thoughts and memories of the deceased; yearning, longing, and sadness; as well as a full range of other dysphoric emotions, including anxiety, guilt, anger, and shame. Positive emotions also occur and may be as frequent as negative ones as early as one month after the loss [7]. A bereaved person may feel joy in reminiscing about touching and amusing anecdotes, warmth in recalling the closeness they shared, and pride in honoring the deceased [8]. Moreover, while it can be devastatingly painful, bereavement can also be associated with a renewed appreciation for life, personal growth, and enhanced coping skills [9]. Although there are no good data about the time frame for acute grief, studies suggest that the transformation to integrated grief is usually well underway by six months [10]. Grief symptoms become less intense and frequent as the bereaved person finds a way to come to terms with the reality of the loss, reconfigure their relationship to the deceased, and redefine their own goals and plans.

The intensity of acute grief subsides and instinctively transitions into "integrated grief" as the bereaved person grows increasingly able to shift their attention from their deceased loved one to both the world around them and the future. Hallmark features of integrated grief include the ability of the bereaved to understand and accept the finality and consequences of the death, return to life, function adequately, envision their lives as again having the potential for happiness, and seek the companionship and love of others [5]. One is not cured of grief. Rather, integrated grief lasts throughout life and evolves over time [11]. Episodes of increased yearning, longing, or sadness may be triggered by anniversary dates, family holidays, celebratory life events, stressful life experiences, or other losses. These surges in grief symptoms generally attenuate within a short period of time.

Ideally, for most bereaved individuals, grief provides an opportunity to say goodbye, pay their respects, acknowledge the pain of loss, and mourn with the comfort and support of friends, relatives, and neighbors. Rituals can be an important and helpful part of mourning, instilling a sense of control over an otherwise uncontrollable situation [12] and serving as reminders that loss and suffering are shared by all humanity. Overall, the mourning process is the way bereaved individuals come to terms with their loss and ultimately transition to a life in which the deceased loved ones are not forgotten, but rather find a comfortable place in the bereaved individuals' hearts and memories.

Fig. 1 Loss, grief, and potential adverse consequences

Complicated Grief

The phrase "time heals all wounds" is often spoken to the newly bereaved as comforting words of advice. For many, this statement is accurate; time provides an opportunity to mourn the loss and, as time passes, the painful and debilitating symptoms of acute grief begin to subside. Eventually, integration of the loss occurs as one is able to find enjoyment and meaning in life again. However, for those struggling with CG, time does not heal the wound. In fact, the grief may become increasingly crippling as those with CG experience an intensified, chronic state of grief which does not get better with time.

CG is the response that occurs when maladaptive thoughts, feelings, or behaviors occur and derail the mourning process. Acute grief does not transition into integrated grief. The mourning process stalls, and the bereaved person feels stuck, indefinitely, in prolonged, acute grief. Some symptoms of CG resemble those of MDD and PTSD; however, CG has a unique pattern of clinical features which is distinct from these disorders. Although there is not yet consensus about the symptoms, time course, or name for this syndrome, it is clear that it can be reliably identified [13, 14]. Typical symptoms of CG include intense yearning and longing for the loved one; insistent intrusive thoughts about the deceased; inability to accept the death; excessive guilt; intense feelings of anger; avoidance of people, places, or reminders of their loved one; difficulty finding meaning in life; and feeling that they could or should have prevented the loss. CG is characterized by frequent, intense grief symptoms which cause significant distress and functional impairment.

While there is not yet research to confirm rates of CG, it is estimated that as many as 7% of individuals grieving a loss will suffer from CG [15]. Risk factors for developing CG include a past or current history of anxiety or mood disorders, multiple losses, lack of perceived social support, insecure attachments developed in childhood, and concomitant life stressors that can interfere with the ability to cope [6, 15]. Additionally, loss of a child is associated with increased risk [16] as is suicide and other instances of sudden and/or violent death [17, 18].

While distinct from MDD and PTSD, CG often co-occurs with these and other clinical conditions [19]. CG has been shown to impair mental and physical health and is associated with risk of cancer, cardiac events, sleeping problems, depression, anxiety, suicidal ideation and attempts, and increased mortality [19–24]. Yet, many individuals still go undiagnosed by clinicians. DSM-IV and IDC-10 did not include this condition and many have been unaware of its existence. Moreover, it can be challenging for clinicians to differentiate between normal grief and CG and, because of the symptomatic overlap, between CG and MDD/PTSD. The clinical distinctions between CG and both MDD and PTSD are beyond the scope of this paper, but have been discussed in detail elsewhere [14]. In brief, in CG, the predominant affect is pining and yearning, and the preoccupation is with the loss. In MDD,

the affect is sadness and anhedonia, and the preoccupation is with feelings of hopelessness or helplessness. In PTSD, the affect is fear, and the preoccupation is with threat. Assessment of CG can be aided with the Inventory of Complicated Grief-Revised (ICG-R) [25], or screening can occur with the Brief Grief Questionnaire (BGQ) [26]. The addition of the closely related condition, Persistent Complex Bereavement Disorder, in DSM-5 [89] will facilitate broader recognition of and more research on CG.

Although there is no gold standard treatment for CG at this point, our group advocates the use of Complicated Grief Treatment (CGT)—a proven efficacious, targeted psychotherapy. Two randomized controlled trials funded by the National Institute of Mental Health (NIMH) demonstrated significantly higher response rates for CGT than interpersonal therapy (IPT), a well-established efficacious treatment for depression [27] (http://clinicaltrials.gov/ct2/show/NCT01244295?term=complicated+grief+treatment&rank=1). CGT is a 16 week, manualized intervention that targets resolution of grief complications and facilitates the natural mourning process [28, 29]. Several small studies also support the efficacy of antidepressant medications for some people with CG [19, 30–32]. In order to better delineate the role of antidepressants and psychotherapy for the treatment of CG, the authors of the current paper were funded by the NIMH to conduct a multi-site study investigating the efficacy of the antidepressant citalopram when administered with clinical management alone or in combination with CGT. This study is nearly completed, and we expect to have results within the next year (http://www.clinicaltrials.gov/ct2/show/NCT01179568?term=complicated+grief&rank=2).

Bereavement and Medical Morbidity

A substantial literature supports the idea that bereavement is associated with increased general medical morbidity and mortality and, in particular, increased risk for cardiovascular and cerebrovascular events. Although some studies have been inconclusive or found no increase in risk [33, 34], many studies indicate an association between medical morbidity and various losses, including loss of a child [35, 36••], spouse [37, 38], and sibling [39, 40]. It is possible that this risk is largely carried by people with CG. For example, mortality risk appears to be associated with unexpected loss, also a risk factor for CG. One study following over 170,000 primary care patients over the age of 60 for an average of about 4 years found that the 1-year mortality risk was substantially higher for those who experienced unexpected (OR 1.61, CI1.39, 1.86) bereavement compared with expected (OR 1.21, CI 1.14, 1.30) bereavement [41••]. Neither good health at baseline nor better socioeconomic status protected individuals from the increased mortality risk [42]. When a cohort of 30,000 patients from the same database who lost their partner were compared with age-matched controls, those experiencing loss were at increased risk for cardiovascular events, including myocardial infarction, pulmonary embolism, and acute coronary syndrome. This increased risk may be related to differences in medical care received before and after the loss [43] and changes in health related behaviors, such as increased smoking and alcohol intake or poor diet associated with bereavement [33], which could contribute to adverse outcomes. The current authors have been impressed by the profundity and persistence of sleep disturbances seen in individuals with CG [20]. In addition to being a potential precipitant to the development of CG, these sleep disturbances may also contribute to the associated medical morbidity.

Several biological pathways may contribute to the increased morbidity and mortality conferred by bereavement, such as increased cortisol [44] and cortisol dysregulation [45, 46], immune system dysfunction [47, 48], and cellular inflammation [49••]. One small study found that variability in the IL-6 gene may moderate vulnerability to the bereavement-related inflammatory response [50].

Recent prospective studies have also shown that bereavement is associated with hemodynamic, pro-thrombotic, and autonomic changes in the weeks following the loss, any of which could contribute to the increase in cardiovascular risk. Specifically, early bereavement has been associated with elevated blood pressure, increased heart rate, and decreased heart rate variability [51, 52]. Early bereavement has also been associated with elevated levels of pro-thrombotic proteins including von Willebrand factor antigen, Factor VIII, and platelet/granulocyte aggregates [48, 52]. Although the physiological effects of CG have not been as well studied, the risk of hypertension has been found to be elevated 10-fold among older adults meeting criteria for CG compared with those who do not [24].

These studies underscore the importance of helping newly bereaved individuals and those with CG attend to their own medical and mental health care needs.

Major Depressive Disorder

Major depressive episodes often occur in the context of adversity. No life event is more likely to trigger a major depressive episode (MDE) in a vulnerable individual than the death of a loved one [53–55]. In a meta-analysis of older individuals, bereavement was shown to be a stronger predictor of MDE (OR =3.3) than prior episodes of depression (OR=2.3), female gender (OR=1.4), or disability (OR=2.5) [56]. Indeed, throughout the life course, from childhood through old age, the unexpected death of a loved one is a frequent precipitant for the onset of MDE [1••], and other studies have found MDEs occur with high frequency, even after expected and

anticipated deaths [57–59]. Some studies have found rates of major depressive syndromes in newly bereaved widows and widowers to be at about 20% [55, 60], with about a third to half of these being chronic and associated with all the sequelae of other MDEs [61, 62].

Yet, the relationship between depression and bereavement has been hotly debated for years, perhaps never so intensely or publicly as during the deliberations of the DSM-5 mood disorders task force over whether to eliminate the 'Bereavement Exclusion' (BE) [63–68]. The BE, introduced into the DSM-III MDE diagnostic criteria in 1980, was meant to protect against normal sadness or grief from being mistaken for depression, pathologized, and/or inappropriately treated [69]. In DSM-IV, the BE stated that MDE should not be diagnosed during the first two months of bereavement, unless the depressive symptoms and dysfunction were characterized by feelings of morbid worthlessness, psychomotor retardation, suicidal ideation, psychotic features, or marked disability.

However, several studies suggested that major depressive syndromes occurring in the context of bereavement are essentially the same as other, non-bereavement related major depressive syndromes in terms of risk factors, chronicity, course, associated features, and treatment response [64, 70, 71••, 72]. Furthermore, bereavement-related MDEs are every bit as likely to be associated with the very features that the DSM-IV stated are not part of normal bereavement: feelings of worthlessness, psychomotor retardation, and suicidality [71••]. Therefore, it made no sense to single out bereavement as the sole life event that could negate the diagnosis of MDE. In addition, other studies have shown that the BE was inconsistently used and poorly understood [73••]. Since major depression is such a disruptive, distressing, costly, and morbid syndrome, it is important to remove roadblocks to its accurate diagnosis and timely treatment. It was felt that eliminating the BE was one way to accomplish this goal. "It is very important that clinicians have an opportunity to make sure that patients and their families receive the appropriate diagnosis and the correct intervention without necessarily being constrained by a period of time" (http://www.empr.com/controversial-dsm-5-changes-task-force-chair-addresses-critical-questions/article/273675/1/).

It is not likely that the elimination of the BE in DSM-5 will lead to the willy-nilly diagnosis of MDE and unnecessary treatment as some have prophesized [74, 75]. As a safeguard, the DSM-5 explicitly states that normal grief is **not** a mental disorder, while also stressing the importance of utilizing **clinical judgment** and contextualizing diagnostic information both culturally and socially. In the introduction to depressive disorders, the DSM-5 emphasizes the importance of delineating normal sadness and grief, not just bereavement, from a MDE [89]. Furthermore the DSM-5 adds a footnote to help clinicians differentiate grief from MDE (page 161). For example, in grief, the predominant affect is emptiness and loss as opposed to the persistent depressed mood and inability to anticipate pleasure seen in MDE. In grief, the dysphoria decreases in intensity over the pursuant days and weeks and occurs in waves- the so-called pangs of grief- which are associated with thoughts or reminders of the deceased. In MDE, on the other hand, the dysphoria tends to be persistent. In grief, thought content is characterized by a preoccupation with thoughts and memories of the deceased, whereas in MDE, the preoccupation often is with self-critical or pessimistic ruminations. Self-esteem is preserved in grief, whereas in MDE general feelings of worthlessness and self-loathing predominate. And finally, thoughts of death and dying in grief are generally focused on the deceased and possibly about "joining" them, whereas in MDE they are focused on feeling unworthy, undeserving of life, or unable to cope with the pain and misery of depression [5, 71••, 76]. The question is not so much whether a recently bereaved individual is depressed **or** grieving; but rather whether or not the person is grieving **and** also has a MDE triggered by their loss, which accompanies and exacerbates the grief.

Although far less recognized than MDE as a potential consequence of bereavement, there are some emerging data that indicate mania may also be triggered by the death of a loved one, especially after an unexpected death [1••] or in the context of CG [77].

The treatment of MDE occurring in the aftermath of bereavement is much like the treatment of MDE in any context [5, 78]. Although there is a dearth of studies assessing the effectiveness of psychotherapy for MDE in the context of grief, there is no reason to think that psychotherapy approaches would not be equally effective in MDE accompanying bereavement as in any other context. Several open trials [30, 79–83], a few community based naturalistic studies [65, 79, 84], and one controlled trial [85] suggest a role for antidepressant medications. Since most studies suggest that the most effective treatment for major depression is a combination of evidence-based psychotherapy plus well delivered pharmacotherapy, this more likely than not will also prove true for bereavement related MDE [86].

Posttraumatic Stress and Anxiety Disorders

Most research on anxiety disorders and bereavement has focused on PTSD, with few additional studies addressing panic disorder (PD), generalized anxiety disorder (GAD), and anxiety disorders as a whole [87]. Recent trends in the literature have focused less on anxiety and bereavement, per se, and more on the relationships of PTSD and anxiety disorders to CG.

In every edition of the DSM, the stressor criterion (criterion "A") for PTSD has excluded "normal" bereavement, i.e., the

anticipated or non-sudden passing of a love one as an event warranting a diagnosis of PTSD [88–90]. Changes to the PTSD diagnostic criteria from DSM-IV to DSM-5, however, have widened the scope of criterion "A" to include indirect exposure to a violent or accidental trauma/death [88, 89]. In one community based study assessing PTSD symptoms in conjugally bereaved individuals which used DSM-IV criteria B, C, and D for PTSD, 10% of those whose spouses had died after a chronic illness met these criteria for PTSD, 9% whose spouses died unexpectedly, and 36% whose spouses died from "unnatural" causes, such as suicide or accident met these criteria. Additionally, symptoms were chronic in 40% or more of the sample and often included comorbid depression and substantial morbidity [91]. More recent studies that have incorporated the "A" criteria have also reported high rates of PTSD among the bereaved. One found that violent and unnatural death was predictive of PTSD symptoms, whereas sudden death from natural causes (e.g., a heart attack) was not [92]. A systematic review of the prevalence of PTSD in widowed individuals across five studies reported a prevalence of PTSD of 11.8%, with the prevalence declining with time since the loss [93]. One population study found the unexpected death of a loved one was associated with an increased incidence risk of PTSD, regardless of the age at which the unexpected death was experienced [1••]. Several other studies have documented high rates of PTSD among bereaved survivors of disasters; however, it is unclear whether the trigger of PTSD in these studies is related to the trauma of the disaster or the loss of a loved one [87].

Other anxiety disorders, like PD and GAD, remain understudied in the bereaved population [87, 93]. Not surprisingly, the few available studies suggest elevated risk for both PD and GAD after the stress of bereavement [1••, 87, 94, 95]. These findings indicate that PD and GAD are more prevalent in the bereaved population than they are in the general community.

Several studies have examined the association between PTSD and anxiety disorders with CG. These studies report high rates of PTSD and anxiety disorders in individuals with CG, both before and after the loss [19, 95]. Additionally, persons with PTSD and/or an anxiety disorder and CG report much worse CG symptomatology and impairment than those with CG alone [19, 96••, 97]. These correlations have led bereavement researchers to postulate that pre-existing PTSD and anxiety disorders are risk factors for CG [87, 98].

There are no clear-cut, universally accepted guidelines for the treatment of grief accompanied by PTSD or anxiety disorders. Unless symptoms of CG are present, we suggest providing support and education for the bereaved while actively addressing the traumatic distress and anxiety, as in other, non-bereavement related circumstances. When CG also is present, we believe that both conditions may be treated simultaneously. Indeed many of the components of CGT encompass evidence-based therapeutic techniques for treating PTSD and anxiety disorders. The role of medications is unclear and deserving of further study.

Substance Use and Abuse

Unresolved grief after the death of a loved one has long been acknowledged as a precipitant of substance use disorders [99]; and, conversely, history of substance use disorders has been proposed as a risk factor for the development of CG after bereavement [100]. Despite the acknowledgment of a link between intense grief and worsening of substance use [24], the area of substance use and bereavement is only recently gaining attention in the literature as a topic of importance in its own right.

Of the research conducted to date, the cohorts found to be at particular risk for developing alcohol or substance use disorders, or for increased substance use after bereavement include a) individuals grieving the unexpected death of a loved one, particularly those over the age of 45 and those grieving more than one unexpected death [1••], b) homicide survivors [101], c) patients with bipolar disorder who also meet criteria for CG [102], d) HIV-positive men with personality disorders and low social support, grieving the death of a loved one to AIDS-related complications [103], e) parents grieving the death of a child, infant death or stillbirth [104, 105], particularly mothers during the first year following the death, f) mothers with few or no other surviving offspring [105], g) parentally bereaved children [106, 107], particularly those bereaved by parental suicide [106], and h) males over age 13 with a history of disruptive disorders or MDE [107]. Although results are mixed, it seems that in general, men may be at greater risk than women for increased problematic substance use after the death of a loved one [108, 109].

For those who already use substances inappropriately, substance misuse tends to increase during the first year after the death of a loved one [109] and, like the trajectory of normal grief, abates with time [108]. However, for some, substance misuse during that first year may be associated with comorbid depression, anxiety, PTSD, and avoidant coping [104] and thus, may be associated with an increased likelihood of an individual experiencing CG if both mood and substance use are not addressed.

While many grief treatment trials tend to exclude participants with substance use disorders, one study to date has demonstrated an effective strategy for treating CG in the context of substance use disorders [99]. As these researchers demonstrated, and other researchers have suggested, treatment should focus first on promoting healthy coping skills [107] to address the avoidant substance use behaviors which impede healthy healing and normal integration of grief into daily life.

Conclusions

Although bereavement often is a very difficult and challenging experience, most people are able to come to terms with their loss and regain their ability to engage in ongoing life. Most bereaved people recoup emotional stability, return to full functioning, and even manage new tasks as needed. Most are able to develop new friendships and potentially redefine their sense of who they are in the months following their loss. For many, this difficult time also becomes a potential opportunity for remarkable growth and resilience [8, 9].

However, for some people, bereavement is complicated by the onset of CG, MDE, mania, PTSD, anxiety disorders, poor health and risk of death, or increased substance use. This article describes each of these potential complications and reviews some of the pertinent literature about prevalence, risks, consequences, and management strategies. Armed with an appreciation of these bereavement-related problems, clinicians may be better poised to provide informed care and comfort.

Compliance with Ethics Guidelines

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