# Chapter 2
# Grief and Post-Traumatic Stress Following Bereavement

**Madelyn R. Frumkin and Donald J. Robinaugh**

## Introduction

The death of a loved one is among the most painful and disruptive events many of us will face over the course of our lives. The grief that follows bereavement can be profound, often described as coming in intense waves or pangs that are interspersed with an enduring sense of absence, emptiness, and loss of meaning. Although there is neither a predetermined set of stages by which grief progresses nor a timetable it must follow, the frequency and intensity of bereavement-related distress does tend to subside over time for most bereaved adults [1].

M.R. Frumkin, B.A.
Center for Anxiety and Traumatic Stress Disorders and Complicated Grief, Center for Anxiety and Traumatic Stress Disorders and Complicated Grief Program, Massachusetts General Hospital, Boston, MA, USA

D.J. Robinaugh, Ph.D. (✉)
Center for Anxiety and Traumatic Stress Disorders and Complicated Grief Program, Massachusetts General Hospital, Boston, MA, USA

Harvard Medical School, Boston, MA, USA
e-mail: drobinaugh@mgh.harvard.edu



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For some, however, the psychological effects of bereavement do not improve with time, remaining severe and impairing. When this distress persists long after the death and the ability to function effectively at home, socially, or at work remains compromised, some bereaved adults choose to seek support from mental health professionals.

For clinicians working with these bereaved adults, the first step toward creating a treatment plan is assessing for the presence of psychiatric disorders and formulating a case conceptualization. Bereavement increases risk for numerous psychiatric disorders, so a thorough diagnostic assessment is necessary. However, the disorders most commonly associated with bereavement are depression, post-traumatic stress disorder, and complicated grief [2]. Among these, it can be especially difficult to disentangle the presence of post-traumatic stress disorder and the presence of complicated grief, disorders that share considerable phenomenological overlap and are unique in the DSM by virtue of being tied to a specific etiological event. Consider three vignettes inspired by bereaved patients we have seen in our clinic (names and details of these stories have been modified to protect patient confidentiality).

Deborah is a 45-year-old woman reporting intense and impairing distress tied to the death of her son. Four years ago, Deborah and her son were the victims of an armed robbery. The assailant shot at and struck both Deborah and her son. Deborah survived, but her son died instantly. In the years following the loss, Deborah's grief has remained intensely painful. She returned to her job several months after the death, but was unable to concentrate on her work, continuously distracted by thoughts about the death and waves of intense grief. After several weeks, she left her job and has been unable to return to work since. Although friends and family were very supportive in the initial months following her son's death, she avoids talking to them about the loss and has begun to feel distant and cut-off from the people in her life. She denies experiencing any fear or anxiety about similar events happening in the future, and she denies heightened physiological reactivity or hypervigilance for danger in her

surroundings. Instead, she feels a discomforting numbness interrupted only by a yearning to be with her son again and an intense guilt stemming from the belief that she failed to protect him from harm. Deborah experiences persistent suicidal thoughts and frequently uses alcohol in the evenings, wishing for anything that will relieve her pain.

Joan is a 52-year-old woman who was recently hospitalized due to debilitating grief that arose in the days leading up to the anniversary of her father's death. Two years ago, her sister passed away after a years-long battle with cancer. Only weeks later, Joan's father collapsed in his kitchen, overcome by intense chest pain. By the time Joan arrived at the hospital, he had been declared dead. Joan reports overwhelming pain when reminded of his absence and an intense urge to be with and talk with him again. She is haunted by memories of her father's face when she saw him in the hospital and dreads going to bed for fear of having nightmares about her father's death. She frequently ruminates about what she could have done to prevent the loss. In addition, she reports that she no longer believes the world is a safe place; feeling that if her father died so suddenly, danger and death could occur at any moment. She has difficulty sleeping and is always on guard, expecting disaster at every turn.

Matt is a 36-year-old man seeking treatment for distress tied to a severe car accident he experienced two years ago. Matt had been in the passenger seat when his wife ran a stop sign and drove into the path of an oncoming truck. His wife was pronounced dead at the scene, while Matt was taken to a nearby hospital to be treated for minor injuries. In the years following the accident, Matt has continued to raise their two young children and, while he misses his wife deeply, he does not consider grief over their relationship to be his primary source of distress. Instead, he reports intense distress around the accident itself, including nightmares and intrusive memories of seeing the approaching truck moments before the accident. Since the accident, Matt has been so afraid of being in another car accident that he refuses to drive on anything

but local residential roads and experiences great anxiety on the few occasions he lets others drive him places that requires getting on the highway. He ultimately moved into an apartment in the city so that driving is rarely necessary, and his parents assist with getting the children to school and other activities as needed. Although his boss had been flexible with him in the months following the accident, Matt was recently put on a performance improvement plan and believes he is at risk of losing his job if he is not able to resume a normal travelling schedule.

Did these patients experience bereavement or trauma? Are they now experiencing complicated grief or post-traumatic stress disorder? What is the most appropriate case conceptualization for these patients and what treatments are most appropriate? In this chapter, we aim to provide information about complicated grief and post-traumatic stress disorder that can help guide these decisions. We begin by providing a brief overview of the historical development of the complicated grief and post-traumatic stress disorder diagnoses in order to provide an appreciation for the extent to which these syndromes are, and always have been, closely related. We then conclude with considerations for how to assess, conceptualize, and treat complicated grief and post-traumatic stress disorder in the clinic.

## The History of Complicated Grief and Post-Traumatic Stress Disorder

### *The Cocoanut Grove Disaster: Bereavement or Trauma?*

On Saturday, November 28, 1942, an estimated 1000 people filled a popular Boston club, more than doubling its legal capacity. Late in the evening, a small fire began in one of the palm tree decorations of the club known as Cocoanut Grove. The flames spread rapidly through other decorations, filling

the club with fire and toxic gas. As the fire spread, panicked guests forced their way toward the exits of the overcapacity club and many were trapped by locked doors and exits forced shut by the crush of people attempting to escape. Ultimately, 492 people died and 166 more were injured in what remains one of the deadliest fires in American history [3].

In the aftermath of the Cocoanut Grove fire, a psychiatrist at Massachusetts General Hospital named Erich Lindemann interviewed individuals who had experienced the death of a loved one in the fire, including some who had themselves been in the club and had experienced significant threat to their own lives. These interviews became part of the first empirical study of grief, published 2 years later in the American Journal of Psychiatry [4]. In this seminal study, Lindemann described grief as a "remarkably uniform" syndrome that included waves of intense somatic distress and mental pain, preoccupation with thoughts about the death, restlessness, grief-related avoidance, and feelings of guilt and social isolation ([4], p. 187). This descriptive account of grief was highly influential (as of 2016, it had been cited more than 4300 times) and laid the foundation for our current understanding of grief.

Interestingly, Lindemann was not the only researcher who studied the psychological toll of the Cocoanut Grove disaster. Over the course of the first year following the fire, Alexandra Adler, a psychiatrist at Boston City Hospital, studied the "post-traumatic mental complications" of more than 100 victims of the fire who were treated at Boston City Hospital. The experiences of these survivors were harrowing. Many had been severely injured or had lost consciousness as toxic gas and smoke filled the club. Notably, more than half had experienced the death of a friend or relative in the fire. In 1943, Alexandra Adler published a report of the neuropsychiatric complications of these survivors in the Journal of the American Medical Association [5]. Although less widely known than Lindemann's seminal work, Adler's research also proved to be influential. Her description of patients who experienced preoccupying thoughts about the event, terrifying

nightmares, depressed mood, feelings of guilt, "general nervousness," irritability, fatigue, and insomnia are immediately recognizable as the syndrome we now refer to as post-traumatic stress disorder (PTSD). Indeed, Adler's work was among the first to systematically describe the PTSD syndrome in a civilian population and influenced the formation of PTSD diagnostic criteria when it first emerged as a diagnosis in 1980 with the third edition of the Diagnostic and Statistical Manual (DSM-III).

Lindemann and Adler both studied survivors of the Cocoanut Grove fire, many of whom who had faced both a threat to their own lives and the death of a loved one in the fire. One described the syndrome they observed as grief, whereas the other labeled the syndrome as post-traumatic mental complications. These two conceptualizations would go on to influence the development of two distinct mental disorders, one focused on the psychological consequences of bereavement and the other on the consequences of trauma. Yet, the syndromes reported by Lindemann and Adler have considerable overlap and are based, in part, on samples that were exposed to both bereavement and trauma. These early studies in the history of grief and post-traumatic stress reactions illustrate the extent to which the two have been closely intertwined since the earliest empirical research on these conditions, and they raise a fundamental question: How do we as clinicians and clinical researchers distinguish between grief and post-traumatic stress?

## *PTSD in the DSM*

Although PTSD is a well-established diagnosis today, in the 1970s its proposed inclusion in the DSM-III faced considerable opposition. This opposition was overcome, in part, by the intense lobbying efforts of a group of psychiatrists and activists working in support of veterans of the Vietnam War (for a review of the historical development of PTSD, see [6]). These psychiatrists, led by Chaim Shatan and Robert Lifton,

believed that the inclusion of a "post-Vietnam syndrome" in the DSM was critical to calling attention to and receiving resources to address the psychological toll enacted by the Vietnam War. Their advocacy was bolstered by researchers studying responses to other highly stressful life events, including burn victims and survivors of the holocaust. Among these, perhaps the most influential was the psychiatrist Mardi Horowitz. Drawing in part on Lindemann's account of grief following the Cocoanut Grove fire, Horowitz had formulated a theory of stress response syndromes, a framework for understanding the psychological consequences that follow highly stressful life events and the forces that lead those consequences to persist over time [7]. Central to Horowitz's theory was the assertion that many stressors will evoke significant symptoms in the majority of individuals. Although pre-existing factors such as personality features may exacerbate the stress response, the syndrome was attributable to the stressor itself, rather than solely to vulnerability factors. Horowitz's work on stress response syndromes provided a firm empirical backing for the political pressure applied by Shatan and Lifton and, together, they persuaded the DSM committee to include PTSD in the DSM-III.

The influence of Horowitz's stress response theory is readily apparent in the DSM-III PTSD diagnostic criteria. The intrusive memories, re-experiencing of the trauma, and trauma-related avoidance symptoms that are now hallmarks of PTSD were present in Horowitz's writings years earlier. However, in a significant departure from Horowitz's theory, the DSM committee added a stipulation that the stressful events precipitating the symptoms (i.e., the trauma) must be "outside the range of usual human experience," thereby excluding "such common experiences as simple bereavement" ([8], p. 247). Neither Horowitz nor Shatan and Lifton drew such a distinction between trauma and bereavement in their work that led up to the PTSD diagnosis. Indeed, bereavement and grief were each featured prominently in their work. Shatan described post-Vietnam syndrome, as the "the unconsummated grief of

soldiers," noting that "…much of what passes for cynicism is really the veterans' numbed apathy from a surfeit of bereavement and death." ([9], p. 648). Similarly, Horowitz drew no distinction between bereavement and other stressors in his description of stress response syndromes, arguing that the most common precipitants of stress response syndromes included "injury, assault, or loss of a loved one" ([10], p. 241).

The definition of trauma in the DSM-III raised an important question that set the stage for how we interpret trauma and bereavement today: What falls within the bounds of "usual human experience"? Given that the vast majority of people will experience the death of a loved one at some point in their lives, it seems clear that bereavement in and of itself is well within the bounds of "usual human experience." However, the boundaries containing "usual" become quickly muddied when considering the details of a specific patient's loss. Is it within the bounds of usual human experience to lose a child to cancer? Is it usual to lose an elderly father to suicide? The vague and undefined term "simple bereavement" provided clinicians little further guidance as to when the deaths described by their patients should be considered a trauma.

In the fourth edition of the DSM (DSM-IV), the DSM committee attempted to clarify the issue, stipulating that a diagnosis of PTSD following bereavement should be given only in the context of the "sudden, unexpected death of a family member or close friend" ([11], p. 463). The new criteria also stated that "learning that one's child has a life-threatening disease" should qualify as a traumatic event ([11], p. 464). The rationale behind designating "sudden and unexpected" bereavement as uniquely traumatic was unspecified, but may have been tied to research demonstrating that sudden and unexpected loss was capable of eliciting the PTSD syndrome. Indeed, in a study of over 2000 individuals in the Detroit area, epidemiologist Naomi Breslau found that the sudden and unexpected death of a

loved one was the most commonly reported trauma among those with PTSD [12]. In other words, if an individual was experiencing PTSD, the most likely precipitating event was sudden and unexpected loss of a loved one. This study did not assess for the presence of PTSD following other types of bereavement, thereby making it unclear if similar rates of PTSD would be observed following other types of losses. However, it did provide strong support for the notion that sudden and unexpected loss was an event important to our understanding of PTSD.

It is perhaps surprising then that in the DSM-5, the guidelines for when bereavement qualifies as trauma was modified again, restricting inclusion to only those instances of "violent or accidental" death ([13], p. 271). The death of a child to cancer no longer qualified as a trauma, nor would the sudden and unexpected loss of a spouse due to illness. As with previous editions of the DSM, no evidence was provided to support this modification. Nonetheless, the result is that most instances of bereavement do not qualify as a traumatic event, thus precluding the diagnosis of PTSD.

## *Complicated Grief in the DSM*

In the 1990s, Mardi Horowitz and his colleagues responded to this exclusion of most bereavement from the PTSD diagnosis by calling for a new diagnostic category that would address those with chronic distress following bereavement. As previously noted, Horowitz significantly shaped our understanding of post-traumatic stress reactions with his work on stress response syndromes, and he explicitly and prominently included bereavement in the category of stressors capable of eliciting this syndrome. Observing that the PTSD diagnosis excluded many of those chronically struggling with the death of a loved one, he proposed a "pathological grief" disorder

rooted in this theory of stress response syndromes. Horowitz's "pathological grief" criteria included intrusive memories, social withdrawal, inability to return to normal daily life, loss of connection with others, fatigue, and other somatic symptoms—all symptoms that appear in his descriptions of stress response syndromes and in the diagnosis of PTSD.

In the subsequent decades, the "pathological grief" diagnosis has been subjected to considerable empirical scrutiny and, in the DSM-5, the syndrome was included for the first time under the name Persistent Complex Bereavement Disorder (PCBD) as a condition in need of further study. As reviewed in Chap. 2 of this book, the diagnostic criteria for this diagnosis have evolved since Horowitz's initial proposal, and a variety of terms have been used to refer to the syndrome, including traumatic grief, prolonged grief, and complicated grief (the term we use here). However, the syndrome remains very much rooted in the same formulation of stress response syndromes that was so influential in the development of the PTSD diagnosis, contributing to the substantial overlap in these syndromes that we see today.

## Considerations for Assessing CG and PTSD in the Clinic

The historical development of the CG and PTSD diagnoses illustrates the close relationship between these syndromes and the difficulty disentangling them in individuals who have experienced the death of a loved one. Compounding this problem, there has been relatively minimal research aimed at providing guidance for clinicians about how best to assess and treat patients who present with distress resulting from an event that does not fall cleanly into the category of trauma vs. bereavement. In the remainder of this chapter, we will identify issues relevant to assessing and treating CG and PTSD in the clinic that can guide clinical decision-making and provide directions for future clinical research.

## *Assessing Trauma*

As is evident from the evolution of the PTSD diagnostic criteria in the DSM, attempts to define a boundary between PTSD and bereavement-related disorders have relied heavily on drawing a distinction between trauma and bereavement. Implicit in this distinction is the notion that some types of bereavement are not traumatic. However, when put into practice, this distinction between traumatic and nontraumatic loss is often difficult to discern.

Consider, again, our clinical vignettes—Deborah, who witnessed the shooting death of her son and experienced significant threat to her own life; Joan, whose elderly father died suddenly of heart failure in the weeks following her sister's death; and Matt, who was involved in a severe car accident in which his wife died immediately. Each of these patients experienced the death of a family member and each is seeking treatment more than a year following the death. Did these patients experience a traumatic event?

Deborah's loss would meet diagnostic criteria for a traumatic event across all versions of the DSM PTSD diagnostic criteria because she also experienced significant threat to her own life in the event. Even if she had not experienced this direct threat to her own life, most would agree that her son's death was "outside the range of human experience" (DSM-III), was sudden and unexpected (DSM-IV), and was violent (DSM-5), thus qualifying it as a trauma across all editions of the DSM. Similarly, Matt's loss would meet diagnostic criteria for a traumatic event across all versions of the DSM by virtue of the direct threat to his own life. Considering only the loss itself, losing a loved one in a deadly car accident would presumably be considered "outside the range of human experience" by most (DSM-III), and was certainly sudden (DSM-IV) and accidental (DSM-5), suggesting that Matt's experience of bereavement would also meet diagnostic criteria for a traumatic event across each iteration of DSM PTSD criteria.

Joan's case is less clear. Under DSM-III, many would likely conclude that the death of her father would be considered within the range of "usual human experience" given his age and the nature of his death, thereby excluding this death from qualifying as a traumatic event. With revisions adopted in the DSM-IV, however, Joan would be considered to have experienced a traumatic event, as her experience precisely matches the required "sudden, unexpected death of a family member or close friend." Yet, 13 years later, the DSM-5 revised the trauma criterion and stipulated that the death must be "violent or accidental," thereby removing Joan's eligibility for a PTSD diagnosis. As is often the case, the details of the loss Joan experienced blur the hard lines drawn in the DSM. Joan experienced the death of her father only following the death of her sister, an experience that perhaps falls less clearly into the category of "usual human experience" than if her father's death had occurred as an isolated event. Similarly, the characterization of his death as nonviolent belies the nature of death due to sudden illness, which often involves witnessing a loved one in highly distressing circumstances (e.g., violent seizures) or receiving aggressive interventions aimed at saving the person's life. In Joan's case, she was highly troubled by intrusive thoughts about her father's death and the intense pain she believed he must have been in, despite this event not meeting diagnostic criteria for a traumatic event in the current edition of the DSM.

As Joan's case illustrates, the line between bereavement and traumatic bereavement is often unclear. In large part, this lack of clarity arises from the fact that there is no agreed upon definition of what it means for an event to be traumatic, nor a general objective measure of trauma severity [14] that would inform a distinction between traumatic and nontraumatic bereavement. This vagueness has almost certainly contributed to the shifting lines drawn around the types of events that qualify as traumatic.

## *Assessing CG and PTSD Symptoms*

Before reviewing our assessment of symptoms for each of our case examples, it is important to consider the similarities and differences between CG and PTSD symptoms. The table below displays the symptoms of PTSD and CG as enumerated in the DSM-5. There is substantial overlap between the two syndromes. Many symptoms are included in the diagnostic criteria for both CG and PTSD, including preoccupying thoughts about the death, avoidance, negative beliefs about oneself or others, negative emotional states, and feeling detached from others. In some cases, the overlapping symptoms are identical (e.g., avoidance of thoughts related to the death). In other cases, two symptoms may share similar themes, but are nonetheless distinguishable constructs. For example, while PTSD may be characterized by self-destructive behavior, CG may involve a desire to die in order to be with the deceased. The theme of self-harm is present in both; however, the CG symptom is more narrowly defined, requiring a motivation tied specifically to grief (Table 2.1).

Yet despite this substantial overlap, there are noteworthy differences. PTSD is characterized principally by thoughts and memories related to the traumatic event (i.e., the death in the case of bereavement), avoidance, and alterations in physiological arousal and reactivity. Together, symptoms from these domains make up 14 of the 20 PTSD symptoms, and these symptoms are a primary focus of PTSD treatments. In contrast, thoughts and memories in those with CG include not only thoughts related to the death, but also of the deceased. Similarly, avoidance is not only tied to the death, but also to reminders of the deceased and their absence. The symptoms of heightened arousal so prominent in PTSD are largely absent from diagnostic criteria for CG. Conversely, CG criteria include many symptoms not highlighted in PTSD diagnostic criteria, such as a lost sense of meaning or purpose, confusion about one's identity, and difficulty imagining one's personal future. Importantly, the absence of a symptom from a diagnostic criteria set does not mean that the symptom is

Table 2.1 Post-traumatic stress disorder and complicated grief symptoms as enumerated in the DSM-5

| | Post-traumatic stress disorder | Complicated grief |
|---|---|---|
| Memories and thoughts related to the death and the deceased | • Recurrent, involuntary, and intrusive distressing memories of the trauma<br>• Recurrent distressing dreams related to the trauma<br>• Dissociative reactions (e.g., flashbacks)<br>• Intense or prolonged psychological distress at exposure to reminders of the trauma<br>• Marked physiological reactions to reminders of the trauma<br>• Inability to remember important aspects of the trauma | • Preoccupation with the deceased<br>• Preoccupation with the circumstances of the death<br>• Difficulty with positive reminiscing about the deceased |
| Avoidance | • Avoidance or efforts to avoid distressing memories, thoughts, or feelings related to the trauma<br>• Avoidance or efforts to avoid external reminders (people, places, situations) | • Excessive avoidance of reminders of the loss (e.g., individuals, places, or situations associated with the deceased) |
| Emotion and mood | • Persistent negative emotional state<br>• Loss of interest in significant activities<br>• Persistent inability to experience positive emotions | • Persistent yearning/longing for the deceased<br>• Intense sorrow and emotional pain<br>• Bitterness or anger related to the loss<br>• [Disbelief or] emotional numbness over the loss |

Table 2.1 (continued)

| | Post-traumatic stress disorder | Complicated grief |
|---|---|---|
| Thoughts and beliefs about oneself, one's future, or the world | • Distorted cognitions that lead to blaming oneself or others<br>• Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world | • Maladaptive appraisals about oneself (e.g., self-blame)<br>• Difficulty or reluctance to pursue interests since the loss or to plan for the future<br>• Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased<br>• Confusion about one's role in life, or a diminished sense of identity |
| Social disconnection | • Feeling detached or estranged from others | • Feeling alone or detached from others<br>• Difficulty trusting others since the death |
| Alterations in arousal and reactivity | • Verbal or physical aggression<br>• Reckless or self-destructive behavior<br>• Hypervigilance<br>• Exaggerated startle response<br>• Problems concentrating<br>• Difficulty sleeping | |

(continued)

Table 2.1 (continued)

| | Post-traumatic stress disorder | Complicated grief |
|---|---|---|
| Difficulty accepting the loss | | • Marked difficulty accepting the death<br>• Disbelief [or emotional numbness] over the loss |
| Suicidal thoughts | | • A desire to die in order to be with the deceased |

*Note.* The symptoms listed for complicated grief here are the diagnostic criteria for the syndrome in the DSM-5, where the syndrome is referred to as Persistent Complex Bereavement Disorder. The categorization of symptoms here is based solely on our interpretation of the symptoms and is not drawn from the DSM-5 or from any statistical analyses

not part of the phenomenology of the disorder. Indeed, many of the symptoms present in one of these disorders (e.g., difficulty imagining one's future in CG) have also been observed in those with the other disorder (e.g., a sense of foreshortened future in PTSD). Nonetheless, the non-overlapping symptoms in PTSD and CG suggest that failing to assess one of these disorders following bereavement may limit one's understanding of what the patient is experiencing and, thus, may hinder efforts to form an appropriate case conceptualization and treatment plan; a possibility illustrated in our clinical vignettes.

Deborah endorses several symptoms of PTSD regarding the death of her son, including frequent and intrusive thoughts about the death, emotional reactivity to reminders of the event, emotional numbness, a sense of foreshortened future, and a feeling of being distant or cut-off from other people since the event. However, she does not report hypervigilance, hyperarousal, or difficulty sleeping. She does not feel that the world was a dangerous place and did not fear events like the

one she experienced happening to her again. When she gets lost in intrusive thoughts about the event, her focus is not on the threat to her life, but on her perceived failure to protect her son. Instead of reacting to these memories with fear or horror, she reports intense guilt. She reports that her most intense emotional experience is yearning to be with her son again and a deep sense of emptiness without him. Based on her reporting of these symptoms, a full diagnostic interview would reveal that Deborah meets criteria for CG, but not for PTSD.

Joan yearns for her father, feels overwhelming waves of pain when reminded of his absence, and was hospitalized in the days leading up to the anniversary of his death due to an inability to cope with the overwhelming emotions tied to the loss. She is very bothered by frequent intrusive memories of her father lying dead in a hospital bed and her perception that he appeared to have been in great pain. She avoids all thoughts and reminders of his death, refusing even to say out loud that he had died for months following the death. She reports feeling constantly on guard and worried about her ability to manage without him. She jumps almost every time the phone rang for fear that she will learn that another family member had died. Joan meets diagnostic criteria for both CG and PTSD.

Finally, Matt is seeking treatment for his intense anxiety about driving; anxiety that led him to avoid being in a car at considerable and growing cost to his ability to function. Every time he is in a car, or even thinks about driving, Matt has intense physiological reactivity. In addition, vivid memories of the accident frequently intruded into his thoughts while he attempts to go about his day-to-day life. Matt has been irritable and had difficulty sleeping since the accident, reporting that he is often jumpy and quickly loses his temper. He has withdrawn from many of his friends and family and felt isolated from them. Although Matt greatly misses his wife, he feels he has been able to accept her passing and has begun to move forward in reestablishing his life with his daughters. However, those efforts have been limited by his inability to drive. Matt meets diagnostic criteria for PTSD without CG.

As these vignettes illustrate, the relationship between the type of bereavement and the presence of the PTSD syndrome is not especially straightforward. Deborah experienced a traumatic event by any conceivable definition of the word, yet does not meet diagnostic criteria for PTSD after the shooting death of her son. Joan meets full diagnostic criteria for PTSD under DSM-IV criteria, but under DSM-III or DSM-5 criteria she would be excluded from the diagnosis solely by virtue of the type of loss she experienced. In other words, she would be experiencing the PTSD syndrome despite not having technically experienced a trauma according to the letter of the diagnostic criteria.

Joan's case suggests that the sudden and unexpected death of one's father to heart failure is an event capable of eliciting the PTSD syndrome; a clinical anecdote consistent with Breslau's finding that sudden and unexpected death of a loved one was the most commonly reported event by patients meeting diagnostic criteria for PTSD. Looking beyond these clinical vignettes, it is important to note that, to our knowledge, there is no evidence to suggest that some types of bereavement cannot lead to PTSD. Accordingly, there is no evidence to support categorically excluding any type of bereavement from the definition of trauma. Although certain types of loss may place individuals at greater risk than do others, this does not mean that only those losses with high conditional probability should be considered traumatic. Analogously, although assaultive violence has a higher conditional probability of provoking PTSD than does a motor vehicle accident [12], it does not follow that motor vehicle accidents should no longer qualify as a traumatic event. Indeed, if an event is capable of eliciting the PTSD syndrome, it is unclear whether there is any clinical rationale for excluding that event from the diagnostic criteria for PTSD.

## *Summary and Recommendations*

These clinical vignettes suggest that it is not sufficient to simply infer the presence or absence of the PTSD and CG syndromes from the type of loss. One patient may have

experienced an unequivocally traumatic event and not meet criteria for PTSD while another may have experienced a loss that seems natural and within the course of "usual human experience" on the surface, but has nonetheless provoked the full PTSD syndrome. Although some losses will not technically qualify a patient for the diagnosis of PTSD based on current criteria, we would recommend to both clinicians and clinical researchers that both CG and PTSD symptoms be assessed for all instances of bereavement. For researchers, gathering these data can be used to examine the question of whether there is a privileged relationship between specific types of loss and the PTSD syndrome; a position that is implicit in DSM diagnostic criteria but that is not support by any evidence of which we are aware and is inconsistent with our clinical experience. If the data fail to support this position, it would suggest that the DSM should refrain from restricting the types of loss that qualify one for the PTSD diagnosis. It will be of particular interest to know whether there are any patients who (a) do not meet diagnostic criteria for a traumatic event, (b) do not meet diagnostic criteria for CG, and (c) do endorse experiencing the PTSD syndrome, as this pattern of experience would suggest that some patients persistently struggling since the loss are being omitted from the diagnostic category that best fits the symptoms they are experiencing.

For clinicians, gathering these data will provide critical information about the full breadth of the patient's experiences, informing the case conceptualization and, in turn, how best to work with that patient to alleviate bereavement-related distress. Of particular relevance will be those symptoms of PTSD that are not well captured in CG diagnostic criteria (e.g., verbal or physical aggression, self-destructive behavior, hypervigilance, exaggerated startle response, difficulty concentrating, and difficulty sleeping) and those symptoms of CG not well captured in PTSD criteria (e.g., difficulty accepting the loss, loss of meaning or purpose, lost sense of identity, and difficulty imagining the future).

## Considerations for Conceptualizing and Treating CG and PTSD in the Clinic

A complete assessment of CG and PTSD is critical to formulating a case conceptualization and treatment plan because while treatments for the two disorders do overlap in many ways, there are important differences. Here, we discuss the similarities and differences among three evidence-based treatments that one might consider for a patient experiencing PTSD and/or CG: Prolonged Exposure (PE; [15]), Cognitive Processing Therapy (CPT; [16]), and Complicated Grief Therapy (CGT; [17]). We will also discuss which treatments we would choose for our case examples based on the factors we have illustrated in this chapter as helping us to conceptualize CG and PTSD in bereaved patients.

Prolonged Exposure is rooted in the emotional processing theory of PTSD, which emphasizes the importance of directly addressing the traumatic memory in order to reduce PTSD symptoms [15]. This goal is achieved in large part by exposing the patient to feared memories, thoughts, and feelings associated with the traumatic event (imaginal exposure), as well as to situations, places, and people connected to the events that the patient may be avoiding (in vivo exposure). Over repeated exposures, the patient habituates to the memory of the trauma and the cues that trigger its recollection, learning that the memory is not dangerous and that situations that cue reminders of the trauma need not be avoided.

Cognitive Processing Therapy is based on a social cognitive theory of PTSD that focuses on the content of cognitions and the role of distorted thoughts on emotions and behaviors. Although brief exposure exercises are used, the purpose of these exercises is not for habituation; rather, the patient is guided toward recognizing and changing faulty beliefs about the trauma (e.g., guilt, self-blame) and over-generalized beliefs about oneself or the world (e.g., "I can't ever trust my judgment again," "The world is unsafe"). Of particular relevance to PTSD arising in the context of bereavement, some

cognitive processing therapy manuals include an optional half session to address "traumatic bereavement." Here, the authors emphasize the importance of considering the role of losses that may be associated with PTSD, for example the "sudden, unexpected, and perhaps violent death of a significant other" ([18], p. 191). Before this optional session, the patient is asked to write a statement of at least one page on "why you think this event happened to you," and "how has it changed or strengthened your views about yourself, other people, and the world in general?" The patient reads the written statement in session, after which the therapist helps the patient identify faulty thoughts and beliefs (e.g., guilt, denial, distorted sense of power or responsibility) that may be causing the individual to be stuck in grief. Other goals of this optional session include normalizing the grief process and differentiating it from PTSD symptoms, as well as beginning to assist the patient in viewing his/her relationship with the person who died as altered but not finished.

Lastly, CGT (see Chap. 12 for further detail on CGT) draws on a range of theoretical approaches, most notably on attachment theory, as well as on cognitive behavioral approaches for PTSD, such as prolonged exposure therapy. Perhaps not surprisingly, CGT shares similarities with prolonged exposure therapy, including an "imaginal revisiting" exercise in which patients repeatedly revisit the moment at which they first learned of the loss (cf. imaginal exposure for PTSD). Similarly, patients complete "situational revisiting" in which they face grief-related situations and activities they have been avoiding because they elicit intense grief-related distress, an exercise akin to Prolonged Exposure's in vivo exposure. These exercises are, together, referred to as loss-focused exercises and directly address the loss event itself in much the same way that Prolonged Exposure addresses trauma.

However, there are also differences between CGT and treatments for PTSD. CGT includes a significant focus on helping the patient come to terms with the continued absence of his/her deceased loved one rather than focusing only on the loss itself. In this way, CG treatment has a broader focus on

the relationship that has been lost, rather than predominately focusing on the event in which the loss occurred. Moreover, CGT places considerable focus on restoration-oriented activities that aim to restore a sense of meaning or purpose and a capacity for joy and satisfaction in life. These exercises include discussions around personal values and aspirations and engagement in activities that move one toward those values and activities. Although there may be opportunities for such conversations in the context of Prolonged Exposure or Cognitive Processing Therapy, they are more explicitly a focus of CGT and the CGT treatment protocol provides a framework in which to explain the importance of these activities and strategies for how to achieve them. Accordingly, the focus of CGT (and, thus, the tools and strategies provided by the treatment) is somewhat broader than the focus of PTSD treatments and is more tailored to experiences commonly reported in those struggling to come to terms with loss, including considerable attention to the relationship with the deceased and a restored sense of meaning or purpose in the future.

With these considerations in mind, we would provide Deborah with CGT. Although the loss she experienced was unequivocally traumatic, Deborah does not frequently experience elevated physiological arousal, fear, or feelings that the world is unsafe in response to reminders of her son's death. She meets criteria for CG and not PTSD and the primary source of her distress is not isolated to the loss event itself, but rather includes the continued absence of her son, the loss of meaning or purpose in life, and guilt around her perception that she failed as a mother. Although Prolonged Exposure and Cognitive Processing Therapy would address some of her concerns, CGT provides a better framework for addressing the full range of her experiences. In particular, CGT provides a framework for addressing the patient's difficulty accepting the ongoing absence of her son, guilt surrounding her son's death, and difficulty restoring meaning and purpose in her own life.

Conversely, we would recommend to Matt that he complete Prolonged Exposure therapy focusing on the motor vehicle accident. Although the loss of his wife was a source

of profound grief in the weeks and months following the loss, he has made considerable progress in coming to terms with the loss. He has not, however, been able to make similar progress in his efforts to return to driving and sought care specifically to address his ongoing distress around memories of the car accident, physiological and emotional reactivity to even the thought of driving, and considerable avoidance of being on the road. The imaginal and in vivo exposure entailed in Prolonged Exposure specifically address the patient's primary focus of concern and when grief-related issues do arise in treatment, they can be incorporated as part of the standard prolonged exposure treatment protocol.

Finally, we would recommend that Joan receive CGT. Given that Joan meets criteria for both CG and PTSD, this decision is less straightforward than for the other two patients. However, it is clear that a primary source of the patient's distress is around the continued absence of her father. Even for traditional symptoms of PTSD, those symptoms are often rooted as much in her father's absence as the death itself. For example, the patient's hypervigilance stems not only from a perception that terrible events can occur at any time, but also that she is unsure how she would manage such events without her father's support. Although much of the patient's distress around the loss may have been addressed in Prolonged Exposure, the shared focus in CGT on issues related to the loss itself, the relationship with the deceased, and a restoration of meaning and purpose better addresses the full breadth of the patient's symptoms.

## *Summary and Recommendations*

These clinical vignettes illustrate the importance of building a clear understanding of the nature of our bereaved patients' symptoms. In the clinic, we recommend considering PTSD-focused therapy (i.e., Prolonged Exposure, Cognitive Processing Therapy) for those bereaved patients who are primarily

concerned with ongoing distress around memories of the death, physiological and emotional reactivity to reminders of the death, and considerable avoidance. However, when patients also experience distress and difficulty accepting the continued absence of their loved ones and a lost sense of meaning, purpose, or personal future, CGT may offer a broader toolbox for addressing both concerns around the death itself and problems moving forward in life more generally. Importantly, we know of no empirical research that can help guide this clinical decision-making. That is, while CGT, Prolonged Exposure, and Cognitive Processing Therapy have each been shown to be effective treatments, no studies have compared their efficacy in bereaved individuals, let alone examined which therapy may be most appropriate for specific subgroups of bereaved adults. Given the overlapping nature of the PTSD and CG symptoms, as well as their respective treatments, further research is needed to build a firm understanding of the most efficacious treatment options for bereaved individuals.

## Conclusion

CG and PTSD are both common psychological reactions to bereavement with considerable historical and phenomenological overlap. The overlap between these disorders poses a challenge for clinicians and clinical researchers. Often our patients' experiences do not fall cleanly in the categories of trauma vs. bereavement, nor do their emotional responses fall cleanly into the categories of CG vs. PTSD. Therefore, it is important that we assess and consider symptoms of both disorders when working with bereaved individuals, allowing the primary concerns of the patient to guide the course of treatment. As CG continues to become established in our field, it is our hope that clinical researchers will do more to assess co-occurring PTSD and CG and to evaluate the effect of treatment on these conditions in order to guide clinical decision-making regarding the assessment and treatment of the conditions in bereaved adults.

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