

Prolonged Grief Disorder

Lizel Craig, RN, BSN

After so many years of angst, I can admit to myself that today, 17 years later, I am happy again. People who genuinely wanted to provide support gave me all kinds of puzzling advice. In general, people just don't know what to say to a person who has had such a life-changing tragedy as I experienced. Good-intentioned well wishers have said, "Oh, you're young. You'll meet someone else." "You should start dating right away." It is still uncomfortable when people ask about the father of my two daughters; they get embarrassed and immediately apologize once I tell them about my loss. I find myself consoling them by letting them know it was almost a lifetime ago. In reality, time does heal all wounds (if you allow yourself to integrate the healing). However, it has been a difficult journey; and I have needed a lot of time and distance to fully live my life again. Last week, sitting in my oncology nursing course, as a family nurse practitioner graduate student, I began a bewildering and unanticipated journey back in time. I don't know what possessed me to take an oncology course as an elective anyway. What was I thinking about? Maybe it was involuntary. Maybe my soul needed to remember the dark days of 1993. Although I am no longer actively grieving, I continue to struggle with the residual consequences of pathological grief, sometimes called complicated grief. Maybe, subconsciously, I finally realized that letting go could only happen once I fully reflected on and relinquished the key events that forever changed the course of my life.

Bereavement-Related Disorders

Individuals suffering from loss and comorbidities of depression-related symptoms may be diagnosed with post-traumatic stress disorder (PTSD) or major depressive disorder (MDD) (American Psychiatric Association [APA], 1994). Prolonged grief disorder (PGD) sometimes occurs simultaneously with MDD and PTSD (about 21%–54% and 30%–50%, respectively); however, research has shown that PGD has significantly different symptoms (Prigerson et al., 2009; Shear, Frank, Houch, & Reynolds, 2005). The fourth edition of the *Diagnostic and Statis-*

tical Manual of Mental Disorders (DSM-IV) excluded grief as a mental illness, defining it instead as "an expectable and culturally sanctioned response to a particular event" (Prigerson et al., 2009, p. 2). In the *DSM-IV*, bereavement is considered a "V" code: a condition that needs attention but presents with symptoms characteristic of MDD, such as feelings of sadness, insomnia, or anorexia. Criteria for differentiating bereavement from MDD are provided in the *DSM-IV* and include symptoms such as guilt, feelings of worthlessness, hallucinations, psychomotor retardation, thoughts of death, and functional impairment. PGD is a recent diagnosis being studied to identify criteria for inclusion in the fifth edition of the *DSM (DSM-V)* (see Table 1) and the 11th revision of *International Statistical Classification of Diseases and Related Health Problems (ICD-11)* (Prigerson et al., 2009).

Prolonged Pathologic Grief

Grief is universal. Virtually every person will experience the death of a close relative or friend over a lifetime (National Center for Health Statistics [NCHS], 2005). According to Kubler-Ross (1969), grieving is a stepwise progression resulting in healing: denial, anger, bargaining, depression, and, finally, acceptance. Although most individuals are able to mourn effectively, researchers have found that prolonged ineffectual patterns, termed PGD, are experienced by 10%–20% of the population (Shear et al., 2005). Prolonged grief may begin 6–12 months after the death of a loved one and is defined as the inability of the survivor to accept the reality of the death (Maciejewski, Zhang, Block, & Prigerson, 2007). This aggregate, estimated to include 1 million people, shares specific risk factors that can be identified by assessment of a spouse, family members, or friends (Kissane et al., 2006; Shear et al., 2005).

Characteristics of PGD include a strong denial of the loss, lowered self-worth, difficulty adapting to life without

the deceased loved one, and an inability to form new bonds or relationships with others (Prigerson et al., 2009). Cumulative loss or trauma prior to the death of a loved one can contribute to the risk factors of PGD, including childhood separation anxiety, an insecure attachment style, parental abuse or death, parental control, and yearning for a reunion with a loved one (Prigerson et al., 2009). The loved one's dependency on the deceased, a close kinship with the family of the deceased, and an unanticipated or complicated death (e.g., suicide) are additional risk factors (Prigerson et al., 2009).

By identifying risk factors and definitive diagnostic criteria, assessment of spouse or family members who are most vulnerable for prolonged grief can be carried out to provide early intervention strategies and prevention of PGD. African Americans have been identified as having a 2.5 times higher risk for PGD than the general population, most likely a result of confounding societal stressors (Goldsmith, Morrison, Vanderwerker, & Prigerson, 2008). Populations at high risk for PGD also include individuals with a previous psychiatric history of depression, anxiety, and bipolar disease (Redfield Jamison, 2009; Simon, Pollack, Fischmann, Perlman, & Muriel, 2005).

PGD symptoms can persist for years, negatively affecting quality of life. Symptoms include flashbacks of the death experience and detachment from life; avoidant or intrusive blocking of thoughts related to the experience; emotional lassitude ranging from numbness to bitterness and excessive anger; identity confusion with desperate loneliness, helplessness, and the inability to move on; and detachment, identity confusion, occupational difficulties, and suicidal ideation (Horowitz et al., 2003). Research has recognized these distinguishing symptoms to support the psychiatric diagnosis of PGD, subsequently validating criteria for inclusion in the forthcoming *DSM-V* (Prigerson et al., 2009). Acknowledging the reality of this

disorder can facilitate healing by identifying specific criteria and interventions for suffering individuals. Providing its own nomenclature will stimulate future research and encourage the development of social support networks that meet the specific needs of individuals at high risk for PGD (Horowitz et al., 2003).

My initial “flashback” occurred on the second day of the oncology class, during a lecture. As I sat motionless, mesmerized with glazed eyes open, I suddenly became very warm, almost feverish. Gradually my mind clamped down on the densely packed, miniature classroom. It became devoid of people as it transformed into a cylindrical darkened tomb tunneling toward my most hidden compartmentalized memories. After several moments, I remembered myself. I stood and quietly escaped the suddenly distressing classroom. I was astonished and in disbelief at the freshness of the deep, dark, and dreadfully sad memories that flooded my every thought. The intensity was severe, the pain crisp. The traumatic experience of my husband’s death came flooding into the present.

My husband, David, was only 22 years old when he died. Unexpectedly, I became a young widow and the single parent of two

daughters, both under the age of two years. I gave birth to my second daughter during my husband’s last cycle of chemotherapy. When he became acutely ill, I was only two months postpartum, lactating, and potty training our oldest daughter at 18 months. Looking back, the experience is surreal for even me—I was faced with sudden shock, horror, and devastation. David had non-Hodgkin lymphoma, grade IV, with liver, spleen, and spinal metastasis. Of course I knew he was very ill, but both of us were too young to understand the gravity of the situation. We had no idea. We had hope. At such a young age, who knew life was so fragile? It was unimaginable that chemotherapy would ravage his body and he would succumb to the very treatment designed to cure him. I could not integrate his death only six months after diagnosis. I was not prepared for the finality of death, and, suddenly, I was alone.

Differential Diagnosis and Criteria

Prigerson et al. (2009) provided a comprehensive overview differentiating PGD criteria from *DSM-IV* criteria for MDD, PTSD, and generalized anxiety disorder (GAD). Symptoms of PGD have been as-

sessed with the Inventory of Complicated Grief-Revised (ICG-R) in combination with the Structured Clinical Interview for *DSM-IV* (non-patient version) (Prigerson et al., 2009). PTSD has been inextricably linked with combat military service. In 1980, the APA created the diagnosis of PTSD to replace the stigmatizing terms used during the American Civil War and World War I of “battle fatigue,” “postwar shell and psychosis,” and “combat stress” (U.S. Department of Veterans Affairs, 2010).

The experience of PTSD has proven different than PGD; however, similarities do exist: vivid flashbacks of the trauma, an inability to function, and difficulty reintegrating into society (APA, 1994; Prigerson et al., 2009). The similarities between PTSD and bereavement supported the decision to expand the definition of PTSD in the *DSM-IV* (APA, 1994). Treatment for PTSD differs from that proposed for PGD. The U.S. Department of Veterans Affairs’ (2010) clinical guidelines for PTSD include antidepressants, eye movement desensitization reprocessing, stress inoculation, prolonged

Table 1. Proposed Diagnostic Criteria for Prolonged Grief Disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.)

Category	Definition
A. Event criterion	Bereavement (loss of a significant other)
B. Separation distress	The bereaved person experiences at least one of the following symptoms, which must be experienced daily or to a distressing or disruptive degree: • Intrusive thoughts related to the lost relationship • Intense feelings or emotional pain, sorrow, or pangs or grief related to the lost relationship • Yearning for the lost person
C. Cognitive, emotional, and behavioral symptoms	The bereaved person must experience five (or more) of the following symptoms daily or to a distressing or disruptive degree: • Confusion about one’s identity (e.g., role in life, diminished sense of self, feeling that a part of oneself has died) • Difficulty accepting the loss • Avoidance of reminders of the reality of the loss • Inability to trust others since the loss • Bitterness or anger related to the loss • Difficulty moving on with life (e.g., making new friends, pursuing interests) • Numbness (absence of emotion) since the loss • Feeling that life is unfulfilling, empty, and meaningless since the loss • Feeling stunned, dazed, or shocked by the loss
D. Duration	Duration at least six months from the onset of separation distress
E. Impairment	The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (e.g., domestic responsibilities).
F. Relation to other mental disorders	Should not be better accounted for by major depressive disorder, generalized anxiety disorder, or post-traumatic stress disorder

Note. From “Prolonged Grief Disorder: Psychometric Validation of Criteria Proposed for DSM-V and ICD-11,” by H.G. Prigerson, M.J. Horowitz, S.C. Jacobs, C.M. Parkes, M. Aslan, K. Goodwin, . . . P.K. Maciejewski, 2009, *PLoS Medicine*, 6(8), p. 9. Copyright 2009 by Prigerson et al. Reprinted with permission.

exposure therapy, and cognitive therapy (Friedman & Schnurr, 2008).

Risk factors for PGD have been found to differ dramatically from PTSD with respect to patient and family psychosocial history, socioeconomic status, age, time frame after traumatic event for onset, clinical manifestation, treatment modalities, and objectives (see Table 2). Research findings have identified that criteria for PGD must exist for a minimum of six months after the time of a loved one's death, with continued functional impairment of the survivor (Prigerson et al., 2009). Yearning for reunion with the loved one and the inability to accept the death interfere with the survivor's ability to move forward in life. Denial of the reality of the death leaves the survivor with feelings of mistrust, bitterness, and identity confusion (Prigerson et al., 2009). Research has found that people suffering from PGD do not respond to antidepressant therapy as do PTSD sufferers (Szanto, Prigerson, & Reynolds, 2001). PGD symptoms also have been found to increase the risk of suicidal ideation and attempts, and medical complications such as cancer, immune suppression, hypertension, and cardiac events also are increased in this population (Prigerson et al., 2009).

Writing these words, my first words about David's death, I can vividly recall the sound of the final beep before looking up to see the flat line on his cardiac monitor. Years later, I can still smell the metallic odor on his breath. I can close my eyes and envision the young nurse giving my husband chest compressions. I can visualize the angst on his sister's face as she set her eyes on mine; shaking her head "no" when the attending physician swirled around to face me—seeking my approval to "call an end" to the unexpected code.

As I traced what had been David's familiar scars, tender body, and soft hair, the foreign sensations of emptiness and rigidity were heart wrenching. I was experiencing for the first time the unfamiliar postmortem body that now encased him. My husband remains etched in my brain—memorized. I can still "feel him." When triggered unexpectedly, like sitting in a lecture related to cancer, the brief memories ripple forth like calm undulating waves caused by a passing ship upon a pristine shoreline. If I stop to reflect before the waves subside, I re-experience the heightened emotions I felt the day before he died.

I remember the fear of abandonment and the unknown that was expressed in his eyes. He called his last word, "Mamma," into the air and his eyes turned into a frantic gaze locked to the back of the hospital room. He clenched his bed sheets; his body jarred and jerked into a full tonic-clonic seizure. The room burst into

chaotic screams and pleadings to God, for someone, *anyone*, to do something! I felt helpless and scared along with his parents, siblings, and the clergy. Then suddenly, silence befell the room. After a brief moment, he gasped deeply. David became unconscious and unresponsive, sweaty and lifeless. The nurses, doctors, and respiratory therapists quickly got him sedated, intubated, and transported to the intensive care unit. This is the first time I remember going completely numb. My mind vacated my body—I was floating above all the "actors" of this horrific scene. I could see my still figure taking up geometrically quantifiable space, but I no longer felt a physical part of it

all. The painful reality of this trauma proved too much for my psyche. I became broken.

From dark until dawn, on June 12, 1993, I sat alone at David's bedside wondering why and how this could happen to him—to me—to our little family. From the time of diagnosis, David prayed while I fumed, "How can you pray to God when He let you get cancer?" David's response haunts me to this day: "This is God's opportunity to show me how good he can be to me." When David died, I pondered, "How could God fail to save such a good person, loving father, devoted husband, decent man, and faithful servant?" From my perspective, God allowed David to

Table 2. Differential Diagnosis for Post-Traumatic Stress Disorder (PTSD) and Prolonged Grief Disorder (PGD)

Differential Diagnosis	PTSD	PGD
Age	Any	Young
Desperate loneliness or "feeling adrift"	No	Yes
Detachment from life	Yes	Yes
Family history	None	Yes
Gender	Any	More common in women than men
Helplessness	Yes	Yes
Hypervigilance or unrealistic fears	Yes	Yes
Intrusive thoughts	Yes	Yes
Lower socioeconomic status	No	Yes
Occupational difficulties	Yes	Yes
Onset of symptoms	After trauma	Six months after event
Psychosocial history	None	Yes
Re-experience	Yes	Yes
Suicidal ideation or action	Yes	Yes
Traumatic events	Yes/death or near death of self or loved one	Yes/sudden loss or death of loved one
Painful yearning ^a	No	Required
• Avoidance, thought blocking, or foreshortened future	Yes	Required
• Bitterness over loss ^b	Yes	Required
• Difficulty accepting loss ^b	No	Required
• Difficulty moving on ^b	Yes	Required
• Emotional numbness ^b	No	Required
• Functional impairment ^b	Yes	Required
• Identity confusion ^b	No	Required
• Life is meaningless ^b	No	Required
• Stunned ^b	No	Required

^a A PGD diagnosis requires five out of the nine criteria listed.

^b These symptoms must occur for 6–12 months, minimum, after the loss to meet criteria for PGD diagnosis.

Note. Based on information from Horowitz et al., 2003; Prigerson et al., 2009.

die—let me die. By inference, I felt that God had killed my family. God abandoned David; so in turn, I took deliberate strides to abandon my belief in God. Inside I felt rage, sin, and hate in response to my sadness, loneliness, and confused desperation.

Psychiatric Treatments

If PGD is recognized and treated effectively, the estimated 1 million who may suffer from it may begin to gain some level of support (NCHS, 2005; Shear et al., 2005). Once an accurate diagnosis is made, patients can receive specific guidance and counseling, appropriate pharmacologic interventions, and psychotherapies to assist them in recovering from intrusive thoughts, dissociative moments, and flashbacks. Providing emotional support to a person suffering from PGD is imperative given that this cohort has a higher suicide rate than other mental illnesses, such as PTSD (Szanto et al., 2001). It has been suggested that suicide occurs when other coping mechanisms such as faith, social, family, and societal supports fail (U.S. Department of Health and Human Services, 2009).

The *DSM-V* proposes to outline criteria for PGD to provide clinicians with identified symptoms that differentiate prolonged grief from normal, expected grief responses. The proposed treatment goal for PGD is prevention: stress, anxiety, and anger management; conflict resolution; improved sleep patterns; and structured participation in social activities.

Because the diagnosis and treatment of PGD have formally been associated with MDD or PTSD, clearly delineated treatment regimens are lacking. To date, no randomized clinical studies have investigated pharmacologic treatments of PGD (Maciejewski et al., 2007). Research suggests that although selective serotonin reuptake inhibitors (SSRIs) (e.g., paroxetine) and tricyclic antidepressants (e.g., nortriptyline), with or without psychotherapy, are effective in reducing symptoms of MDD, they are ineffective in PGD management (Maciejewski et al., 2007; Prigerson et al., 2009). A small cohort case study demonstrated that norepinephrine and dopamine reuptake inhibitors (e.g., bupropion) and SSRIs (e.g., escitalopram) may have modest to significant symptom improvements, respectively (Maciejewski et al., 2007).

Psychotherapy may prove to be a valuable intervention to treat individuals suffering from PGD. Cognitive-behavioral therapy could assist survivors in changing negative perceptions related to their loss and help them “re-engage with the

world” (Prigerson et al., 2009, p. 12). Risk factors for PGD are related to abnormal attachment issues that precede the death and increase the individual’s vulnerability for prolonged grief (Prigerson et al., 2009). Early identification of marital dependency issues or abnormal family cohesion could prove important. Providing effective treatments for PGD would decrease the personal agony and societal costs of unresolved grief. Establishing criteria for PGD in the *DSM-V* would provide an ICD code (NCHS, 2009) and ensure reimbursement for treatment (Prigerson et al., 2009).

My grieving and behavior became hazardous. I grieved my husband’s death for at least 10 years, on and off, depending on arousing triggers and life’s daily challenges. Every disappointment or letdown or perceived failure dredged up ill feelings, and my deep depression prompted suicidal ideation. I habitually over-reacted to small misfortunes and disagreements with either visceral, gut-wrenching, body-jerking tears or raging outbursts. My emotions were inconsistent. I became uncompromisingly strong and self-assured or indecisively neurotic. My behaviors became so unpredictable that it became impossible for anyone to recognize me, let alone help me. My ineffectual grieving led to a stone wall of denial and an inability to form healthy relationships. After David’s death, I rejected my religion and faith, my family, and friends, only to find myself disappearing into solitary confinement and self-pity.

Nursing Interventions

Family-focused bereavement care needs to start during the stage of terminal disease to prevent pathologic grief onset. Individuals with a history of personal or family depression meet screening criteria. Oncology nurses are educated to interface with and gain critical trust from people under duress. Recognizing that a cancer diagnosis may result in failed treatment or sudden death, oncology nurses must understand the family’s grieving process, particularly the risk factors for complicated bereavement. Oncology nurses must be cognizant of research efforts to include PGD in *DSM-V* and *ICD-11* given that new practice guidelines and interventions may be introduced to identify and assist people at risk (Prigerson et al., 2009). Oncology nurses can then refer the patient and family to the appropriate resource for additional assessment and intervention (e.g., psychiatric or oncology advanced practice nurse, psychologist, psychiatrist). Interventions are more effective before a cancer-related

death occurs. The oncology nurse can ascertain those at risk by using specific mental health questions directed to the spouse or family members during the initial history and physical interview. Examples may include those identified by the National Comprehensive Cancer Network (NCCN), (2007) *Guidelines for the Assessment of Distress in Patients With Cancer*. Often the patient’s and spouse’s emotions will be interdependent; if the patient is in emotional distress or depressed, most likely the spouse will share the same emotions. Underlying the diagnostic criteria for PGD are issues related to attachment and dependency—this may increase the likelihood that the patient and spouse may share the same feelings in relationship to grief and loss. Therefore, simple questions for both the patient and spouse may be helpful for the oncology nurse to identify emotional, psychological, social, or spiritual distress (NCCN, 2007). Simple questions may include, “Are you feeling sad, blue, or depressed?” “Do you have any feelings of fear or anxiety?” “Do you have a desire to hurt yourself?”

Oncology nurses can contribute to the development of assessment guides for identification of PGD and for the development of protocols that incorporate follow-up and referral. The psychosocial assessment must allow adequate time for sensitive, personal questions. A safe and private environment will elicit meaningful and thoughtful responses from the patient, spouse, or other family members. Creative solutions can assist the oncology nurse to feel comfortable to address these psychosocial issues. Educational staff meetings and nurse support groups can help the oncology caregiver to feel more confident in addressing emotionally challenging situations. For the spouse and family, referral and follow-up care can be delineated by using brochures related to support groups and a designated area for posting family-centered events on grief and loss, educational seminars on coping and end-of-life care, and cohort-based group counseling sessions. Initially the spouse may experience great zeal and unrivaled enthusiasm for meeting the patient’s needs during illness, but toward the end of the cancer trajectory, the caregiver is at higher risk of feeling overwhelmed and overcome by sadness. The PGD criteria address the possible internal conflicts with coping that may stem from internalized guilt, anger, confusion, and denial. Feelings of “survivor guilt”—the spouse feeling no right to happiness in the face

of recent or imminent death of a loved one—are not uncommon.

Once death occurs, sadness and grief may catapult the surviving loved one into an ineffectual prolonged grief that can contribute to emotional, cognitive, or behavioral illnesses. Sharing the journey with a psychotherapist or in a support group can expedite the healing process. As with all mental health disorders, the oncology nurse must be vigilant in observing for and directly asking about suicidal ideation and attempts. In accordance with APA (1995) guidelines, when individuals present with moderate to severe symptoms of mental illness, it is a professional imperative to refer the person for psychological evaluation and consultation.

Residual Consequences and New Beginnings

According to the U.S. Census Bureau (2005), only 0.3% of all women in America aged 20–34 years have been widowed. Cultural differences, socioeconomic inequality, educational status, gender, and age may compound the challenges to adapt to loss. Limitations of the research carried out to identify criteria for PGD include that the majority of the population studied was female, Caucasian, and older (Prigerson et al., 2009). Future research should test criteria for bereavement-related mental illness associated with gender, age, race, education, cause of death (e.g., natural versus catastrophic), and the relationship patterns involved (e.g., parent losing a child). Despite the identified need for additional research, validation for the criteria for PGD to be included in the *DSM-IV* and *ICD-11* has been considered undisputable (Prigerson et al., 2009).

At many times I felt alone in my standing as a cancer-related surviving young widow, particularly a young African American widow with two young children in tow. The U.S. Census Bureau claimed in 2005 that only 30% of African Americans were getting married and 46% said they never would. These statistics blunted my hopes of ever becoming happily united in marital bliss again. I developed fears and anxiety about traumatic injury and sudden death, growing old alone, or being unlovable and unworthy of happiness. These fears manifested in pessimism, isolation, and avoidant behaviors. Unrealistic fears stifled my personal growth and ability to experience simple joy and love. I became anxious every time my children or I would leave the house—I feared a tragic event was always impending. Seventeen years later, I still battle

with irrational fears and have a preoccupation with our safety. I admit jealousy of married couples and two-parent families. For years, my painful envy kept me from going to many family functions; I felt like an outcast amongst married couples and families.

From early childhood parental loss, my intense abandonment issues were amplified by the painful experience of my husband's early death. Writing my story has provided a healing process, and I now have a name for my suffering, PGD. Ultimately, after a great deal of introspection and an abundance of family support, I feel whole again. I feel blessed to be in a happy, committed relationship, but I continue to struggle with insecure attachment issues. If allowed, the intense fear of abandonment creeps back into my psyche. I continue on with my new journey of self-discovery. My experiences of grief and loss have given me a stronger and deeper appreciation for life and for the people I dearly love. The journey has been painful and long, but I continue to heal and recover. I try to stay in the present now and, when I become anxious and afraid, I have learned to try to take a deep breath, wait before speaking or reacting, exhale, and respond carefully and slowly. This permits me to experience and distinguish my turbulent emotions without alienating myself from my loved ones. I am proud that I can look back at my past and know that I am a survivor. I have gained pearls of wisdom through my personal experience and, as a nurse, I hope to use this wisdom to guide and comfort my patients.

Lizel Craig, RN, BSN, is an RN in the neonatal intensive care unit at the University of California, Los Angeles, Medical Center and a graduate family nurse practitioner student in the School of Nursing at the University of California, Los Angeles. No financial relationships to disclose. Craig can be reached at leedyer@ucla.edu, with copy to editor at ONFEditor@ons.org.

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Clinical Highlights: Prolonged Grief Disorder

Definition

The essential feature of prolonged grief disorder (PGD) is unresolved grief that involves denial of the death of a loved one and subsequent unrealistic yearning to be reunited (Prigerson et al., 2009). PGD criteria have been researched and validated to be included in the forthcoming fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*. PGD was not identified in the fourth edition of the *DSM (DSM-IV)* (American Psychiatric Association [APA], 1994) as a mental illness. The *DSM-IV* associated bereavement, customarily referred to as "complicated grief," with other mental disorders such as major depressive disorder (MDD), post-traumatic stress disorder (PTSD), or generalized anxiety disorder (GAD).

Risk Factors

Abnormal attachment disorders underlie the majority of risk factors for PGD. These include childhood separation anxiety, insecure attachment style, spouse dependency, parental loss or abuse, and sudden unexpected death (Prigerson et al., 2009). The majority of research has been carried out on female, Caucasian, and older adult populations. Therefore, additional research is needed to determine the effect of gender and age, race and ethnicity, and socioeconomic and educational risk factors (Prigerson et al., 2009). One small cohort study demonstrated that African Americans had a 2.5 times higher incidence of PGD than the Caucasian population (Goldsmith, Morrison, Vanderwerker, & Prigerson, 2008).

Clinical Presentation

In addition to symptoms of denial and yearning, patients with PGD must present with five of the following identified criteria: emotional numbness, stunned by the loss, life feels meaningless following the death, mistrust, bitterness, inability to accept the reality

of the loss, identity confusion following the loss, avoidance and blocking the reality of the loss, and difficulty moving forward in life (Prigerson et al., 2009). Essentially, the survivor becomes immobilized from the unresolved grief with emotional, cognitive, and behavioral manifestations.

Differential Diagnosis

Grief related to the loss of a loved one is a natural consequence, and death of a loved one is a life-changing experience. Normal grief reactions identified by the *DSM-IV* include symptoms similar to MDD such as sadness, insomnia, anorexia and weight loss, and difficulty concentrating. Criteria for the diagnosis of PTSD also overlap those of PGD and may include flashbacks of the trauma, inability to function, and difficulty integrating back into life. GAD is closely aligned with MDD, but anxiety is not a criterion for PGD (APA, 1994). The diagnosis of PGD should not be made until symptoms persist beyond a six-month period from the death of the loved one and the symptoms cannot be accounted for by any other mental illness such as MDD, PTSD, or GAD (Prigerson et al., 2009).

Treatment

Because of the research to identify PGD criteria for inclusion in the *DSM-V* as a mental illness, limited research has been carried out to identify the most effective treatment modalities. What is recognized is the necessity for early detection to prevent the emotional and societal costs of PGD (Prigerson et al., 2009). PGD has not consistently shown responsiveness to pharmacologic interventions; however, case studies indicate that dopamine reuptake inhibitors may induce modest response, whereas selective serotonin reuptake inhibitors have shown significant symptom improvement (Maciejewski, Zhang, Block, & Prigerson, 2007). Psychotherapy plays an important role in all diagnoses of mental illness. In the case of PGD, cognitive-

behavioral therapy could prove effective by assisting the survivor to "reframe" negative perceptions regarding the death of their loved one. Positive reassurance that feelings of guilt, remorse, and self-punishment are unhealthy can contribute to healing. Support groups also may reduce feelings of isolation and despair.

Implications for Nursing

Oncology nurses are in a pivotal position to identify patients at high risk for PGD. Oncology nursing provides holistic and family-centered care with a major focus on psychosocial responses to cancer and end-of-life experiences. The role of the oncology nurse is to validate the spouse or family members' feelings and refer patients for psychological consultation and treatment if appropriate. APA (1995) guidelines also advised that all patients with mental illness be evaluated for suicidal ideation or attempts.

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