SPECIAL ARTICLE

Grief and bereavement: what psychiatrists need to know

SIDNEY ZISOOK, KATHERINE SHEAR

Department of Psychiatry, University of California at San Diego, 9500 Gilman Drive, 9116A, La Jolla, CA 92093, USA

This review covers four areas of clinical importance to practicing psychiatrists: a) symptoms and course of uncomplicated (normal) grief; b) differential diagnosis, clinical characteristics and treatment of complicated grief; c) differential diagnosis, clinical characteristics and treatment of grief-related major depression; and d) psychiatrists' reactions to patient suicides. Psychiatrists often are ill prepared to identify complicated grief and grief-related major depression, and may not always be trained to identify or provide the most appropriate course of treatment. Both conditions overlap with symptoms found in ordinary, uncomplicated grief, and often are written off as "normal" with the faulty assumption that time, strength of character and the natural support system will heal. While uncomplicated grief may be extremely painful, disruptive and consuming, it is usually tolerable and self-limited and does not require formal treatment. However, both complicated grief and grief-related major depression can be persistent and gravely disabling, can dramatically interfere with function and quality of life, and may even be life threatening in the absence of treatment; and both usually respond to targeted psychiatric interventions. In addition, patient suicide has been reported as one of the most frequent and stressful crises experienced by health providers, and psychiatrists are not immune to complicated grief or grief-related depression when they, themselves, become survivors. Thus, it is essential for psychiatrists to recognize their own vulnerabilities to the personal assaults that often accompany such losses, not only for their own mental health and well-being, but also to provide the most sensitive and enlightened care to their patients.

Key words: Bereavement, grief, uncomplicated grief, major depression, suicide

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Unfortunately, grief is not a topic of in-depth discussion at most medical schools or general medical or psychiatry residency training programs. Thus, myth and innuendo substitute for evidence-based wisdom when it comes to understanding and dealing with this universal, sometimes debilitating human experience.

When Engel (1) raised the question "Is grief a disease?" as the title of his now classic article on the subject, he argued convincingly that grief shares many characteristics of physical diseases, such as a known etiology (in this case, death of a loved one), distress, a relatively predictable symptomatology and course and functional impairment. And while healing usually occurs, it is not always complete. In some bereaved individuals with preexisting vulnerabilities, for example, the intense pain and distress festers, can go on interminably (as "complicated grief"), and the loss may provoke psychiatric complications, such as major depression.

Engel's work, followed by several empirical studies on the phenomenology and course of grief, and its complication and treatment, has legitimized the study of grief for mental health practitioners. Yet, to this day, the bulk of what is known about grief and its biomedical complications has not been widely disseminated to clinicians. This review is meant to help fill that gap.

In order to appreciate how grief can go awry and transition from a normal response to a disabling condition warranting medical attention, the clinician must first know the characteristics of normal grief and how to differentiate normal grief from complicated grief and/or grief-related major depression. Consequently, this review begins with a section on "normal" grief, followed by sections on the phenomenology, differential diagnosis, course and treatment of "complicated" grief, and grief-related major depression. Since psychiatrists themselves are not immune to the potential ravages of grief, a final section focuses on the personal and emotional consequences of one of our most disturbing occupational hazards, a patient's suicide.

WHAT IS UNCOMPLICATED (NORMAL) GRIEF?

Some investigators have attempted to define discrete stages of grief, such as an initial period of numbness leading to depression and finally to reorganization and recovery. However, most modern grief specialists recognize the variations and fluidity of grief experiences, that differ considerably in intensity and length among cultural groups and from person to person (2,3). To date, no grief stage theory has been able to account for how people cope with loss, why they experience varying degrees and types of distress at different times, and how or when they adjust to a life without their loved one over time.

The terms *bereavement* and *grief* are used inconsistently in the literature to refer to either the state of having lost someone to death, or the response to such a loss. Researchers have suggested that the term bereavement be used to refer to the fact of the loss; the term grief should then be used to describe the emotional, cognitive, functional and behavioral responses to the death. Also, grief is often used more broadly to refer to the response to other kinds of loss; people grieve the loss of their youth, of opportunities, and of functional abilities. Mourning is also sometimes used interchangeably with bereavement and grief, usually referring more specifically to the behavioral manifestations of grief, which are influenced by social and cultural rituals, such as funerals, visitations, or other customs. *Complicated grief*, sometimes referred to as unresolved or traumatic grief, is the current designation for a syndrome of prolonged and intense grief that is associated

with substantial impairment in work, health, and social functioning.

What constitutes "normal" grief? There is no simple answer. Grief is different for every person and every loss, and it can be damaging to judge or label a person's grief, especially during early bereavement. However, a clinician needs to make a judgment about whether a person's grief is progressing adaptively in order to make categorical decisions about whether or not to intervene. A clinician who does not understand the range of grief symptoms is at risk for intervening in a normal process and possibly derailing it. At the same time, knowledge about the boundaries of uncomplicated, adaptive grief can guard against failure to recognize complicated grief and/or depression occurring in the wake of a loved one's death. If complicated grief or major depression is mistakenly judged as "normal", bereaved individuals may be at risk for inattention to, or ineffective treatment of, clinically important problems. For pragmatic reasons, we favor the term "uncomplicated" over "normal" grief, as it is easier to categorize complications of grief, such as the syndrome of complicated grief or bereavement-related depression, than to resolve the endless debate of what is, and is not, normal.

How long does grief last? The intensity and duration of grief is highly variable, not only in the same individual over time or after different losses, but also in different people dealing with ostensibly similar losses. The intensity and duration is determined by multiple forces, including, among others: the individual's preexisting personality, attachment style, genetic makeup and unique vulnerabilities; age and health; spirituality and cultural identity; supports and resources; the number of losses; the nature of the relationship (e.g., interdependent vs. distant, loving vs. ambivalent); the relation (parent vs. child vs. spouse vs. sibling vs. friend, etc.); type of loss (sudden and unanticipated vs. gradual and anticipated, or natural causes vs. suicide, accident or homicide) (4). Certainly, many of these factors also contribute to the proclivity for complicated grief, major depression, and other adverse consequences. Nonetheless, there are general guidelines to help the clinician determine the expected phenomenology, course, and duration of uncomplicated grief.

First, grief is not a state, but rather a process. Second, the grief process typically proceeds in fits and starts, with attention oscillating to and from the painful reality of the death. Third, the spectrum of emotional, cognitive, social and behavioral disruptions of grief is broad, ranging from barely noticeable alterations to profound anguish and dysfunction. Sometimes, clinicians mistakenly label the lack of observable grief or mourning as pathological, suggesting vulnerability to delayed intense grief or medical complications. However, there is little empirical validation of this assumption and significant data to refute it (5,6). On the other side of the spectrum, bereavement can be one of the most gut-wrenching and painful experiences an individual ever faces. Shock, anguish, loss, anger, guilt, regret, anxiety, fear, loneliness, unhappiness, depression, intrusive images, depersonalization, and the feeling of being overwhelmed are but a few of the sentient states grieving individuals often describe. At first, these acute feelings of anguish and despair may seem omnipresent, but soon they evolve into waves or bursts, initially unprovoked, and later brought on by specific reminders of the deceased. Healthy, generally adaptive people likely have not experienced such an emotional roller coaster, and typically find the intense, uncontrollable emotionality of acute grief disconcerting or even shameful or frightening. If these reactions are prominent, a person may attempt to avoid reminders or over-control stimuli which can interfere with the normal grief progression.

Yet, grief is not only about pain. In an uncomplicated grief process, painful experiences are intermingled with positive feelings, such as relief, joy, peace, and happiness that emerge after the loss of an important person. Frequently, these positive feelings elicit negative emotions of disloyalty and guilt in the bereaved. Of note, at least one investigator has found that positive feelings at 6 months following a death are a sign of resilience and associated with good long-term outcomes (7).

Fourth, for most people grief is never fully completed. However, there are two easily distinguishable forms of grief (8). First, the *acute grief* that occurs in the early aftermath of a death can be intensely painful and is often characterized by behaviors and emotions that would be considered unusual in normal everyday life. These include intense sadness and crying, other unfamiliar dysphoric emotions, preoccupation with thoughts and memories of the deceased person, disturbed neurovegetative functions, difficulty concentrating, and relative disinterest in other people and in activities of daily life (apart from their role in mourning the deceased). This form of grief is distinguished from a later form of grief, *integrated or abiding grief*, in which the deceased is easily called to mind, often with associated sadness and longing. During the transition from acute to integrated grief, usually beginning within the first few months of the death, the wounds begin to heal, and the bereaved person finds his or her way back to a fulfilling life. The reality and meaning of the death are assimilated and the bereaved are able to engage once again in pleasurable and satisfying relationships and activities. Even though the grief has been integrated, they do not forget the people they lost, relinquish their sadness nor do they stop missing their loved ones. The loss becomes integrated into autobiographical memory and the thoughts and memories of the deceased are no longer preoccupying or disabling. Unlike acute grief, integrated grief does not persistently preoccupy the mind or disrupt other activities. However, there may be periods when the acute grief reawakens. This can occur around the time of significant events, such as holidays, birthdays, anniversaries, another loss, or a particularly stressful time.

Fifth, grief is not only about separation from the person who died, but about finding new and meaningful ways of continuing the relationship with the deceased (9,10). Faced with the dilemma of balancing inner and outer realities, the bereaved gradually learn to accept the loved one back into their lives as deceased. What occurs for survivors is the trans-

formation of a relationship that had heretofore operated on several levels of actual, symbolic, internalized, and imagined relatedness to one in which the actual (living and breathing) relationship has been lost. However, other forms of the relationship remain, and continue to evolve and change. Thus, it is not unusual for bereaved individuals to dream of their deceased loved ones, to half look for them in crowds, to sense their presence, feel them watching out for or protecting them, to rehearse discussions or "speak" to them. Auditory or visual hallucinations of the deceased person are often seen during acute grief. Sometimes people maintain a sense of connection through objects such as clothing, writings, favorite possessions, and rings, which may be kept indefinitely. Some people continue a relationship with the deceased through living legacies, such as identification phenomena, carrying out the deceased's mission, memorial donations, or seeing them live on in others through genetic endowments. For others, periodically visiting the grave or lighting candles may help keep memories alive. Bereaved individuals may take some comfort in learning that the relationship does not need to be totally severed, but that it is perfectly acceptable and even normal for the relationship to endure indefinitely.

There is no evidence that uncomplicated grief requires formal treatment or professional intervention (11). For most bereaved individuals, the arduous journey through grief will ultimately culminate in an acceptable level of adjustment to a life without their loved one. Thus, most bereaved individuals do fine without treatment. Certainly, if someone struggling with grief seeks help, they should have access to empathic support and information that validates that their response is typical after a loss. When support, reassurance, and information generally provided by family, friends, and, sometimes, clergy is not available or sufficient, mutual support groups may help fill the gap. Support groups can be particularly helpful after traumatic losses, such as the death of a child, a death after suicide (12) or deaths from other "unnatural" causes (13).

COMPLICATED GRIEF

Complicated grief, a syndrome that occurs in about 10% of bereaved people, results from the failure to transition from acute to integrated grief. As a result, acute grief is prolonged, perhaps indefinitely. Symptoms include separation distress (recurrent pangs of painful emotions, with intense yearning and longing for the deceased, and preoccupation with thoughts of the loved one) and traumatic distress (sense of disbelief regarding the death, anger and bitterness, distressing, intrusive thoughts related to the death, and pronounced avoidance of reminders of the painful loss) (10). Characteristically, individuals experiencing complicated grief have difficulty accepting the death, and the intense separation and traumatic distress may last well beyond six months (1,4). Bereaved individuals with complicated grief find themselves in a repetitive loop of intense yearning and longing that becomes the major focus of their lives, albeit accompanied by inevitable sadness, frustration, and anxiety. Complicated grievers may perceive their grief as frightening, shameful, and strange. They may believe that their life is over and that the intense pain they constantly endure will never cease. Alternatively, there are grievers who do not want the grief to end, as they feel it is all that is left of the relationship with their loved one. Sometimes, people think that, by enjoying their life, they are betraying their lost loved one. Maladaptive behaviors consist of over-involvement in activities related to the deceased, on the one hand, and excessive avoidance on the other. Preoccupation with the deceased may include daydreaming, sitting at the cemetery, or rearranging belongings. At the same time, the bereaved person may avoid activities and situations that remind them that the loved one is gone, or of the good times they spent with the deceased. Frequently, people with complicated grief feel estranged from others, including people that used to be close.

Risk factors for complicated grief have not been well studied. However, individuals who have a history of difficult early relationships and lose a person with whom they had a deeply satisfying relationship seem to be at risk. Additionally, those with a history of mood or anxiety disorders, those who have experienced multiple important losses, have a history of adverse life events and whose poor health, lack of social supports, or concurrent life stresses have overwhelmed their capacity to cope, may be at risk for complicated grief (8,10). An interesting unanswered question is why one person develops complicated grief, while another suffers from major depression or post-traumatic stress disorder in the wake of a loss.

Complicated grief can be reliably identified using the Inventory of Complicated Grief (ICG, 14). It is indicated by a score ≥ 30 on the ICG at least six months after the death. It is associated with significant distress, impairment, and negative health consequences (14,15). Studies have documented chronic sleep disturbance (16,17) and disruption in daily routine (18). People with complicated grief have been found to be at increased risk for cancer, cardiac disease, hypertension, substance abuse, and suicidality (19). Among bereaved spouses over the age of 50, 57% of those with complicated grief had suicidal ideation compared to the remaining 24% who did not endorse. Among adolescent friends of adolescent suicides, young adults with complicated grief were 4.12 times more likely to endorse suicidal thoughts, controlling for syndromal depression, than subjects who did not have syndromal level complicated grief (20). In studies of clinical populations, complicated grief was associated with a high rate of suicidal ideation, a history of suicide attempts and indirect suicidal behavior, not explained by co-occurring major depression (19), and with elevated rates of lifetime suicide attempts in bipolar patients (21). Once established, complicated grief tends to be chronic and unremitting. Clearly, complicated grief must be taken seriously and treated appropriately.

Psychotropic medications and standard grief-focused supportive psychotherapies appear to have little impact on this

syndrome. By contrast, a targeted intervention, complicated grief treatment (CGT), has demonstrated significantly better outcomes than standard psychotherapy in treating this syndrome (21). CGT combines cognitive behavioral techniques with aspects of interpersonal psychotherapy and motivational interviewing. The treatment includes a dual focus on coming to terms with the loss and on finding a pathway to restoration. It includes a structured exercise focused on repeatedly revisiting the time of the death as well as gradual re-engagement in activities and situations that have been avoided. Personal goals are addressed and discussed. A randomized controlled trial comparing CGT to standard interpersonal psychotherapy showed that the former performed better (22). Participants were permitted to enter the trial on medication that had been prescribed for more than 3 months if they still met criteria for complicated grief. Compared to those not already taking medication, previously treated individuals appeared to derive modest benefits from the addition of psychotherapy and proved to be more likely to complete a full course of CGT. Given these findings and the frequent occurrence of lifetime mood and anxiety disorders in individuals with complicated grief, it appears likely that combination treatment, including antidepressant medication and targeted psychotherapy, may be the most effective treatment approach (23). Prospective randomized controlled trials examining the role of pharmacotherapy for the treatment of complicated grief with and without concomitant psychotherapy are indicated.

GRIEF-RELATED MAJOR DEPRESSION

There have been numerous longitudinal follow-up studies of the newly bereaved. The majority of studies have focused on the widowed, although there are excellent studies of children who have lost a parent and of parents who have lost a child. Most studies have found roughly similar results, demonstrating a high frequency of depressive symptoms that diminish in frequency and intensity over time, but that may continue to occur at greater frequency than in non-bereaved controls for years after the death (24). In Clayton's classic studies (25-27), a large majority of the sample experienced depressed mood; anorexia and beginning weight loss; initial, middle, and terminal insomnia; marked crying; some fatigue and loss of interest in their surroundings (but not necessarily the people around them); restlessness; and guilt. Irritability was common, while overt anger was uncommon. Suicidal thoughts and ideas were rare and hallucinations were not uncommon. When asked, most widows and widowers reported that they had felt or had been touched by their dead spouse, had heard their voice, seen them, or smelled their presence. The misidentification of their dead spouses in a crowd was common. By the end of the first year, the somatic symptoms of depression had remarkably improved, although low mood (usually associated with specific events or holidays), restlessness and poor sleep continued. The studies demonstrate that symptoms were consistent amongst the following variables: men and women, a sudden versus anticipated death, good and bad marriages, and religious and non-religious subjects. By one year, most bereaved subjects were able to discuss the dead person with equanimity. These findings were largely replicated in Grimby's (28) longitudinal study with an older population. He discovered that low mood, loneliness, and crying were the cardinal symptoms of bereavement, with loneliness persisting the longest.

In Clayton's studies described above, 42% met symptomatic criteria for major depression at one month and 16% met criteria after one year. Forty-seven percent had major depression at some point during the year compared to 8% of controls and 11% for the entire year (25). These findings are remarkably similar to those reported by Zisook and Shuchter (29-32), who found that 24% of their samples were depressed at two months, 23% at seven months, 16% at 13 months and 14% at 25 months. Seven percent were chronically depressed. In all of these studies, the best predictor of major depression at 13 months was depression at one or two months. According to the Zisook and Shuchter studies, a past history of major depression also predicted major depression at one year. In addition, bereaved persons are not only at high risk for major depression, but they are also at risk for lingering subsyndromal depressive symptoms. Such symptoms, even in the absence of full depressive disorders, may be associated with prolonged personal suffering, role dysfunction, and disability (32).

Many clinicians are confused by the relationship between grief and depression and find clinical depression difficult to diagnosis in the context of bereavement. Bereavement is a major stressor and has been found to precipitate episodes of major depression, resulting in a diagnostic quandary that may have profound clinical implications (24,33). Although there are overlapping symptoms, grief can be distinguished from a full depressive episode. Most bereaved individuals experience intense sadness, but only a minority meets DSM-IV-TR criteria for major depression. The principal source of confusion is the common occurrence of low mood, sadness, and social withdrawal in both bereavement and major depression. However, there are also clear differences between the two states. Grief is a complex experience in which positive emotions are experienced alongside negative ones. As time passes, the intense, sad emotions that typically come in waves are spread further apart. Typically, these waves of grief are stimulus bound, correlated to internal and external reminders of the deceased. Furthermore, grief is a fluctuating state with individual variability, in which cognitive and behavioral adjustments are progressively made until the bereaved can hold the deceased in a comfortable place in his or her memory and a satisfying life can be resumed. In contrast, major depression tends to be more pervasive and is characterized by significant difficulty in experiencing self-validating and positive feelings. Major depression is composed of a recognizable and stable cluster of debilitating symptoms, accompanied by a protracted, enduring low mood. It tends to

be persistent and associated with poor work and social functioning, pathological immunological function, and other neurobiological changes, unless treated. This is as true of major depression after the death of a loved one as in non-bereaved individuals with major depression (34-38). Moreover, untreated major depression after bereavement carries the extra burden of prolonging the pain and suffering associated with grief.

The consequences, clinical characteristics and course of bereavement related major depression are similar to those of other, non-bereavement related major depression. Documented adverse consequences of bereavement related major depression include: impaired psychosocial functioning; comorbidity with a number of anxiety disorders; and symptoms of worthlessness, psychomotor changes and suicidality (31,34-36,39). Symptoms of bereavement related major depression are usually severe and long lasting (30,31,40). In addition, bereavement related major depression also has biological characteristics that reflect similarities with other depressions, such as increased adrenocortical activity, impaired immune function and disrupted sleep architecture (39).

Most information about bereavement related major depression is focused on death of a spouse, considered one of the most disruptive and distressing events of ordinary life (41). Compared to married individuals, there is an increase in general medical consultation by depressed widows in the first year (42) after the loss. In addition, there is an increased use of counseling, especially pastoral counseling (25) and significantly increased use of tranquilizers, hypnotics and alcohol (43). Finally, it is likely that unrecognized and untreated major depression accounts for at least a portion of the increased mortality seen in bereaved populations (44). The causes of deaths have varied in different studies, but almost always include suicide and accidents (45).

When a major depressive syndrome occurs soon after the death of a loved one, according to the ICD-10, it should be classified as major depression. The same episode, however, is not major depression according to the DSM-IV, but rather it is labeled with the V-code (no mental illness) of "bereavement". Which is correct? Is the syndrome an illness, likely requiring treatment, or is it a normal phenomenon, requiring, at most, watchful waiting? The DSM-IV states that, under most circumstances, bereavement within two months of the death precludes the diagnosis of major depression, but that major depression should be strongly considered when there is guilt about things unrelated to actions at the time of the death, pronounced psychomotor retardation, morbid feelings of worthlessness, sustained suicidal ideation, or prolonged and marked functional impairment. However, these features are also likely to be present in bereavement related major depression as in any other instances of major depression (36,38), and several studies have found that bereavement related major depression is more similar to, than different from, other forms of major depression (35), and that it responds to treatment in much the same way as other, non-bereavement related major depression. Thus, we feel the DSM-IV convention of excluding the diagnosis of major depression within two months of bereavement no longer fits the best evidence and may have the undesirable consequence of preventing people with potentially life threatening illness, such as major depression, from obtaining the appropriate treatment.

The key to successful treatment is the recognition that bereavement related major depression is similar to other, non-bereavement related major depression. However, clinicians remain uncertain regarding how to intervene with bereavement related major depression and sometimes question whether to intervene at all. Medical professionals, as well as the public, tend to misattribute and normalize bereavement symptoms, leaving vulnerable grieving individuals exposed to the burden of untreated depression and the stressful demands of coping with their recent loss. Thus, we recommend treating bereavement related major depression as seriously and aggressively as when treating depression related to other life events, or unknown psychosocial precipitants.

As with other, non-bereavement related major depression, key factors used to determine whether to treat are past history and the intensity, duration, and pervasiveness of the depressive syndrome. Under certain circumstances, such as when there is a history of previous, severe major depression, prophylactic treatment to prevent the emergence of a new episode in the face of this predictably difficult period should be considered. On the contrary, if there is no past or family history of major depression and the syndrome is relatively mild in terms of severity, reactivity, and impairment, treatment may be delayed for at least the first two months, if not longer, but the patient should be monitored regularly. The clinician may then initiate treatment with educational-supportive psychotherapy, using the same general guidelines as one would for non-bereavement major depression. If the depression does not fully respond to this kind of support, antidepressant medications should be used (46).

At present, there are no psychotherapy studies focusing specifically on bereavement related major depression which demonstrate efficacy, although there are no compelling reasons to believe that psychotherapy would not be as effective in bereavement related major depression as in non-bereavement related major depression. While further research in needed to determine the potential effectiveness of psychotherapy for depression in the context of grief, we advocate for an integrated treatment method that includes individualized psychotherapy.

Currently, there are six published studies on bereavement related depression demonstrating the efficacy and safety of a variety of antidepressant medications (47-52). In each of these studies, grief intensity diminished along with amelioration of depressive symptoms, although improvement in grief was not as robust as relief of depression. No single antidepressant medication is currently designated the "best" treatment for bereavement-related depression. Inquiring about patient preferences and past personal successes or failures with various antidepressant trials can help guide a rational

choice in medication. If the depressive episode is relatively mild and not associated with suicidal risk or melancholic features, support and watchful waiting might be an appropriate initial choice. On the other hand, the more autonomous and severe the symptoms, the more antidepressant medications should enter the treatment equations. For severe or highly comorbid episodes, or where medication has been unsuccessful, combination treatment with multiple medications in addition to targeted psychotherapy may be needed. One notable comorbid condition, unique to bereavement, complicated grief (8), may require a very specific form of psychotherapy (22). In all cases, treatment should be personalized, addressing the individual's specific needs and resources, as well as the availability of various treatment modalities, in deciding the best approach. A treatment model that includes education, a supportive and individualized form of psychotherapy, and medication management maximizes the probability of a positive outcome (46).

WHEN A PATIENT SUICIDES

Mental illness is one of the most robust risk factors for suicide, occurring in >90% of all suicides. Patient suicide is an occupational hazard for psychiatrists, since psychiatrists treat the most chronically and severely ill patients, utilizing treatments that are not perfect. Studies have found that >50% of psychiatrists have lost at least one patient to suicide, and many have lost more than one (53). Thus, it is no surprise that patient suicide has been reported as one of the most frequent and stressful crises experienced by health providers around the world (54-57).

When a patient suicides, psychiatrists should consider the advantages and potential problems in providing care for the family of the deceased. Many survivors will welcome contact with the treating clinician as they seek to make sense of the death and process their own grief (58). Generally, clinicians should proactively offer to meet with family members after a suicide, unless there are clear reasons to not do so. The psychiatrist can provide support, help to normalize the reactions of family members, provide referrals to community resources and, within the bounds of confidentiality, offer a perspective on the suicide that may assist family members in reducing their confusion, guilt, or anger about the death. Attendance at funerals and memorials are an individual matter, but often both the psychiatrist and the family find this restorative. Even when the psychiatrist does not personally know the close family survivors, condolence cards, expressing caring and sympathy, are usually received positively.

When a psychiatrist loses a patient to suicide, personal reactions are as varied as in other survivors. Low mood, poor sleep and irritability, for example, have been described (59). Many studies have found high rates of problematic grief experiences in survivors, such as intense guilt or feelings of responsibility for the death, a ruminative need to explain or make sense of the death, strong feelings of rejection, abandonment and anger at the deceased, trauma symptoms, complicated grief, and shame about the manner of death (6-10). Psychiatrists are not immune to these reactions when they, themselves, become survivors (59). In addition, fear of litigation and retribution from the psychiatric community can complicate the psychiatrist's response (54).

Postvention should be multifaceted and ideally should involve support from family, friends, and colleagues. For some individuals and in certain cultures, healing may be facilitated by prayer and doing merit (57). Psychiatrists who lose a patient to suicide should consider consultation from a trusted and experienced colleague who can serve as a sounding board and source of emotional support, while also consulting on the most helpful response to the survivors impacted by the death.

CONCLUSIONS

After completing their education and formal training, psychiatrists may not be fully prepared to handle some of the most common clinical challenges they will face in practice. Diagnosing and treating complicated grief and bereavement related major depression will undoubtedly rank high on the list of such challenges. Both conditions overlap with symptoms found in ordinary, uncomplicated grief, and often are written off as "normal" with the assumption that time, strength of character and the natural support system will heal.

It is important to realize that, while each individual grief process is unique, there is a form of grief that is disabling, interfering with function and quality of life. This prolonged, complicated grief response tends to be chronic and persistent in the absence of targeted interventions, and may be life threatening. Complicated grief usually responds well to a specific psychotherapy, perhaps best when administered in combination with antidepressant medication. In addition, with patient suicides being a commonplace occupational risk for psychiatrists, it is essential for them to recognize their own vulnerabilities to the personal assaults that often accompany such losses, not only for their own mental health and well-being, but also to provide the most sensitive and enlightened care to their patients.

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