Bereavement and grief in adults: Clinical features

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INTRODUCTION

Bereavement is the situation in which a loved one has died, and grief is the response to this loss [1]. Typical acute grief reactions are often characterized by emotional and somatic distress and impaired functioning, but should not be diagnosed as a psychiatric disorder. However, bereavement is also a stressor that can precipitate or worsen psychiatric disorders (eg, unipolar major depression). In addition, acute grief may progress to prolonged grief disorder, which is a unique and identifiable syndrome marked by intense, unrelenting, and functionally debilitating symptoms that require specific treatment [2,3].

This topic discusses the clinical features of bereavement and grief. The management of grief is discussed separately, as is prolonged grief disorder, palliative care, and hospice:

- (See "Bereavement and grief in adults: Management".)
- (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Prolonged grief disorder in adults: Treatment".)
- (See "Palliative care: The last hours and days of life".)
- (See "Benefits, services, and models of subspecialty palliative care".)
- (See "Hospice: Philosophy of care and appropriate utilization in the United States".)

TERMINOLOGY

The terms bereavement, grief (acute and integrated), mourning, and prolonged grief disorder describe different aspects related to the death of a loved one [1,4-6]:

- **Bereavement** – Bereavement is the situation in which someone who is close dies (rather than the reaction to that loss). (See 'Bereavement' below.)

- **Grief** – Grief is the natural response to bereavement, and includes thoughts, feelings, behaviors, and physiologic reactions. Although grief can occur in response to other meaningful, nonbereavement losses (eg, loss of a job, divorce, or migration), this topic focuses upon grief in response to the death of a loved one.

  The pattern and intensity of grief varies over time and evolves as bereaved individuals adapt to the loss. The experience of grief is influenced by personal, cultural, and religious rituals that vary widely, and is unique to each person and each loss. Acute grief can be intense and disruptive but is usually integrated. Progress from acute to integrated grief is often erratic and may be hard to discern as it is happening. (See 'Typical acute grief' below.)

- **Mourning** – Mourning is the process of adapting to a loss and integrating grief. Adaptation entails accepting the finality and consequences of the loss and a changed relationship with the deceased, restoring the capacity to thrive, and re-envisioning the future with the possibility for happiness and meaning in a world without the deceased. When mourning is successful, the painful and disruptive experience of acute grief is transformed into an experience of integrated grief that is bittersweet, in the background, and permanent. Like grief, mourning is influenced by personal, cultural, and religious beliefs and rituals that vary widely.

- **Prolonged grief disorder** – Prolonged grief disorder is a form of grief that is unusually protracted, intense, and disabling. The disorder is characterized by maladaptive thoughts, dysfunctional behaviors, dysregulated emotions, and/or serious psychosocial problems that impede adaptation to the loss. The syndrome of prolonged grief disorder is a unique and recognizable condition that can be differentiated from other psychiatric disorders. Other names that have historically been used for prolonged grief disorder include chronic grief, complex grief, complicated grief, pathological grief, persistent complex bereavement disorder, traumatic grief, and unresolved grief. Prolonged grief disorder is approved for inclusion in the World Health Organization's International Classification of Diseases-11th Revision (ICD-11) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) [7,8]. (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)

BEREAVEMENT

Overview — Bereavement (loss of a loved one) is one of the most stressful experiences of a lifetime. In addition to the loss itself, bereavement often requires one to redefine goals and plans to restore a meaningful and satisfying life, and may involve new responsibilities and roles. In addition, the stress of bereavement can precipitate or worsen general medical or psychiatric disorders.

Each person who dies leaves behind approximately nine close relatives and a variable number of other relatives and friends [9]. People typically have a range of close relationships throughout their lives that can be portrayed with a diagram of concentric circles as “close,” “closer,” and “closest” [10]. Although there is no standard definition of bereavement that identifies who should be considered bereaved, those with close relationships to the deceased are most affected by a person’s death and are most vulnerable to problems with adapting to the loss. However, people may grieve the loss of anyone who is important in their lives and sometimes this can be a person (eg, mentor) to whom they have an important relationship, but not necessarily a close, personal one.

The great majority of deaths occur as a natural consequence of aging-related illness. Most people grieve with support from family and friends, naturally moving over time from acute to integrated grief. This progression occurs even when a death occurs in an untimely way by violent means. However, difficult circumstances or consequences of a death can slow or halt this process. As an example, the death of a life partner or a child, or death by violent means, increase the likelihood of prolonged grief disorder. (See 'Type of loss' below.)

Close attachments appear to be internalized in neural networks that underpin both the capacity to form and maintain relationships across the lifespan [11], and responses to their loss [12]. Preliminary studies suggest that the effects of bereavement may be mediated by changes in these networks [13].

Frequency — Approximately 60 percent of the population is bereaved at any given time. As an example, a nationally representative survey in Germany found that 57 percent had lost an important person [14]. The average time since the death was 10 years (range 0 to 71 years).

Death rates — In 2017, worldwide deaths amounted to nearly 56 million [15]. The leading causes of years of life lost were ischemic heart disease, neonatal disorders, stroke, lower respiratory infections, diarrheal diseases, road injuries, chronic obstructive pulmonary disease, HIV/AIDS, congenital anomalies, and malaria.

The crude annual death rate (average number of deaths per 1000 people per year) in the world is 8, meaning that approximately 108 people worldwide die per minute [16]. Reported annual death rates per 1000 population in different countries are as follows [17]:

- Afghanistan – 13
- Aruba – 9
- Australia – 7
- Brazil – 7
- Canada – 8
- China – 8
- Congo, Republic of the – 9
- Costa Rica – 5
- France – 10
- Germany – 12
- India – 7
- Indonesia – 7
- Israel – 5
- Italy – 11
- Japan – 11
- Lithuania – 15
- Mexico – 5
- Norway – 8
- Romania – 12
- Russia – 13
- Qatar – 1
- Saudi Arabia – 4
- Singapore – 4
- Spain – 10
- South Africa – 9
- Sweden – 9
- Taiwan – 8
- Ukraine – 14
- United Kingdom – 9
- United States – 8
- Vietnam – 6
- Venezuela – 7
- Zimbabwe – 9

In the United States in 2019, more than 2.8 million people died [18,19]. The 10 leading causes of death were heart disease, cancer, unintentional injuries, chronic lower respiratory diseases, stroke, Alzheimer disease, diabetes, kidney disease, influenza and pneumonia, and suicide. Nearly 75 percent of deaths occur in people aged 65 years or older [20,21]. In 2020, the coronavirus disease 2019 (COVID-19) pandemic added more than 375,000 deaths, raising the overall death rate to more than 3.3 million [22].

Loss of attachment — According to attachment theory, humans are biologically motivated throughout life to form secure, close relationships with a few other people [23-28]. These are the people whom a person loves and who reciprocate love. A secure attachment relationship means a partner is available, sensitive, and responsive in providing a "safe haven" during periods of stress and a secure base from which one can explore the world, learn new things, and take chances. Loved ones contribute to one's sense of identity and sense of belonging. Representations of attachment relationships are held in a person's memory. These mental representations influence many aspects of daily functioning, both consciously and unconsciously. While attachment security may be impaired for some adults (ie, attachment insecurity), close secure adult relationships are usually reciprocal so that each person provides and receives this support.

Bereavement disrupts attachment. Generally, bereavement entails intense feelings of wanting to find the person who died (yearning and longing for the deceased), accompanied by preoccupation with thoughts and memories of the person, and frustration and sorrow associated with failure to achieve reunion [24]. In addition, one's sense of identity is disrupted and exploration is inhibited, leading to reduced interest in ongoing life and an unfamiliar sense of incompetence and confusion about long-term goals.

Internalized representations of attachment relationships tend to be stable and change slowly with some resistance [12,29-32]. The internalized representation of a deceased person requires major revisions through a learning process in which a bereaved individual gradually assimilates information about the finality of the loss and its meaning. This process takes time. Acute grief occurs during the learning period when the internal representations of the deceased are out of alignment with the reality of the loss and disruption of goals and plans. The process involves grief symptoms such as emotional pain, often accompanied by a sense of internal disorganization. There may also be difficulty with habitual tasks; disrupted attention, concentration, sleep, and appetite; increased memories of the deceased; and emotional and physiologic dysregulation. As the finality and consequences of the loss are fully acknowledged, the mental representation of the attachment relationship is eventually revised, and one's goals

and plans are redefined. There is still an internalized connection to the deceased, but the nature of the connection has changed [24].

Caregiving is part of adult love relationships and it too is affected by bereavement [33-39]. Just as individuals are biologically motivated to seek comfort under stress, they are also motivated to care for others. Among parents, the instinctive predisposition to care for children is especially prominent. However, adults also provide as well as receive care in their close relationships with other adults, and caregiving appears to be at least as important as receiving care [36,39]. Thus, the death of a loved one may be experienced as a failure of caregiving, albeit irrational. Mourners may rebuke themselves for minor deficiencies in how they cared for their loved one, for being unable to prevent the death, and/or failing to make the death easier. Caregiver self-blame is a common response to bereavement, contributes to dysphoria during acute grief, and if persistent can impede adaptation to the loss and increase the risk of prolonged grief disorder.

Type of loss — Bereavement reactions may vary depending upon the circumstances of the death. As an example, there are some typical responses depending upon the type of lost relationship (eg, spouses; children; grandchildren; parents who die during one's childhood, adolescence, or adulthood; and friends) [40,41]. In a community sample of bereaved individuals (n = 120), the intensity of acute grief was greater in parents who lost a child than it was for bereaved spouses, who in turn were more likely to have more intense grief than adult children who lost a parent or caregiver [42]. Other circumstances that can influence acute grief include the age of the deceased and whether the death involved a sudden loss or a chronic or terminal illness. However, there is no normative intensity of acute grief for a specific type of loss, and any important loss can result in prolonged grief disorder.

Type of lost relationship — Loss of a child typically triggers an especially strong sense of caregiver failure. Parents often blame themselves for not protecting the child, however irrational this may be [43-45]. In addition, parents or caregivers may feel that they have lost their own future and identity as a parent, and may experience high levels of survivor guilt that leads them to feel that they should not enjoy their own lives. In one study of administrative health care data, parents bereaved by a motor vehicle accident had an elevated rate of psychiatric illness in the two years after their child's death compared with the two years before, and compared with parents who were not bereaved [46]. A national registry study (n >1,000,000 parents, including 17,000 parents who lost a child) found that the risk of a first lifetime psychiatric hospitalization was 67 percent greater in bereaved parents, compared with parents who did not lose a child [47]. The risk of hospitalization for any psychiatric disorder was highest in the first year after the death of a child, but remained elevated for at least five years after the death.

Cultural factors may impact the persistence of grief following the loss of a child. A prospective study conducted in China (n = 29 bereaved parents) and the United States (n = 23) found that four months after the death of a child, distress in the parents was comparable for the two groups [48]. However, 18 months after the loss, distress in the Chinese parents had decreased significantly, whereas the United States parents showed no decrease in distress.

The death of a spouse or partner who is part of everyday life can also be particularly challenging, especially when the relationship was positive and rewarding [49-52]. Spouses often play multiple important roles, including lover, best friend, confidant, protector, housekeeper, and breadwinner. Similar to what bereaved parents can experience, bereaved spouses may feel guilty about letting their partner down or a sense of failure as a caregiver. They may experience survivor guilt and feel anxious or angry about losing the support and comfort of their loved one. Bereaved spouses may also feel lost without the daily support and comfort of their closest companion, or intensely lonely in a world without them. In addition, the bereaved spouse often must adapt to changes in day-to-day life, such as assuming responsibility for practical issues, such as paying bills.

Sudden loss — The death of a loved one can be intense and painful, regardless of the manner of death. However, loss from a sudden catastrophic illness, suicide, violence, or accident is likely to produce relatively intense acute grief. The acutely bereaved may feel as though they are on autopilot, going through the motions of life while feeling disconnected from the world and from others. There may be a disconcerting feeling of numbness and difficulty comprehending the unexpected loss. Numbness usually recedes as the bereaved person begins to think about the loss and its implications, but it can be distressing as the person may question not crying or experiencing intense sadness. Although most people bereaved by a sudden loss are resilient, the rates of prolonged grief disorder and other psychiatric disorders, including depressive syndromes, posttraumatic stress disorder (PTSD), and substance use disorders, are higher following violent or other sudden deaths, such as suicides [53,54]. (See 'Suicide' below and "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Risk factors'.)

Homicide and suicide, in particular, can trigger guilt or anger about the death that can impede adaptation to the loss. The risk of psychopathology in those bereaved by homicide and suicide seems to remain elevated over many (eg, 8 to 10) years [53,55].

Suicide — The prevalence of bereavement due to suicide varies across studies of different populations. Within families, the estimated one-year prevalence of bereavement due to suicide is 1 percent, based upon a meta-analysis of two general population studies (total n >11,000 individuals) [56]. Among friends and peers, the one-year prevalence of exposure to suicide is

approximately 6 percent. A nationally representative survey in the United States found that the lifetime prevalence of suicide bereavement was 35 percent [57]. It is estimated that worldwide, nearly 50 million people are bereaved by suicide [58].

Prior to bereavement due to suicide, relatives of individuals who die by suicide differ from individuals not exposed to suicide bereavement. As an example:

- A study compared parents who were bereaved due to the suicide of a child (n >1400) with parents bereaved due to the death of a child who died in a motor vehicle crash (n >1100) [59]. Prior to the offspring's death, depression, general medical disorders, and low income were more common in parents bereaved due to suicide.

- A study of school-aged children bereaved by the death of a parent or caregiver found that prior to the death, anxiety and behavioral problems were more common in the children with suicide bereavement than children whose parents died by another cause [60].

Subsequent to suicide deaths, bereavement is associated with psychopathology in the bereaved. In a study that examined parents (n >1400) whose child died by suicide and adjusted for several potential confounds (eg, preexisting psychiatric and general medical disorders), the prevalence of depressive disorders in the first two years of bereavement was 31 percent, which was three times greater than the rate for nonbereaved, matched parents (n >1400) [59]. The association between suicide bereavement and depression in the bereaved may involve perceived stigma [61].

The association between death of a loved one by suicide and an increased risk of psychopathology in the bereaved may also depend upon kinship. One review found that suicide bereavement was associated with an increased risk of psychiatric disorders in the parents of the deceased, but not in the siblings of the deceased [60].

The association between death of a loved one by suicide and the risk of suicidal ideation and behavior in the bereaved is discussed elsewhere in this topic. (See 'Suicidality' below.)

Chronic illness — When individuals die from chronic illnesses, the bereaved may have time to anticipate and prepare for the death, and to begin the adaptation process (see 'Anticipatory grief' below). Acute grief that occurs in response to the loss may be more attenuated in severity or duration. However, chronicity sometimes has the opposite effect; because the illness is long-lasting and the patient is still alive, family members may fail to anticipate a death. Further, caregiver roles may have become prominent and add an additional level of role adaptation after the death. In any case, bereavement often evokes an intense response even among those whose loved one's deaths are predictable, and psychiatric morbidity may ensue. In a

prospective study of family caregivers (n = 217) for patients with dementia who died, depression occurred in 30 percent of the caregivers one year postdeath [62], and prolonged grief disorder occurred in 20 percent over 18 months of follow-up [63]. (See 'Associated psychopathology' below.)

Terminal illness — Bereavement may be preceded by a stressful period of caring for a loved one who is terminally ill; the sensitivity and effectiveness with which terminal illness is medically managed can impact the course of the caregiver's bereavement reaction [64-67]. The caregiver's ability to cope with the illness and death of a loved one, as well as the experience of the dying patient, are improved by mitigation of patient suffering; good communication between the medical staff and caregivers, and between caregivers and dying patients; and preparation for the death (see 'Anticipatory grief' below). Although most caregivers are resilient following the death of a loved one from a terminal illness, a prospective study of caregivers (n = 668) for terminal cancer patients found that prolonged grief disorder occurred in 25 percent [68]. (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)

Hospice can be beneficial:

- Use of hospice by older adult patients may be associated with decreased bereavement-related mortality among surviving spouses [69].
- Caregivers of spouses with longer hospice enrollment (≥4 days) may have a lower incidence of unipolar major depression [70,71].

(See "Hospice: Philosophy of care and appropriate utilization in the United States".)

Palliative care clinicians managing terminal illnesses may be uncertain about how best to address the psychological needs of dying patients and their families. Many clinicians lack expertise in discussing prognosis and may experience discomfort with the family's emotional responses [72]. Clinicians may overestimate a patient's or family members' understanding of prognosis and be unaware of their preferences about receiving this information. Individuals with a low level of preparation for their spouse's death are at increased risk for anxiety, emotional numbness, and sleep disorders that can persist for years [49]. When clinicians are insensitive or avoid their dying patients, caregivers may be at risk for prolonged grief disorder and other mental health problems [73]. Conversely, when family members are included in end-of-life discussions, they exhibit lower rates of depression and prolonged grief disorder after their loss [74]. (See 'Associated psychopathology' below.)

The American Hospice Foundation has produced a monograph for caregivers called The Dying Process: A Guide for Caregivers, which outlines the physical and mental consequences of

terminal illness, and discusses the goals of care, management of pain, and psychological concerns that can occur during the dying process. This booklet should be offered to caregivers because they generally fare better when they have a sense of competence fostered by information.

Additional information about palliative care is discussed separately. (See "The initial interview in palliative care consultation" and "Benefits, services, and models of subspecialty palliative care" and "Palliative care: The last hours and days of life" and "Communication of prognosis in palliative care".)

Adverse general medical outcomes — Bereaved individuals are at increased risk of adverse general medical outcomes. Much of this increased risk may be related to depression and prolonged grief disorder, which appear to be associated with negative health outcomes. (See 'Unipolar major depression' below and "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)

Morbidity — Bereavement is associated with increased rates of somatic symptoms (eg, chest and other pain, dizziness, gastrointestinal distress, and headaches), especially during the first several (eg, six) months after the loss [40,75-77]. In addition, the loss of a loved one may lead to disability [40,78]. These outcomes may stem from bereavement-related unhealthy behaviors, including worsened nutrition, increased alcohol consumption and smoking, poor sleep quality, and involuntary weight loss [40,52,77,79]. Weakening of the immune system secondary to stress may also be involved [77].

Bereavement is also associated with an increased risk of general medical illnesses such as stress-induced cardiomyopathy. (See "Clinical manifestations and diagnosis of stress (takotsubo) cardiomyopathy".)

The risk of acute cardiovascular events is increased soon after bereavement. As an example, a study of an administrative health care database included individuals whose partner died (n >30,000) and controls matched for age and sex, whose partner was alive on the same day (n >80,000) [80]. After adjusting for potential confounding factors (eg, smoking and history of diabetes mellitus and cardiovascular disease), the incidence of myocardial infarction or stroke within 30 days of bereavement was greater in the bereaved than the nonbereaved (0.2 versus 0.1 percent). In addition, a retrospective study of patients with myocardial infarction (n = 1985) found that within one day of the death of a significant person, the risk of myocardial infarction was 21 times greater than the risk 31 to 180 days after the death [81]. The risk was still elevated 7 to 30 days after the loss (incidence rate ratio 4). The increased risk of cardiovascular events in the weeks following loss may be related in part to the association of early bereavement with

neglecting one's health care [80], as well as adverse physiologic responses, such as increased heart rate, systolic blood pressure [82,83], cortisol [84-86], and pro-inflammatory cytokines [87]. Cardiovascular disease accounts for much of the increased mortality that is observed among the bereaved. (See 'Mortality' below.)

In addition, the bereaved may be at higher risk for arthritis, cancer, diabetes, and hepatic cirrhosis [40,75-77]. Again, one possible reason is that the bereaved may neglect seeking medical care [77].

Bereavement during pregnancy, including loss of a partner, older child, parent or caregiver, or sibling, is associated with a small increased risk of adverse pregnancy outcomes, such as stillbirth (hazard ratio 1.18) [88-90] and preterm delivery (hazard ratio 1.07) [91].

Information about general medical morbidity in the context of bereavement and prolonged grief disorder is discussed separately. (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'General medical'.)

Mortality — Bereavement is associated with an increased risk of all-cause mortality, after controlling for chronic medical conditions and access to resources, as well as age, sex, and smoking status [92]. Losing a spouse, child, or sibling are each associated with an increased risk of dying [93,94], and the risk can persist for at least 10 years [95]. However, the absolute number of bereaved people who die is relatively low [40,95].

The evidence connecting bereavement with increased mortality in the bereaved is perhaps best established for conjugal bereavement [40,96]:

- A meta-analysis included 10 prospective observational studies of spousal bereavement (sample size not reported), and found that during the first six months after the loss, mortality was greater in the bereaved than nonbereaved (relative risk 1.4, 95% CI 1.3-1.57) [97]. Six or more months after bereavement, the risk of mortality decreased but was still higher in the bereaved than nonbereaved. In addition, the risk of mortality among the bereaved was comparable for those <65 years of age and those ≥65 years.

- Subsequently, a national registry study compared men (n >4000) and women (n >10,000) who were bereaved by a spouse's suicide, with the general population of men (n >3 million) and women (n >3 million) [77]. After controlling for potential confounding factors such as age, psychiatric disorders, and chronic general medical disorders, the analyses found that within five years of bereavement, the risk of all-cause mortality was greater in the bereaved than the general population (males: incident rate ratio 1.7, 95% CI 1.5-1.9; females: incident rate ratio 2.0, 95% CI 1.8-2.2).

Following the death of a spouse, the risk of all-cause mortality in the bereaved is highest in the first month after the loss. A national registry study compared individuals whose spouse died (n >380,000) with nonbereaved controls (n >1.9 million) who were matched for age and sex [95]. After adjusting for potential confounding factors (eg, education, general medical illnesses, and psychiatric disorders), the analyses showed that all-cause mortality in the first month after bereavement was two and a half times greater in the bereaved than the nonbereaved (hazard ratio 2.5, 95% CI 2.4-2.6). The risk of mortality diminished as time elapsed; nevertheless, mortality remained elevated for at least 10 years after the loss (hazard ratio 1.34, 95% CI 1.32-1.36).

The greatest causes of death following conjugal bereavement are cardiovascular diseases and cancer [98,99]. In addition, alcohol-related deaths are about twice as likely to occur in the bereaved, compared with people who are not bereaved, and suicide occurs more often in the bereaved than those not bereaved (see 'Suicidality' below). Mortality is greater when one loses a spouse unexpectedly, compared with losing a spouse with known morbidity [100].

Among parents who lose a child, their increased risk of mortality may also persist for many years. A national registry study found that all-cause mortality was elevated in bereaved parents 9 to 18 years after the loss, compared with parents whose children were alive [101].

Sibling bereavement also appears to be associated with increased mortality both in the short and long term [102]. A national registry study included individuals who had a sibling die during the individual's childhood (age <18 years, n >50,000), and individuals without sibling bereavement (n >4 million); the two groups were followed for up to 37 years [94]. After adjusting for potential confounders (eg, age, sex, and maternal smoking during pregnancy), the analyses found that all-cause mortality was 70 percent greater in the bereaved than nonbereaved (mortality rate ratio 1.7, 95% CI 1.6-1.9). The increased risk was greatest in the first year after bereavement, but remained elevated across follow-up.

Factors that are implicated in the increased mortality of the bereaved include psychological distress, loneliness, loss of a confidant, substance misuse, changes in social relationships and living arrangements, and economic hardship [60]. Another possible explanation is that the bereaved are less likely to pursue attention for medical problems [77].

Associated psychopathology — Losing a spouse or child is associated with a small to moderate increased risk of psychopathology [40,47,50,77,103]. As an example, a national registry study identified bereaved individuals who lost a child, spouse, sibling, or parent (n >1.4 million), and nonbereaved controls matched for age and sex (n >7 million); the two groups were

followed for up to 19 years [104]. The cumulative incidence of psychiatric disorders was greater in the bereaved than the nonbereaved (5.3 versus 4.5 percent).

Although most people adjust to the loss of a loved one, bereavement can precipitate or worsen one or more mental disorders, including:

- Prolonged grief disorder
- Unipolar or bipolar major depression
- Anxiety disorders
- PTSD
- Other disorders
- Suicidal ideation and behavior

There may be a dose-response relationship between the number of unexpected deaths that one endures and the number of subsequent psychiatric disorders that one suffers [105]. A community survey in the United States found that among individuals who were unexpectedly bereaved at least once, there was a monotonic increase in the first time onset of psychiatric disorders [103].

In addition, the risk of bereavement-related psychopathology may be greater if the loss is the result of accidents, disasters, suicide, or violence [54,106]. As an example, a national registry study identified men (n >4000) and women (n >10,000) bereaved by a spouse's suicide, and men (n >250,000) and women (n >530,000) bereaved by spousal deaths from other causes [77]. After controlling for potential confounding factors such as age, psychiatric disorders, and chronic general medical disorders, the analyses found that within five years of bereavement, the risk of psychiatric disorders was greater in those bereaved by suicide than by other causes (males: incident rate ratio 1.7, 95% CI 1.5-1.9; females: incident rate ratio 2.0, 95% CI 1.8-2.2). Sudden deaths may cause more psychological distress than other types of bereavement [54].

Bereavement-related disorders need to be diagnosed and treated. If not, they may complicate grief and interfere with adaptation to the loss. There is no evidence that bereavement protects patients from the morbidity and mortality of untreated mental disorders; to the contrary, bereavement increases the risk for these disorders and their course can be severe and persistent. Response to treatment of psychiatric disorders in bereaved patients is comparable to that in the nonbereaved [107].

Diagnosing psychiatric disorders in the context of bereavement can be challenging because the pain and disruption of acute grief can resemble symptoms of mood and anxiety disorders. Concerns have been raised about "medicalizing" a normal response and inappropriately treating normal distress with medications [108-110]; however, understanding the clinical picture

of acute grief and diagnostic criteria for mental disorders can help clinicians with the differential diagnosis (see 'Differential diagnosis' below) and reduce the risk of overdiagnosing psychiatric disorders. A systematic review found that clinicians are aware of the challenges, and work to avoid "pathologizing" normal grief [111].

Prolonged grief disorder — Bereavement can lead to prolonged grief disorder, which is a diagnosable condition distinguished from acute grief by the persistence of strong emotions and/or preoccupying thoughts of the deceased for a prolonged period of time, and is associated with significant distress and/or impairment [7,8]. Grief is a natural reaction to the loss of a loved one, which can impair functioning for a limited time. Prolonged grief disorder is a chronic disabling condition in which some early grief elements (thoughts, feelings, and behaviors) intensify and interrupt the natural adaptive process. The epidemiology, clinical features, assessment, diagnosis, and treatment of prolonged grief disorder are discussed separately. (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis" and "Prolonged grief disorder in adults: Treatment".)

Unipolar major depression — Bereavement is a major stressor that can trigger the onset or worsening of a depressive episode. Although diagnosing unipolar major depression in the context of recent bereavement has been controversial [108,112], and the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) did not permit the diagnosis of major depression within two months of bereavement (commonly referred to as the "bereavement exclusion") [113], the balance of data did not support this exclusion [112,114] and it was removed in the DSM-5 (table 1) [115], as well as the World Health Organization's International Classification of Diseases-10th Revision (ICD-10) [116].

The rationale for diagnosing unipolar major depression in bereaved individuals is based upon the best available evidence, which indicates that major depressive episodes that occur in the aftermath of the death of a loved one are comparable with major depression not in close proximity to bereavement, with regard to risk factors (eg, genetic influences and past history of depression), symptoms (including guilt, psychomotor retardation, and suicidal ideation), impaired functioning, comorbidities, course of illness, and response to treatment [2,5,107,114,117-120]. In addition, studies indicate that major depressive episodes that occur in the context of bereavement and depression occurring after other stressors (eg, divorce, impoverishment, or disability) are comparable [121]. At least one study indicates that early untreated depression is a risk factor for prolonged grief disorder [122]. Although some studies suggest that bereavement-related major depression is less severe (eg, less likely to include suicidal ideation) and less recurrent than depression not related to bereavement [123,124], the preponderance of the evidence indicates otherwise [112,114].

Most bereaved people do not endorse symptoms sufficient to diagnose unipolar major depression; nevertheless, major depression is more prevalent among the bereaved than the nonbereaved [40,46,115,125,126]. This supports the idea that bereavement is associated with major depressive disorder. Across different types of kinship and time frames (eg, one year or two years following bereavement), the prevalence of major depression is approximately 20 to 30 percent:

- Spousal bereavement – Pooled analyses of community studies suggest that in the 12 months following bereavement, the estimated prevalence of major depression in widowed individuals is 20 percent, which is greater than the prevalence in nonbereaved individuals:
  - In a systematic review that identified eight studies of bereaved spouses (n = 1051), the pooled prevalence of major depression in the first 12 months of bereavement was approximately 22 percent; across different studies, major depression was 4 to 10 times more likely to occur in widowed individuals than nonwidowed controls [50].
  - A meta-analysis of 12 studies found that the prevalence of major depression in widowed individuals (n >5000) was 19 percent; however, the time frame was not reported and heterogeneity across studies was large [127]. Subgroup analyses found that prevalence rates were comparable for men and women, and for those aged ≥65 years and those <65 years.
- Death of child – A study examined parents (n >1200) who lost a child and found that after adjusting for several potential confounds (eg, preexisting psychiatric and general medical disorders), the prevalence of depressive disorders in the first two years of bereavement was 31 percent, which was nearly three times greater than what was found in nonbereaved, matched parents [46].

A community survey found that unexpected death of a loved one was associated with an increased risk of suffering major depression, regardless of the age at which the loss occurred [103].

The clinical features, diagnosis, and treatment of unipolar major depression are discussed separately. (See "Unipolar depression in adults: Clinical features" and "Unipolar depression in adults: Assessment and diagnosis" and "Unipolar major depression in adults: Choosing initial treatment".)

Anxiety disorders — Anxiety disorders are common among the bereaved, and the risk of these disorders is greater in the bereaved than the nonbereaved. Based upon multiple studies,

the prevalence of anxiety disorders following bereavement is approximately 25 percent; however, the time since bereavement in some of the studies is not clear:

- Spousal bereavement – A meta-analysis of five studies found that the prevalence of anxiety disorders in widowed individuals (n >3500) was 27 percent; however, the time frame was not reported and heterogeneity across studies was large [127].

- Death of child – A registry study included bereaved parents (n >1200) who suddenly lost a child due to a motor vehicle accident, and nonbereaved parents matched on variables such as the offspring's age at time of death and age of the parent [46]. After adjusting for multiple potential confounds, the analyses found that in the two years following bereavement, the prevalence of anxiety disorders in bereaved parents was 22 percent, which was 70 percent greater than what was found in nonbereaved parents.

A community survey found that at nearly every age across the lifespan, unexpected bereavement is associated with an increased risk of suffering panic disorder [103].

The clinical features, diagnosis, and treatment of anxiety disorders are discussed separately.

Posttraumatic stress disorder — Bereavement can trigger the onset of PTSD [126,128-131], and PTSD may occur more often in response to bereavement than other traumas and stressors.

The prevalence of PTSD during the first year of bereavement is approximately 10 percent, based upon community studies. A community-based sample of bereaved individuals (n = 309) found that PTSD was present in 7 percent [125], and in a pooled analysis of five community studies (n = 772 bereaved spouses), the prevalence of PTSD was 12 percent [50].

However, the prevalence of PTSD varies depending upon the type of loss and nature of the death, such that the prevalence is higher following violent deaths (eg, accident, homicide, or suicide), compared with natural causes (eg, cardiac disease and cancer). As an example, a national registry study identified men (n >4000) and women (n >10,000) bereaved by a spouse's suicide, and men (n >250,000) and women (n >530,000) bereaved by spousal deaths from other causes [77]. After controlling for potential confounding factors such as age, psychiatric disorders, and chronic general medical disorders, the analyses found that within five years of bereavement, the risk of PTSD was much greater in those bereaved by suicide than by other causes (males: incident rate ratio 6, 95% CI 3-11; females: incident rate ratio 4, 95% CI 2-6).

A community survey found that unexpected death of a loved one was associated with an increased risk of suffering PTSD, regardless of the age at which the loss occurred [103].

Years after the loss, PTSD may be found in the bereaved at rates that exceed what is found in control groups. A study of bereaved parents (n = 173) observed that five years after the violent death of their child, the prevalence of PTSD in the mothers was nearly three times higher than the rate in the United States general population of women (28 and 10 percent) [132]. Among the bereaved fathers, the prevalence of PTSD was twice as high as the rate in the general population of men (13 and 6 percent).

The clinical features, diagnosis, and treatment of PTSD are discussed separately. (See "Posttraumatic stress disorder in adults: Epidemiology, pathophysiology, clinical features, assessment, and diagnosis" and "Posttraumatic stress disorder in adults: Psychotherapy and psychosocial interventions" and "Posttraumatic stress disorder in adults: Treatment overview".)

Other psychiatric disorders — In addition to prolonged grief disorder, major depression, anxiety disorders, and PTSD, bereavement may be associated with onset of other mental disorders:

- Eating disorders [133-136]
- Mania [103]
- Psychotic disorders [47]
- Sleep disorders [49,77,79,137]
- Somatoform disorders [138,139]
- Substance use disorders [47,77,140]

For mania, psychotic disorders, sleep disorders, and substance use disorders, the prevalence was greater in bereaved individuals than controls. In addition, cognitive decline may be greater in older adults after spousal bereavement, compared with nonbereaved older adults [141].

Information about the clinical features and diagnosis of these other mental disorders is discussed separately. (See "Eating disorders: Overview of epidemiology, clinical features, and diagnosis" and "Evaluation and diagnosis of insomnia in adults" and "Psychosis in adults: Epidemiology, clinical manifestations, and diagnostic evaluation" and "Somatic symptom disorder: Epidemiology and clinical presentation" and "Somatic symptom disorder: Assessment and diagnosis" and "Substance use disorders: Clinical assessment".)

Suicidality — Bereavement is associated with suicidal ideation and behavior. However, the risk of suicidality may in part be accounted for by prolonged grief disorder, which many studies did not control for in their analyses. (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Suicidality'.)

Evidence that bereavement increases the risk of suicide in the bereaved includes national registry studies:

- One study followed two cohorts for up to 40 years: children who had a parent or caregiver die before the child reached age 18 years (bereaved, n >180,000), and children matched by age and sex who did not have a parent die before the child reached age 18 years (controls, n >1.8 million) [142]. After adjusting for potential confounding factors (eg, sex of offspring, time since bereavement, and parental psychiatric disorders), the analyses found that suicide occurred twice as often in the bereaved than the controls (incident rate ratio 2.0, 95% CI 1.7-2.4), and remained elevated at this level for at least 25 years. However, the absolute risk of suicide was relatively low in the bereaved and controls (0.14 and 0.07 percent).

- Another study from the same group of investigators identified bereaved individuals who lost a child, spouse, sibling, or parent (n >1.4 million), and nonbereaved controls matched for age and sex (n >7 million); the two groups were followed for up to 19 years [104]. The cumulative incidence of suicide was greater in the bereaved than the nonbereaved (0.6 versus 0.01 percent).

Several studies have found that bereavement is associated with suicidal ideation and behavior that is independent of psychopathology such as major depression or PTSD [125,143-146]. As an example, in a national registry study (n >9000 suicide deaths and 180,000 matched controls) that adjusted the analyses for psychiatric disorders, the risk of suicide was approximately eight times greater among individuals whose spouse died in the prior two years, compared with individuals whose spouse was alive [147]. The risk of suicide was approximately three times greater among bereaved males than females, which is comparable to sex ratios for suicide in the general population. (See "Suicidal ideation and behavior in adults", section on 'Sex'.)

Risk factors for suicidal ideation and behavior among the bereaved include [125]:

- Prior psychiatric history
- Current psychopathology (eg, prolonged grief disorder, PTSD, or unipolar major depression)
- Less social support
- Female sex
- Race other than White people
- Bereavement due to suicide

The risk of suicide in the bereaved appears to be particularly high in those who lose a loved one through suicide [60]. As an example, a national registry study found that suicides occurred 22

times more often among individuals whose spouse committed suicide in the prior two years, compared with individuals whose spouse was alive [147]. In another national registry study, individuals bereaved due to sibling suicide were eight times more likely to die by suicide, compared with nonbereaved individuals [94].

In addition, the risk of suicidal behavior following bereavement is greater in those bereaved by suicide than those bereaved by other causes, across different types of kinship [148]:

- An online, retrospective study included individuals who had experienced sudden bereavement of a close friend or relative, either through suicide (n = 614) or natural causes such as cardiac arrest (controls, n = 2106) [58]. After adjusting for potential confounding factors (eg, prebereavement depression, suicide attempt, and nonsuicidal self-injury), the analyses showed that postbereavement suicide attempts occurred more often in those exposed to bereavement by suicide than controls (odds ratio 1.7, 95% CI 1.1-2.4). However, the difference between the two groups was no longer significant when perceived stigma was added to the adjusted analyses.

- A national registry study identified men (n >4000) and women (n >10,000) bereaved by a spouse's suicide, and men (n >250,000) and women (n >530,000) bereaved by spousal deaths from other causes [77]. After controlling for potential confounding factors such as age, psychiatric disorders, and chronic general medical disorders, the analyses found that within five years of the loss, suicide occurred four times more often in those bereaved by suicide than by other causes (males: incident rate ratio 3.5, 95% CI 2.8-4.3; females: incident rate ratio 4.2, 95% CI 3.3-5.2).

- Another national registry study followed two cohorts for up to 40 years: children who had a parent die by suicide before the child reached age 18 years (n >26,000), and children who had a parent die by an accident before the child reached age 18 years (n >11,000) [142]. After adjusting for potential confounding factors (eg, offspring age at time of bereavement and sex of offspring), the analyses found that the risk of suicide was 82 percent higher in those bereaved by suicide than by accident (incident rate ratio 1.82, 95% CI 0.98-3.38).

The association between death of a loved one by suicide and an increased risk of suicidal ideation and behavior in the bereaved may depend upon kinship. As an example, a review found that suicide bereavement was associated with an increased risk of suicide in the partner of the deceased, but not in the parents of the deceased [60].

Following the suicide of a loved one, the increased risk of suicidality in the bereaved may perhaps be due to genetic factors, shared familial environment, assortative mating, health

concordance among spouses; nonspecific effects of bereavement, including loneliness, loss of a confidant, economic hardship, and psychiatric disorders secondary to bereavement; and specific effects of suicide bereavement, such as social modeling/contagion, shame, and perceived stigma [58,60,61,149]. In addition, the burden of providing care, such as monitoring (suicide watch), to a family member who is at known risk of suicide and ultimately dies by suicide, may lead to suicidality in the bereaved. General information about suicide is discussed separately. (See "Suicidal ideation and behavior in adults".)

TYPICAL ACUTE GRIEF

The hallmark of acute grief is an intense focus on thoughts and memories of the deceased person, accompanied by sadness and yearning.

This topic focuses upon grief in response to the death of a loved one. Nevertheless, grief can occur in response to other meaningful (nonbereavement) losses, including an interpersonal loss (eg, separation from a loved one through divorce) or loss of a pet, job, property, health, security, or community. In a study of survivors of a natural disaster who showed signs of unusually prolonged, intense, and disabling grief (ie, prolonged grief disorder), the large majority of survivors suffered nonbereavement losses [150].

Presentation — Mourners focus their attention, emotions, thoughts, and behavior upon the deceased person and what has been lost. However, the painful feelings and memories are commonly intermingled with periods of respite and positive feelings, thoughts, and reminiscing [5,151]. These positive experiences during bereavement reflect resilience and foretell better outcomes [24,152].

Acute grief symptoms vary across individuals and differ in the same person after different losses. Symptoms also vary over time and are influenced by social, religious, and cultural norms [5,25,40]. The features, intensity, and duration of grief are also influenced by age, health, religious and ethnic identity, coping style, attachment style, available social support and material resources, situation and circumstances of the death (see 'Type of loss' above), and the experience of prior losses [40].

The symptoms of acute grief are typically related to either separation from the deceased or to stress and trauma [1,5,40,110,153-156]:

- Symptoms of separation distress
    - Yearning for and seeking proximity to the deceased

- Loneliness
- Sadness, crying, guilt, shame, anxiety, and anger when confronted with reminders of the loss
- Disrupted appetite and sleep, as well as somatic symptoms such as heart palpitations, stomach sensations ("butterflies"), and dizziness
- Insistent thoughts and memories of the lost person, sometimes including hallucinations
- Feeling drawn to things associated with the deceased
- Social withdrawal and disinterest in other people and activities not associated with the deceased
- Confusion about one's identity and feeling lost or uncertain without the deceased

- Symptoms of trauma/stress reaction
  - Disbelief and difficulty accepting the loss
  - Shock
  - Numbness
  - Impaired attention, concentration, or memory

A study of adults aged 55 years and older with acute grief (n >800) found that the most common symptoms were yearning, distressing memories, emptiness, and feeling drawn to things associated with the deceased [157].

Anxiety may occur as part of grief, with patients struggling to determine what the loss means, what the future holds in the absence of the deceased, and whether their pain will persist indefinitely.

Despite wanting and needing other people, the bereaved often find it difficult to feel connected to them [25,110,158]. In addition, bereavement may leave people uncertain about changes in their roles and future. The bereaved may lose their sense of purpose and belonging and feel guilty about pursuing new activities and relationships.

During acute grief, people sometimes transiently wish they had died with their loved one or instead of that person. These fleeting thoughts may be relatively common among bereaved

individuals, but should nevertheless be taken seriously, and warrant assessment for active suicidal thoughts, plans, intent, and acts. (See 'Suicidality' above and "Suicidal ideation and behavior in adults", section on 'Patient evaluation'.)

Thoughts, images, and feeling the presence of the deceased occur frequently, and may be vivid to the point that they are hallucinatory. Visual, auditory, or tactile hallucinations represent a more general and intense sensation of the presence of the deceased. The prevalence of bereavement-related hallucinations in the general population ranges from 10 to 25 percent, and among bereaved spouses, 30 to 60 percent [159]. Patients may be frightened by these experiences and can be reassured that transient hallucinations are usually a means of maintaining proximity to the deceased and are not abnormal.

Bereaved people may consult a clinician because they are surprised and alarmed by the intensity of their acute grief. Although acute grief can be highly painful and debilitating, it should not be viewed as pathological ("medicalized") [6,110]. Rather, it can be helpful to provide information about grief to promote a better understanding of the experience, and to encourage patients to talk about their loved one. Additional information about managing grief is discussed separately. (See "Bereavement and grief in adults: Management", section on 'Management'.)

Following suicide — Suicide can be devastating and traumatizing, and cause grief that is especially intense, long-lasting, and qualitatively different from other losses [160,161]. Feelings of disbelief, stunned loss, loneliness, rejection, anger, and guilt for missing warning signs are often accompanied by confusion and uncertainty about one's basic beliefs, as well as shame, self-stigma, and repeated questions of "why." In addition, family conflicts may ensue and relatives of the deceased may worry about their mental health or a genetic predisposition for suicide within themselves or other family members.

Information about bereavement due to suicide is discussed elsewhere in this topic and postsuicide interventions for the bereaved are discussed separately. (See 'Suicide' above and 'Suicidality' above and "Suicidal ideation and behavior in adults", section on 'Postsuicide intervention'.)

Cultural aspects — Several cultural influences that are not specific to bereavement can affect grief. These include one's background, family, and community, as well as a social group's concepts, customs and practices, ceremonial rituals, religion and spirituality, and institutions [106,115]:

- Cultural identity – Includes race, ethnicity, sexual orientation, socioeconomic status, primary language, religious affiliation, place of birth and childhood, and migrant status.

- Conceptualization of distress – How members of the social group understand, explain, and communicate their problems and symptoms (eg, what others in one's social network think is causing the individual's problems).
- Psychosocial stressors and supports – Includes stressful aspects of one's environment and sources of support such as family and friends.
- Coping and help seeking – How one copes and where one looks for help.

These factors are assessed as part of the Cultural Formulation Interview that is published in the DSM-5 [115]. The interview provides clinicians a comprehensive and general assessment of a patient's social background and cultural origin, which can be used as part of evaluating grief-related psychopathology. (See 'Associated psychopathology' above.)

The cultural aspects of grief that are specific to bereavement include [106]:

- The nature of funerals and how they are arranged.
- Other important rituals after someone has died, such as a wake.
- Who attends the funeral and participates in the rituals.
- How members of one's community express their grief and mourn the deceased. This may include cultural or religious expectations about the time course of the acute grief period.
- Occasions when one remembers the deceased, such as a yearly commemoration.
- What the bereaved and others in one's community think happens after death.
- Specific activities, practices, or rituals, such as prayer or gatherings, that are helpful as part of mourning and coping with the loss.

Course — The evolution of acute grief does not proceed according to a predictable series of stages; rather, symptoms occur in fits and starts with a time course that varies as bereaved people adapt to the loss and acute grief is transformed and integrated [1,5,25,110]. The course of acute grief varies from person to person and in the same person after different losses and over time, depending upon the individual and the relationship to the deceased, available resources and supports, the circumstances and consequences of the death, and social and cultural expectations [1,115].

Some individuals cope better with losses than others [40]. Coping may depend in part upon how individuals make sense of and interpret what is happening to them, as well as the

strategies that are used to regulate intense emotions. In some people there is relatively little distress or disruption in functioning [152]. These may include people who have lost someone to whom they were not so close or someone whose death they had anticipated (see 'Anticipatory grief' below). Many people ultimately find that bereavement leads to psychological growth [40].

Acute grief usually evolves over time [48]. For most people, considerable progress in adapting to the loss occurs within six months and re-engagement in ongoing life is well underway within 6 to 12 months [156]; in some cases, adjustment occurs more quickly (eg, within weeks of the loss) [162] and in some cases adapting to a loss takes longer. As a person adapts to the loss, grief becomes more subdued; thoughts and memories of the deceased are no longer insistent and recede to the background, and overall emotionality diminishes. Grief becomes integrated as the finality and consequences of the death are understood and adaptations occur. One way of thinking about adaptation to loss is that the sense of connection to the deceased gradually moves from preoccupying the mind to residing comfortably in the heart.

However, the response to the loss of a loved one does not end. Reminders of the deceased might still evoke intense emotional reactions many years after the death. The deceased person is not forgotten and is still missed, and the intensity of grief may flare during anniversaries of the death, holidays, or periods of heightened stress without being pathological.

In some instances, the intensity and frequency of grief does not abate because certain thoughts and behavior derail and impede the process of adapting to the loss. Examples of this include second-guessing oneself or someone else in relation to the death, thinking “if only” something different had happened, the loved one would have lived longer and may still be alive. In addition, excessive avoidance can also stall or halt adaptation.

Inability to adapt to the loss can lead to the distressing and disabling syndrome of prolonged grief disorder. Other types of psychopathology may arise as well, such as major depression, anxiety disorders, and posttraumatic stress disorder (PTSD), even when grief is not intense or prolonged. (See 'Associated psychopathology' above.)

Delayed or absent grief has not been found in systematic, community-based studies of bereaved individuals [163]. However, when the death occurs in a circumstance that threatens the survival of the bereaved person, it is hypothesized that grief may be postponed until the survival issue is resolved.

Anticipatory grief — Both terminally ill patients and their caregivers experience grief around the impending loss of life as well as the existing losses that accompany serious illness; anticipatory grief is the response to the situation of current and anticipated loss. The symptoms include sadness, anxiety, anger, and disbelief, as well as yearning for past health and/or a more

hopeful future. Anticipatory grief also includes thoughts and plans for a future without the terminally ill loved one. Anticipation and psychological preparation for the death may facilitate adaptation to the loss after death. It is usually helpful for clinicians to discuss death and bereavement with caregivers, and a study (n = 893) found that interview questions about this topic provoked little or no distress in nearly 90 percent [164].

Occasionally, anticipatory grief may be severe and disabling [165]. As an example, anticipatory grief may provoke suicidal thinking in family caregivers, especially when family members have difficulty imagining their future without the person who is expected to die [166]. Clinicians can help by identifying suicidal thinking, evaluating the risk of suicidal behavior (algorithm 1), and discussing the impending bereavement, as well as providing support and monitoring acute grief symptoms after the death. Assessment of suicidality is discussed separately. (See "Suicidal ideation and behavior in adults", section on 'Patient evaluation'.)

Differential diagnosis — The differential diagnosis of typical acute grief includes:

- Prolonged grief disorder
- Major depression
- PTSD

Acute grief includes symptoms that overlap with those of common mental disorders. Anxiety and insomnia are also common during acute grief. The natural grief process is painful and impairing but should not be diagnosed as a psychiatric disorder. However, mental disorders that are present during bereavement should be diagnosed and treated as indicated.

Prolonged grief disorder — A subgroup of bereaved people experience prolonged grief disorder. Yearning for the deceased person, preoccupation with thoughts and memories of the deceased, emotional pain, and disbelief about the death can occur in both typical acute grief and prolonged grief disorder. However, prolonged grief disorder is marked by maladaptive thoughts, excessive avoidance of reminders of the death, excessive dysregulated emotions, and dysfunctional behaviors that do not occur as part of acute typical grief. In addition, the intense, disabling symptoms of prolonged grief disorder persist for at least 12 months after the death. (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Diagnosis'.)

Major depression — Typical acute grief and major depression (table 1) are both generally characterized by feelings of sadness and guilt, a diminished ability to experience positive emotions, and insomnia. However, the two conditions can be distinguished as follows [110,115]:

- In acute grief, the predominant affect is yearning for the deceased, accompanied by feelings of loneliness related to the absences of the deceased; these feelings are typically intermittent and oscillate with periods of respite when the pain subsides and euthymia or even positive emotions are experienced [5,167-169]. By contrast, major depression is characterized by pervasive and persistent sadness, feeling "blue" or "down in the dumps," and the inability to experience positive emotions most of the day, nearly every day; even when dysphoria abates, euthymia and positive emotions rarely occur.

- Dysphoria in grieving individuals is specifically associated with thoughts or reminders of the deceased. In major depression, the miserable mood is usually not focused upon any specific thought or preoccupation.

- Guilt that occurs in grief often focuses upon the relationship to the deceased and/or the death and caregiving missteps, such as not having prevented the death or made the deceased person's life easier, or not having professed love enough. This differs from guilt in major depression, which derives from a pervasive sense of failure, worthlessness, or self-loathing.

- Suicidal ideation can occur in both acute grief and major depression. In acute grief, these thoughts are centered upon the deceased (eg, wanting to join the deceased, a wish that the bereaved had died instead of the loved one, or feeling that life without the deceased is not worth living). In depression, thoughts of wanting to die are related to feelings of despondency associated with negative thoughts about oneself, the world, and the future.

- Acute grief symptoms are a response to loss of the deceased. As an example, sadness and loss of interest or pleasure in usual activities occur only because the deceased person is gone. The bereaved person can easily imagine being happy again if they could be reunited with their loved one. By contrast, patients with major depression often feel hopeless and cannot imagine being happy.

- For bereaved spouses or partners, changes in prior routines surrounding sleep may also contribute to a period of sleep disturbance. Sleep in bereaved individuals may be interrupted by worries about functioning without the deceased person and managing specific tasks previously performed by the deceased. These grief-related sleep difficulties differ from insomnia due to major depression, in which interruption of sleep is more likely characterized by early morning wakening or excessive sleep.

- Anhedonia in the bereaved typically manifests as lack of interest in things unrelated to the deceased; mourners may explain that their loved one is not there to help or to share in activities, or that they want to avoid reminders of the loss. The strong interest in the

deceased differentiates this condition from the general and pervasive anhedonia in major depression.

Grieving individuals may become depressed, and increases in the severity of grief are associated with an increased risk of developing depressive syndromes [170]. The severity of grief also correlates with the severity of depressive symptoms.

Additional information about the clinical features and diagnosis of depression is discussed separately. (See "Unipolar depression in adults: Clinical features" and "Unipolar depression in adults: Assessment and diagnosis".)

Posttraumatic stress disorder — Acute grief also needs to be differentiated from PTSD; symptoms that can occur in both conditions include intrusive thoughts, avoidance behavior, and emotional dysregulation. In addition, acute grief and PTSD may include frequent insistent images of someone who is deceased, or emotional or physiologic activation triggered by reminders of the deceased. However, sadness and yearning are the usual response in acute grief, rather than fear, which often occurs in PTSD. During acute grief, there may be dreams about the person who died, which are associated with deep sadness upon awakening; these dreams are distinct from the nightmares that can occur in PTSD. Reminders of the loss are avoided in acute grief, but this represents an attempt to avoid upsurges in grief symptoms rather than an overgeneralized fear of recurrent danger. (See "Posttraumatic stress disorder in adults: Epidemiology, pathophysiology, clinical features, assessment, and diagnosis".)

INFORMATION FOR PATIENTS

Information for patients about grief and prolonged grief disorder is available in the following graphic that can be printed (table 2) and online at The Center for Prolonged Grief. Information for people bereaved by suicide is available at the American Foundation for Suicide Prevention.

SUMMARY

- **Terminology**
  - Bereavement is the situation in which a loved one has died.
  - Grief is the response to bereavement; acute grief can be intense and disruptive, but is usually integrated over time.

- Prolonged grief disorder is a unique and identifiable syndrome marked by unrelenting, intense, and functionally debilitating symptoms that require specific treatment.

(See 'Introduction' above and 'Terminology' above.)

- **Bereavement**

  - Bereavement reactions may vary depending upon the type of lost relationship. The intensity of acute grief is generally greater in parents who lose a child than it is for bereaved spouses, which in turn is greater than the grief of adult children who lose a parent or caregiver. (See 'Type of loss' above.)

  - Bereavement is associated with an increased risk of morbidity and all-cause mortality. (See 'Adverse general medical outcomes' above.)

  - The bereaved are more likely to develop psychiatric disorders such as unipolar major depression, anxiety disorders, and posttraumatic stress disorder (PTSD), compared with the nonbereaved. In addition, suicide occurs more often in the bereaved, especially in those who lose a loved one through suicide. (See 'Associated psychopathology' above.)

- **Typical acute grief**

  - There is no single way to grieve and adapt to a loss. The specific pattern of grief symptoms as well as the process of adaptation is unique to each specific loss situation, influenced by individual factors as well as social, religious, and cultural norms. Nevertheless, the symptoms of typical acute grief are usually related to either separation from the deceased (eg, yearning for and seeking proximity to the deceased, loneliness, and crying) or to stress and trauma (disbelief, shock, and numbness). (See 'Presentation' above.)

  - The course of typical acute grief does not follow a specific series of stages that occur in a fixed order; rather, the trajectory of adaptation is erratic and specific to each loss. However, acute grief is time-limited and integrated such that painful emotions and insistent thoughts diminish in frequency, intensity, and duration. Adaptation to the loss is usually well underway within 6 to 12 months. Grief becomes more subdued but generally does not resolve completely; the deceased person is not forgotten and is still missed, and the intensity of grief may flare during anniversaries of the death, holidays, or periods of heightened stress. (See 'Course' above.)

- Acute grief is not a mental disorder and should not be diagnosed or treated as such. Nevertheless, grief includes symptoms that overlap with those of common mental disorders. The differential diagnosis of acute grief includes prolonged grief disorder, major depression, and PTSD. (See 'Differential diagnosis' above.)

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