Prolonged grief disorder in adults: Treatment

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INTRODUCTION

Bereavement is the situation in which a loved one has died, and grief is the response to the loss. In a minority of patients, acute grief may progress to prolonged grief disorder, which is a unique and recognizable syndrome marked by unusually intense, unrelenting, and functionally debilitating symptoms that require specific treatment [1]. Recognition of problematic grief extends back to at least 1980, when Bowlby explained how grief could lead to a state of "suspended growth in life" if certain natural defensive processes persisted too long and/or dominated the bereaved person's mental functioning [2].

This topic reviews treatment of prolonged grief disorder. The clinical manifestations, assessment, diagnosis, and differential diagnosis of prolonged grief disorder are discussed separately, as are bereavement, grief, and palliative care.

- (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Bereavement and grief in adults: Clinical features".)
- (See "Bereavement and grief in adults: Management".)
- (See "Benefits, services, and models of subspecialty palliative care".)

TERMINOLOGY

Prolonged grief disorder is a form of grief that is abnormally intense, protracted, and disabling, and 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 normal grief as well as other psychiatric disorders, such as unipolar depression or posttraumatic stress disorder. Much of the research establishing this diagnosis and its treatment was conducted using the term complicated grief. Other terms that have been used to describe prolonged grief disorder include chronic grief, complex grief, pathological grief, persistent complex bereavement disorder, traumatic grief, and unresolved grief.

Additional information about the terminology that describes different aspects of death is discussed separately. (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Terminology'.)

GENERAL PRINCIPLES

Goals — The goal of treatment for prolonged grief disorder is to facilitate integration of the loss by addressing impediments to adaptation. Resolution of the disorder is indicated by:

- Accepting the reality of the death, including its finality and consequences, as well as a changed relationship with the deceased loved one.
- Restoring the capacity to thrive – This includes reestablishing:
  - A sense of purpose and meaning in life
  - Belief in one's competence to face and meet important challenges
  - Feelings of belonging and mattering
  - At least one close relationship
- Relief of maladaptive ruminations that represent persistence and/or undue influence of natural defensive responses to the death. Examples of these defenses include disbelief, protest, imagining alternative scenarios to the death (counterfactual thinking) such as daydreaming about being together, and caregiver self-blame.
- Overcoming excessive avoidance of reminders of the loss and/or efforts to escape from the painful reality by seeking proximity to sensory reminders of the deceased (eg, listening to a recording of the deceased person's voice or the smelling the person's clothes).

- Improved regulation of emotions – This includes modulating emotions effectively (eg, by experiencing them and setting them aside) and increasing one's ability to experience and appreciate positive emotions.

Treatment of prolonged grief disorder does not aim to achieve full remission of grief [3]. Rather, feelings of grief diminish in frequency, intensity, and duration as patients learn to adapt to the loss. When adaptation is successful, most bereaved people continue to miss the deceased and feel sadness at times; in this manner, grief is permanent. Occasionally grief may be strongly activated by reminders of the lost loved one, especially on certain calendar days or occasions, such as the anniversary of the death, holidays, or important family events (eg, marriages or births). These periods of activation are usually short-lived and are normal experiences that should not be considered pathological.

Education — One component of most treatments for prolonged grief disorder is education about grief. It is important to help patients understand that the disorder is not a completely different form of grief, but rather an unusually intense form of grief that continues beyond the time that it is expected to recede, according to the patient's social group and culture. Many patients with prolonged grief disorder are discouraged by the persistence of anguishing grief, and surveys suggest that they are usually relieved to receive the diagnosis as well as education about the condition [3].

Although education about prolonged grief disorder is not sufficient on its own to resolve symptoms, its effect might be bolstered by also educating supportive family or friends. Individuals who initially were supportive often become frustrated by seemingly fruitless efforts to try helping. They may withdraw or become harsh and critical because they do not understand prolonged grief disorder and do not realize the patient has a treatable condition. In many cases, patients have been misdiagnosed and treated unsuccessfully for unipolar major depression or another disorder, which can engender hopelessness in patients as well as family.

Evidence that supports educating patients about prolonged grief disorder includes randomized trials:

- A 13-month trial compared education plus usual care with usual care alone in bereaved patients with symptoms of prolonged grief disorder (n = 67) [4]. Patients and primary care clinicians who were assigned to the active intervention received information about the symptoms of prolonged grief disorder and its risk factors, as well as information about two strategies for adapting to the loss: confronting the painful reality of the loss and setting the pain aside to focus upon something emotionally neutral or positive. There was a trend for greater improvement in the group who received education.

- A four-week trial enrolled patients (n = 42) with moderately high levels of prolonged grief disorder symptoms, all of whom received usual care consisting of two sessions of education about prolonged grief disorder [5]. Patients assigned to the active intervention also received two sessions about supportive relationships in bereavement, thus receiving a total of four education sessions. In addition, a close friend or relative of patients in the active intervention received two education sessions about helpful social support. Assessments eight weeks posttreatment showed that improvement of prolonged grief disorder symptoms, as well as depressive symptoms, was greater in patients who received education about both prolonged grief disorder and social support, compared with education about only the disorder.

Education of family members is an element of the psychotherapies that have the strongest data demonstrating efficacy for prolonged grief disorder [1]. (See 'Choosing treatment' below.)

Information about grief and prolonged grief disorder is discussed separately. (See "Bereavement and grief in adults: Clinical features" and "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)

Monitoring — Outpatients with prolonged grief disorder are monitored by clinicians every one to four weeks, depending upon symptom acuity. Response to treatment can be monitored with the:

- Clinical Global Impression Scale for Prolonged Grief Disorder (table 1), which is a two-item, interviewer-administered instrument. The two items are global severity of prolonged grief disorder symptoms and global improvement; each item is rated on a Likert scale ranging from 1 to 7, and each point of the scale includes a behavioral description.

- Reasonable alternatives include self-report questionnaires such as the 19-item Inventory of Complicated Grief (table 2), the 13-item Prolonged Grief Disorder-13-Revised scale, or the five-item Brief Grief Questionnaire (table 3).

Suicidal ideation and behavior should be routinely monitored during treatment of prolonged grief disorder. In addition, patients who have used alcohol and other substances to regulate painful emotions are monitored for ongoing use.

We also encourage patients to self-monitor their grief systems using a tool available online at The Center for Prolonged Grief.

Comorbidity — Prolonged grief disorder is often accompanied by comorbid psychiatric disorders such as unipolar major depression and posttraumatic stress disorder, and by suicidal

thinking or behavior. Following successful treatment of prolonged grief disorder, comorbidity that persists should be managed with indicated treatments (eg, pharmacotherapy and/or psychotherapy). In patients with major depression or other comorbidities, concurrent treatment of prolonged grief disorder and the co-occurring psychiatric disorders may represent an optimal approach [6]. Comorbid psychiatric disorders that commonly occur in prolonged grief disorder are discussed separately. (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Psychiatric'.)

PREVENTION

The possible benefits of psychotherapy during acute grief to prevent prolonged grief disorder are discussed separately. (See "Bereavement and grief in adults: Management", section on 'Interventions'.)

CHOOSING TREATMENT

Overview — Based upon randomized trials, the best treatment for prolonged grief disorder (previously called complicated grief) is psychotherapy that was developed specifically for the disorder, rather than therapies that are effective for bereavement-related unipolar major depression (eg, interpersonal psychotherapy or antidepressant medication) [7,8]. As an example, a meta-analysis of five trials compared psychotherapies tailored for prolonged grief disorder with control conditions in 368 patients with the disorder [9]. The psychotherapies consisted of prolonged grief disorder therapy or cognitive-behavioral therapy (CBT) modified for prolonged grief disorder; control conditions included nonspecific supportive psychotherapy or interpersonal psychotherapy. Improvement was greater with psychotherapy specific for prolonged grief disorder and the clinical benefit was moderately large. However, heterogeneity across studies was also large. In the one study with posttreatment follow-up (six months), improvement was greater with psychotherapy specific for the disorder and the clinical effect was large.

Serious psychosocial problems may occur after bereavement, and therapists may need to address these problems prior to undertaking a psychotherapy targeting prolonged grief disorder. As an example, patients may face financial, occupational, or interpersonal problems, such as homelessness, loss of income, or health problems. If psychosocial problems are present and unrecognized, grief focused treatment may stall, and poor adherence may occur after four to six sessions or patients may demonstrate little or no improvement after 10 to 12 sessions. In these cases, patients may require other treatment; as an example, patients involved in a lawsuit

should receive supportive therapy until the suit is concluded. If prolonged grief disorder symptoms are still present after the psychosocial problem has been addressed, prolonged grief disorder-targeted treatment should be resumed or instituted.

No randomized trials have demonstrated that pharmacotherapy alone is beneficial for prolonged grief disorder. However, medications can help manage comorbid psychopathology such as unipolar major depression [6], and may help patients with anxiety disorders or posttraumatic stress disorder (PTSD).

We suggest that treatment of prolonged grief disorder proceed according to the sequence described in the sections below. Patients begin with initial therapy and progress through each step until they respond.

Initial therapy — For patients with prolonged grief disorder, we recommend "prolonged grief disorder therapy" (formerly called "complicated grief treatment") as first-line treatment. The therapy includes techniques from other psychotherapies, including CBT, interpersonal psychotherapy, motivational interviewing, positive psychology, and psychodynamic psychotherapy; these techniques promote adaptation to loss by addressing impediments to integrating grief, and restore the capacity to thrive in a world without the deceased [3,8,10-12]. Different formats for administering prolonged grief disorder therapy include individual, group, and internet. In the largest randomized trial that studied the therapy, response occurred in more than 80 percent of patients who received it.

Theoretical foundation — The theoretical foundation for prolonged grief disorder therapy is based upon an attachment theory model. The model hypothesizes that people are biologically motivated to form close relationships with other people, and that adaptation to losing a close relationship requires acknowledging the finality and consequences of the loss, revising the internalized representation of the deceased, and re-envisioning life plans and goals [12]. Additional information about bereavement and loss of attachment is described separately. (See "Bereavement and grief in adults: Clinical features", section on 'Loss of attachment'.)

Prolonged grief disorder therapy facilitates adaptation to bereavement by focusing upon two key areas [1,13,14]:

- Loss – Accepting the reality of the death, including its finality and consequences, a changed relationship with the deceased, and the permanence of grief.
- Restoration – Restoring the capacity to thrive in a world without the loved one, including a sense of purpose and meaning, and possibilities for happiness.

Preliminary evidence supports the theoretical model underlying prolonged grief disorder therapy and the importance of specified treatment targets. Studies have found that reducing guilt/self-blame, negative thoughts about the future, and loss-related avoidance precede and help explain positive response to treatment [15]. The studies, along with a randomized trial comparing grief-focused treatment with and without exposure to memories of the death [16], suggest that such exposure is an important component of efficacious treatments for prolonged grief disorder [17].

Administration — The protocol for administering prolonged grief disorder therapy includes four phases with a total of 16 sessions, which target seven healing milestones for adaptation to bereavement [1,6,10]:

- Getting Started (sessions 1 to 3) – Therapists elicit a history of the patient's relationships, interests, and accomplishments, and introduce the first four healing milestones:

  - Milestone 1 – Understanding and accepting grief
  - Milestone 2 – Managing grief-related emotions
  - Milestone 3 – Seeing a promising future
  - Milestone 4 – Strengthening relationships with others

  Monitoring of grief symptoms begins after the first session and continues throughout the treatment (see 'Monitoring' above). In the second session, therapists educate patients about acute grief, integrated grief, prolonged grief disorder, and the elements of prolonged grief disorder therapy. A procedure for identifying aspirational goals (milestone 3) is also introduced in the second session. For the third session, patients are encouraged to invite a close friend or relative, who is educated about prolonged grief disorder, the therapy, and possible ways to support the patient (milestone 4).

- The Core Revisiting Sequence (sessions 4 to 9) – This phase introduces the last three milestones:

  - Milestone 5 – Narrating the story of the death
  - Milestone 6 – Learning to live with reminders of the loss
  - Milestone 7 – Connecting with memories of the deceased

  Each session focuses upon both loss and restoration-related work:

  - Loss – A technique called "imaginal revisiting" is used to address milestone 5. During the four-part imaginal revisiting exercise, patients:

    - Visualize the time that they learned of the death

- Over a period of approximately 10 minutes, tell the story of what happened from that point forward

- Pause and reflect upon this story for another 10 minutes; during the reflection period, the therapist asks the patient to describe what they noticed or observed while telling the story, and helps the patient address any troubling feelings or thoughts about the death

- Set the story aside and plan a rewarding activity

Audio-recordings are made of the 10-minute story of learning about the death, which patients listen to at home between sessions. The revisiting exercise is usually repeated weekly for four to six sessions.

Milestone 6 is addressed using a technique to confront painful reminders of the loss by revisiting, in vivo, avoided situations. Beginning in session 5, a list is developed identifying situations the patient is avoiding and estimating the intensity of grief that each situation might activate; this list of situations is arranged from least to most painful. Each week an activity is planned that focuses on something that is challenging but doable, with patients confronting progressively more painful reminders of the loss. The therapist reviews these experiences with the patient and encourages self-observation and reflection.

Milestone 7 is introduced using a series of questionnaires about memories of the person who died. These are given to the patient weekly beginning in session 6.

- Restoration – The restoration focus (milestones 1 to 4) is continued in each session. This is accomplished by ongoing monitoring of grief (table 1), providing booster education, continued work on aspirational goals using a modification of motivational interviewing goals-work and completing simple, rewarding activities on a daily basis. In addition, the therapist looks for opportunities to encourage ways to strengthen relationships with others. Treatment is intended to help patients leave therapy with at least one close relationship restored and strengthened.

- Midcourse review (session 10) – Progress to date is discussed and plans for the closing sequence are outlined.

- Closing Sequence (sessions 11 to 16) – Patients continue to work on milestone 6 by continuing situational revisiting and milestone 7 by completing memories work and having an imaginal conversation with their deceased loved one. Restoration work

continues, including work on aspirational goals, engaging in rewarding activities, and strengthening relationships. Patients complete a segment on termination that includes making plans for managing difficult times that may arise posttreatment, as well as expressing one's thoughts and feelings about the relationship with the clinician and ending treatment.

Each session has a planned sequence, which includes first reviewing activities (homework) from the preceding week, then focusing on loss-related procedures, followed by restoration procedures, and ending with a discussion of homework to be completed prior to the next session. Throughout treatment, therapists actively listen and are alert to issues that derail adaptation to the loss, and address these impediments when they emerge. In addition, patient self-observation and reflection, as well as self-compassion, are encouraged.

Efficacy — Clinicians can expect that response will occur in as many as 70 to 80 percent of patients who are treated with prolonged grief disorder therapy, based upon randomized trials in different age groups (total n >600) [11]. These rigorous trials compared the therapy to active treatment, including psychotherapy or pharmacotherapy with demonstrated efficacy for unipolar major depression, rather than waiting list controls or usual care. In the following three trials that demonstrated the efficacy of prolonged grief disorder therapy, response was defined as much or very much improved on the Clinical Global Impression Scale for Prolonged Grief Disorder (table 1):

- One trial compared prolonged grief disorder therapy with interpersonal psychotherapy in 95 patients (mean age approximately 48 years) [8]. Both treatments were administered in 16 weekly sessions; some patients continued antidepressants initiated prior to study intake. Response occurred in more patients who received prolonged grief disorder therapy than interpersonal psychotherapy (51 versus 28 percent).

- A second trial using similar methods, compared prolonged grief disorder therapy with interpersonal psychotherapy in 151 older adult patients with a mean age of 66 (range 50 to 91) years [10]. More than twice as many patients responded to prolonged grief disorder therapy than interpersonal psychotherapy (70 versus 32 percent), and response was sustained six months posttreatment.

- A 20-week trial randomly assigned patients with prolonged grief disorder (n = 395, mean age 53 years) to one of four treatments: prolonged grief disorder therapy plus citalopram, prolonged grief disorder therapy plus placebo, citalopram with grief support, or placebo with grief support [6]. Grief support included support, education, and encouragement to re-engage in activities. The median dose of citalopram was 34 mg/day. The results

indicated that prolonged grief disorder therapy, but not citalopram, was effective for prolonged grief disorder:

- Response occurred in more patients who received prolonged grief disorder therapy plus placebo, compared with placebo (83 versus 55 percent).
- Response occurred more frequently with prolonged grief disorder therapy plus citalopram, compared with citalopram (84 versus 69 percent of patients).
- Response was virtually identical in patients who received prolonged grief disorder therapy with either citalopram or placebo (84 and 83 percent).
- Suicidal ideation was present in approximately 30 percent of patients at baseline; posttreatment, suicidal ideation was found in fewer patients who received:
  - Prolonged grief disorder therapy plus citalopram than citalopram (4 versus 18 percent)
  - Prolonged grief disorder therapy plus placebo than placebo (7 versus 19 percent)
- The benefit of prolonged grief disorder therapy persisted at the six-month follow-up assessment.

Subsequent analyses from the 20-week randomized trial supported using prolonged grief disorder therapy specifically for patients with prolonged grief disorder due to bereavement by suicide, which can cause especially severe and debilitating grief because of shame, guilt, and stigma [18]. (See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Suicidality'.)

In addition, other randomized trials have shown that prolonged grief disorder therapy is efficacious [11], and observational studies suggest that the therapy may help patients with prolonged grief disorder and comorbid substance use disorders [19], as well as patients in non-Western settings [20].

Alternatives — If patients with prolonged grief disorder do not respond adequately to a course of prolonged grief disorder therapy, they should be re-evaluated to determine whether the diagnosis is prolonged grief disorder or a different condition such as unipolar major depression or PTSD. In addition, patients with prolonged grief disorder may have comorbid major depression, anxiety disorders, PTSD, or substance use disorders. If a disorder other than prolonged grief disorder is more salient, treatment should refocus upon the primary problem. The differential diagnosis and comorbidity of prolonged grief disorder are discussed separately.

(See "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)

If the evaluation determines that the patient's primary problem is prolonged grief disorder that did not respond satisfactorily to prolonged grief disorder therapy, or a therapist trained in prolonged grief disorder therapy is not available, an alternative is CBT adapted for prolonged grief disorder [7].

- **Cognitive-behavioral therapy** – CBT and prolonged grief disorder therapy are similar in that telling the story of the death may be the most important active ingredient [16]. However, one difference is that CBT utilizes cognitive restructuring, which involves identifying and correcting maladaptive thoughts known as cognitive distortions, such as all-or-nothing thinking, overgeneralization, and catastrophizing [16,21,22]. Therapy may also involve relaxation techniques, writing a letter to the deceased to express unresolved issues, different techniques to remember positive experiences with the deceased, and setting new goals. As with prolonged grief disorder therapy, planning for calendar days that might activate grief is addressed at the end of treatment. CBT can be administered in different formats, including individual, group, and internet [16].

  Relatively small, randomized trials demonstrate that CBT adapted for prolonged grief disorder is efficacious and that the benefits persist posttreatment [9,23,24]:

  - In a 12-week trial (n = 54) that compared CBT with supportive grief counseling (n = 11), the completer analysis found that improvement was greater with CBT and the clinical effect was large [21]. However, the more rigorous intent-to-treat analysis found that improvement was comparable. The results also suggested that administering exposure therapy prior to cognitive restructuring (n = 20) is more effective than providing cognitive restructuring first and then exposure therapy (n = 23). Follow-up assessments six months posttreatment showed that the superiority of CBT in completers was maintained.

  - A five-week trial (n = 51) compared internet-based CBT, which included therapist support by e-mail, with a waiting list control condition [25]. Improvement was greater with CBT, and the treatment effect was large and persisted at follow-up three months posttreatment.

  - Another trial comparing CBT (20 weekly sessions) with a waiting list control in 51 patients also found that improvement was greater with CBT [22]. In addition, the treatment effect was large and was maintained at follow-up approximately 18 months posttreatment [26].

Additional alternatives to prolonged grief disorder therapy include exposure therapy, behavioral activation, and mindfulness-based cognitive therapy, which are related to CBT and have been modified for prolonged grief disorder:

- **Exposure therapy** – Exposure therapy for prolonged grief disorder is a component of all prolonged grief disorder therapies; administered alone, it is briefer than the other therapies. It focuses upon decreasing avoidance of painful memories and situations that are associated with losing a loved one; this occurs by exposure to aversive reminders of the death in a therapeutic manner [24]. Exposure can take the form of imaginal exposure that is typically based on the patient talking or writing about the death event. In vivo exposure involves confronting real-life situations that remind one of the loss, such as looking at pictures, visiting a favorite restaurant, or spending time in a park that the patient frequented with the deceased. By repeatedly confronting these reminders of the loss and its permanence, they become less painful and meaningful memories become more accessible. Additional information about administering exposure therapy is discussed separately in the context of PTSD. (See "Posttraumatic stress disorder in adults: Psychotherapy and psychosocial interventions", section on 'Exposure-based therapies'.)

  Support for treating prolonged grief disorder with exposure therapy includes the studies of prolonged grief disorder therapy and CBT that are described above, as well as two additional randomized trials:

  - In a 10-week trial, all patients (n = 80) received group CBT adapted for prolonged grief disorder and were randomly assigned to four individual sessions of exposure therapy or nondirective therapy [17]. In exposure therapy, patients relived the time they experienced the death of the person. In nondirective therapy, patients discussed whatever they wished without receiving any direction and received no instructions on exposure techniques. Improvement was greater in patients who received exposure therapy and the clinical effect was large. In addition, reduction of depression and negative cognitions about oneself and the world were greater with exposure therapy, and the benefits of CBT with exposure therapy persisted at follow-up assessments two years posttreatment [16].

  - An eight-week trial compared internet-delivered, therapist-supported exposure therapy with a waiting list control in 30 patients [27]. Improvement was greater with active treatment and the clinical effect was large. Follow-up three months posttreatment found that the benefit of exposure therapy persisted.

- **Behavioral activation** – Behavioral activation is a component of CBT that was developed as a free-standing psychotherapy based upon the premise that patients with psychiatric disorders can improve by re-engaging with positive environmental stimuli and reducing avoidance behavior [24]. The therapy consists of clinical strategies that include self-monitoring, structuring and scheduling activities, problem solving, establishing routines, and developing behavioral alternatives to rumination. Although behavioral activation was initially used for treating unipolar depression, it is also prescribed for other psychiatric disorders, as well as promoting well-being in nonclinical populations. Additional information about delivering behavioral activation is discussed separately in the context of depression. (See "Behavioral activation therapy for treating unipolar major depression".)

  Two relatively small, randomized trials suggest that behavioral activation modified for use in prolonged grief disorder may be efficacious:

  - An eight-week trial compared internet-delivered, therapist-supported behavioral activation with a waiting list control in 29 patients [27]. Improvement was greater with behavioral activation and the clinical effect was large. Follow-up three months posttreatment found that the benefit of treatment was maintained.

  - A 12-week trial compared behavioral activation with a waiting list control in 25 patients; after 12 weeks, patients in the control group received behavioral activation [28]. Behavioral activation was administered in 12 to 14 individual sessions, which included education about prolonged grief disorder, self-monitoring of activities, identifying patterns and reinforcers of avoidant behavior, and scheduling rewarding activities. Improvement posttreatment was greater with behavioral activation than no treatment. At the follow-up assessment 12 weeks after treatment ended, response was observed in 60 percent of patients. Symptoms of depression and PTSD also improved.

- **Mindfulness-based cognitive therapy** – Mindfulness-based cognitive therapy combines the clinical application of mindfulness meditation with elements of CBT. The treatment is generally used to delay or prevent recurrence of unipolar major depression, but can also ameliorate acute depressive syndromes and symptoms, and is administered in a group therapy format. Detailed information about delivering mindfulness-based cognitive therapy is discussed separately in the context of depression. (See "Unipolar major depression: Treatment with mindfulness-based cognitive therapy".)

  Evidence supporting the use of mindfulness-based cognitive therapy for prolonged grief disorder includes an eight-week, prospective observational study in 19 patients with self-rated unresolved grief following the death of at least one first-degree relative within six

months to four years [29]. Self-report assessments suggested that symptoms of grief, anxiety, depression, and emotion regulation improved.

Other approaches — For patients with prolonged grief disorder who decline, do not respond to, or do not have access to psychotherapies that have been adapted for the disorder, CBT, exposure therapy, behavioral activation, or mindfulness-based cognitive therapy, we suggest an approach that combines each of the following to help patients adapt to bereavement [3]:

- Education about prolonged grief disorder. (See 'Education' above and "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)
- Grief counseling and support – Empathically listening to patients and validating their grief. (See "Bereavement and grief in adults: Management", section on 'Support'.)
- Encouragement to reduce avoidance behavior – Patients with prolonged grief disorder typically avoid reminders of the deceased, and thus need encouragement make plans for resuming relationships and activities that were shared with the deceased, and help to pursue new, enjoyable activities and relationships.
- Addressing dysfunctional thoughts – Patients often have self-blaming beliefs (eg, “It’s my fault he died” or “It’s a betrayal if I enjoy life again”), and can be helped to correct these maladaptive thoughts by examining the evidence for them and discussing alternative, rational explanations.
- Encouragement to consider intrinsic interests, values, and goals, and to begin planning how to achieve these goals.
- Antidepressant medication – Although there is no evidence that pharmacotherapy is indicated for prolonged grief disorder, antidepressants are often used adjunctively with psychotherapy for prolonged grief disorder [7,30], if comorbid depressive and anxiety disorders are present [8,10,17,21,24].

  Evidence regarding adjunctive antidepressants includes a 20-week trial that randomly assigned patients with prolonged grief disorder (n = 395) to one of four treatments: citalopram (median dose 40 mg/day), placebo, citalopram plus prolonged grief disorder therapy, or placebo plus prolonged grief disorder therapy [6]. The primary findings included the following:

  - Response (prolonged grief disorder much improved or very much improved) with citalopram and placebo was comparable (relative risk 1.26, 95% CI 0.95-1.68)

- Response with citalopram plus psychotherapy and with placebo plus psychotherapy was nearly identical (relative risk 1.01, 95% CI 0.88-1.17)

- However, depression rating scale scores decreased more with citalopram plus psychotherapy than placebo plus psychotherapy

The pharmacology, side effects, and administration of antidepressants are discussed in separate topics.

For patients with prolonged grief disorder who do not respond to the combination of interventions in the preceding bullets, other therapies described in the literature may perhaps be beneficial. These include cognitive narrative therapy [31], meaning making therapy [32,33], psychodynamic psychotherapy [34], accelerated resolution therapy [35], family therapy [36,37], restorative retelling [38], supportive grief therapy [39], eye movement desensitization and reprocessing, or art therapy [40,41]. Adding yoga or acupuncture may also possibly help. (See "Unipolar depression in adults: Psychodynamic psychotherapy" and "Unipolar depression in adults: Family and couples therapy" and "Overview of yoga" and "Overview of the clinical uses of acupuncture".)

If PTSD-like symptoms are prominent, trauma-focused therapies may be helpful; some components of PTSD therapies overlap with prolonged grief disorder therapy and CBT adapted for prolonged grief disorder, and may be used effectively in conjunction with prolonged grief disorder therapy [42]. (See "Posttraumatic stress disorder in adults: Psychotherapy and psychosocial interventions".)

INFORMATION FOR PATIENTS

Information for patients about grief and prolonged grief disorder is available in the following graphic that can be printed (table 4), and online at The Center for Prolonged Grief. Information for patients bereaved by suicide is available online at the American Foundation for Suicide Prevention.

SUMMARY AND RECOMMENDATIONS

- **Terminology** – Prolonged grief disorder is a unique and recognizable syndrome marked by unusually intense, unrelenting, and functionally debilitating symptoms that require specific treatment. (See 'Introduction' above and 'Terminology' above and "Prolonged grief disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)

- **General principles** – The goal of treatment for prolonged grief disorder is to facilitate integration of the loss by addressing impediments to adaptation. However, treatment is not intended to fully remit all grief symptoms. Instead, grief is reduced in frequency and intensity, and no longer interferes with ongoing life. Patients with prolonged grief disorder are often relieved to receive the diagnosis and education about the disorder. Response to treatment can be monitored with the Clinical Global Impression Scale for Complicated Grief (table 1). (See 'General principles' above.)

- **Choosing treatment** – The best established treatment for prolonged grief disorder is psychotherapy that is specific for the condition. (See 'Overview' above.)

  - **Initial therapy** – For patients with prolonged grief disorder, we suggest a psychotherapy called "prolonged grief disorder therapy" (previously labelled "complicated grief treatment") as first-line treatment, rather than other psychotherapies (**Grade 2B**). If patients are not responding to first-line treatment, they should be re-evaluated to verify the diagnosis of prolonged grief disorder and assessed for potential complicating factors such as undiagnosed comorbid psychopathology or psychosocial problems that require attention. (See 'Initial therapy' above.)

  - **Alternatives** – If prolonged grief disorder does not respond to prolonged grief disorder therapy, or if prolonged grief disorder therapy is not available, we typically use cognitive-behavioral therapy (CBT) adapted for prolonged grief disorder. Patients unresponsive to prolonged grief disorder therapy followed by CBT specific for prolonged grief disorder can be treated with other psychotherapies modified for prolonged grief disorder, such as exposure therapy, behavioral activation, or mindfulness-based cognitive therapy. (See 'Alternatives' above.)

- **Other approaches** – Some patients with prolonged grief disorder decline, do not respond to, or have access to initial therapy and alternative psychotherapies modified for prolonged grief disorder. One option for these patients is an approach that combines each of the following: education about prolonged grief disorder, grief counseling and support, encouragement to reduce avoidance behavior, addressing dysfunctional thoughts, and encouragement to consider aspirations and goals, as well as an antidepressant medication for comorbid major depression. (See 'Other approaches' above.)

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