

Prolonged Grief Disorder

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

Bereavement-Related Disorders

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

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

Prolonged Pathologic Grief

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

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

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

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

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