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A call to the field: Complicated grief in the DSM-5

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**A CALL TO THE FIELD:
COMPLICATED GRIEF IN THE DSM-5**

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ABSTRACT

While complicated grief has been addressed in part through some recommendations for modifications in the upcoming fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), there remain reasons for substantial concern about its scope therein and within clinical practice. The authors issue a call to the field, reiterating that complicated grief is

complicated and cannot be confined to just one syndrome or disorder. Continued research is urged, and specific caveats are identified for exploring the complex dimensions of loss and grief. The authors advocate for ongoing dialogue about and investigation of various potential forms of complicated grief.

INTRODUCTION

For many years, there have been calls for a diagnostic category in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* to reflect grief that signals departure from the normal course of accommodating loss and which warrants clinical attention (e.g., Horowitz, Siegel, Holen, Bonanno, Milbrath, & Stinson, 1997; Jacobs, 1999; Parkes, 2007; Prigerson & Jacobs, 2001; Prigerson & Maciejewski, 2006; Rando, 1993). We are pleased that this call has been answered and that it is likely that this omission will be addressed, in part, through some of the recommendations for modifications in the upcoming DSM-5.

The diagnostic term for complications that arise in the course of grieving has been variously defined over the past 20 years, with a multitude of adjectives used to describe variations from normal grief. These terms include absent, abnormal, complicated, distorted, morbid, maladaptive, atypical, intensified and prolonged, unresolved, neurotic, dysfunctional, chronic, delayed, and inhibited.

More recently, systematic attempts have been made to identify a form of grieving that meets the standards of scientific research required for inclusion in the DSM (e.g., Boelen & van den Bout, 2008; Prigerson, Vanderweker, & Maciejewski, 2008; Shear, Simon, Wall, Zisook, Neimeyer, Duan, et al., 2011). Foremost among these authors has been a group of researchers led by Holly Prigerson. This team has developed and made extensive use of a research questionnaire originally called the Inventory of Complicated Grief (ICG) (Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka, et al., 1995). Subsequent revisions include the ICG-R (Prigerson & Jacobs, 2001) and the current PG-13 (Prigerson, Horowitz, Jacobs, Parkes, Aslan, Goodkin, et al., 2009).

This tool (and its various iterations) has now been used very widely as a measure of persisting grief beyond the normal and many who have employed it have used the term "Complicated Grief" for the syndrome that has emerged from these studies. However, Prigerson's group has explicitly recognized that there are numerous forms of complicated grief, of which their syndrome is only one. To avoid confusion, they renamed their proposed syndrome "Prolonged Grief Disorder" (PGD) (Prigerson et al., 2008).

Having received evidence from many sources, the task force members who are planning the fifth edition of the DSM placed on the web a consultation document that includes, within the section headed "G 04 Adjustment Disorders" (American Psychiatric Association, 2012), a category named "Related to Bereavement."

This category falls short of being a precise diagnosis. They also included a modified version of Prigerson's PGD, which they term "Persistent Complex Bereavement-Related Disorder," and placed it in the DSM section for conditions requiring further research.

While we applaud these recommendations, we also wish to acknowledge that these efforts to identify forms of complicated grief should continue to go further. Moreover, they will merit additional attention as subsequent revisions of the DSM are considered. We address our concerns to all our colleagues in the field of grief counseling and grief-related research, as well as those colleagues actively involved in preparation of the DSM-5.

COMPLICATED GRIEF IS COMPLICATED

Our major concern is simply this: *Complicated grief is complicated and cannot be confined to one syndrome or disorder.* In other words, there is not just a single form of complicated grief, but rather many forms of it. No single form should be construed to contain the full range of complicated grief. Instead, we urge that a more comprehensive and robust perspective be maintained regarding this phenomenon and that future endeavors seek to identify other forms of complicated grief.

We call for continued research that would underlie the delineation of additional diagnostic categories with their distinct criteria. We again affirm support for the recognition that, in a certain percentage of cases, grief does not follow the normal course of accommodating loss and creates disorders meriting clinical scrutiny. We believe that the work of Prigerson et al. (2008) and the research underlying the category now termed "Prolonged Grief Disorder" meets the standard of scientific research rightly expected of the DSM. We urge its inclusion *as one of the syndromes of complicated forms of grief.* Other specific grief-related syndromes that we feel may warrant further research and consideration include, but are not limited to, delayed grief, inhibited grief, distorted grief, traumatic grief, and forms of chronic grief that may be differentiated from "Prolonged Grief Disorder." We acknowledge the fact that complications of grief, in addition to the syndromes delineated, can result in increased physical and mental morbidity and mortality.

This editorial represents the opinions of the authors, not the opinions of the Board or membership of the International Work Group on Death, Dying, and Bereavement (IWG). As a group, we represent clinicians, researchers, writers, and educators who come from diverse disciplines, including medicine, psychiatry, nursing, psychology, counseling, and sociology from five countries, and have over 200 years of collective experience focusing on issues related to loss and grief. Convening at the Meeting of the IWG outside of Melbourne, Australia in October 2011, this group decided to develop and issue *A Call to the Field*—

expressing our consensus about concerns related to the development of grief-related issues in the DSM-5 as well as subsequent revisions of the DSM.

To that end, we strongly call for consideration of the following clinical issues and we advocate for further research that will allow this critical dialogue to continue and influence subsequent revisions of the DSM.

CONTINUING THE DIALOGUE

We urge the DSM to broaden the understanding of grief. Grief may occur in non-death related losses and is not restricted to close relatives or friends. Rather, grief should be construed as deriving from separation from, or any significant change in relationship to, someone or something to whom an individual is meaningfully attached.

We request that the DSM be sensitive in its use of terminology—noting the varied meanings and usage of terms such as *mourning*, *grieving*, or *grief work*. For example, the term *mourning* has been used to both describe intrapsychic processes of accommodating the loss, as well as cultural ways of expressing grief. In addition, we are concerned that use of the wording “*may also. . .*” in any proposed criteria for the disorder might introduce a level of ambiguity to the diagnosis that would be unintended.

We recognize, moreover, that cultural and spiritual sensitivities are essential. Clinicians and researchers should assess the ways that cultural and spiritual/philosophical factors complicate and facilitate the grieving process.

We affirm that any diagnosis should be preceded by a full psychosocial assessment of the client. Recognition of multiple influences upon bereavement—pertaining to the mourner, the relationship lost, the circumstances of the loss, social variables, and physical factors—must be considered. Further, because loss can create an “emotional tsunami” in survivors, clinicians should explore, among other factors, the effects of a loss on self and self-identity of the survivors.

We caution that extrapolation to children and adolescents should not be undertaken without appropriate empirical and clinical support.

We are concerned that as of this writing there may no longer be formal recognition of bereavement in “Other Conditions That May Be a Focus of Clinical Attention” (formerly known as V codes). We feel that some recognition of grief and bereavement within such a category would be useful, as such a characterization acknowledges that between “normality” and “pathology” there is a “gray” area of symptoms and issues worthy of clinical attention.

These considerations are offered in a spirit of collegiality and deep respect for the past decade of research and review. We praise these efforts and acknowledge their importance even as we urge continued consideration for the need to explore the complex dimensions of loss and the many ways in which grief may be complicated.

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