Complicated Grief: An Evolving Theoretical Landscape

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Abstract

The bereavement literature has proliferated in recent decades, generating a shift from conceptualizing grief as a stepwise, uniform process to an idiosyncratic experience that varies between individuals. Among the most notable developments is the empirical exploration of complicated grief – a protracted, debilitating, sometimes life-threatening response to the death of a loved one – and the testing of novel interventions to treat it. This article provides counselors with recommendations for identifying and treating complicated grief.

Keywords: grief, complicated grief, grief counseling
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The loss of a loved one through death is a ubiquitous human experience that is associated with heightened psychological and physical distress on the part of the survivor (Shear et al., 2011; Stroebe, Schut, & Stroebe, 2007). For most individuals, grief symptoms attenuate naturally over a period of time (Shear et al., 2011); however, a subset of bereaved adults struggles to adapt to their loss, experiencing what is known as complicated grief (Prigerson et al., 2009; Shear et al., 2011). Complicated grief (CG), also known as prolonged grief disorder (Prigerson et al., 2009) or persistent complex bereavement disorder (American Psychiatric Association, 2013), is a protracted, debilitating, sometimes life-threatening grief response that is prevalent in approximately 10-15% of bereaved individuals (Shear et al., 2011), with recent studies reporting much higher rates (e.g., 31-70%; McDevitt-Murphy, Neimeyer, Burke, Williams, & Lawson, 2012; Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004; Momartin, Silove, Manicavasagar, & Steel, 2004; Shear, Jackson, Essock, Donahue, & Felton, 2006). In contrast to adaptive grief, CG is characterized by intensified grief symptoms that fail to diminish naturally within six months post-loss, resulting in clinically significant psychological and physical distress, as well as impairment in occupational and social functioning (Lannen, Wolfe, Prigerson, Onelov, & Kreicbergs, 2008; Shear et al., 2011). CG is associated with a number of deleterious psychological outcomes, such as suicidal ideation and behavior (Szanto et al., 2006), sleep disturbance (Maytal et al., 2007), disruption in daily activities (Monk, Houck, & Shear, 2006), and increased substance use (Prigerson et al., 2009). CG also may be linked to the development of other mental disorders (e.g., CG is associated with heightened panic and suicidality among individuals with bipolar disorder; Simon et al., 2005).

Although most bereaved individuals are able to adapt to loss without professional support, research suggests that treatment is indicated for individuals with CG (Currier,
Neimeyer, & Berman, 2008). However, with the exception of a brief review of contemporary bereavement research (Howarth, 2011), discussion of CG in the counseling literature is scarce, providing counselors with little guidance for distinguishing between common grief and CG. The purpose of this article is to provide counselors with an overview of CG for clinical utility in identifying and treating this serious, problematic grief response. Specifically, the current article presents an overview of CG and provides approaches for its assessment and treatment.

**Definitions and Key Terms**

Although often used interchangeably, bereavement, grief, and mourning are distinct constructs. *Bereavement* is the state of having lost a significant person through death (Shear, 2012). *Mourning* refers to the public expressions of grief, demonstrated through various rituals and customs that vary by society or cultural group (Stroebe, Hansson, Schut, & Stroebe, 2008). *Grief* is the complex psychological response to bereavement, comprising feelings, thoughts, and behaviors related to the loss (Shear, 2012). *Acute grief* is the distressing initial response to loss, during which the griever may experience shock, disbelief, anguish, sadness, fear, and separation distress, among other reactions (Simon, 2013; Zisook & Shear, 2009), the intensity and duration of which fall on a continuum that ranges from uncomplicated to complicated grief (Holland, Neimeyer, Boelen, & Prigerson, 2009; Horowitz et al., 1993). Although the Kübler-Ross (1969) stage theory has shaped popular thinking on grief, contemporary empirical research has generated an evolution of thought on grief from a linear, uniform process to an idiosyncratic experience that can vary considerably between individuals in terms of symptom type, intensity, and duration. Acute grief is not only a period of preoccupation with distressing thoughts and feelings associated with the loss, but also is a period in which the griever faces the reality of the loss and rebuilds his or her life (Stroebe & Schut, 1999). When acute grief pursues this adaptive process, it is followed by *integrated grief*, in which the griever begins to assimilate the death into
his or her life narrative, with restorative movement toward life without the deceased (Shear, 2012).

On the extreme end of the grief continuum is CG, in which the pathway to integrated grief is obstructed, resulting in profound and unremitting distress in relation to the loss (Shear, 2012; Simon, 2013). Although the bulk of the existing literature refers to this bereavement response as complicated grief (Shear et al., 2011), a number of other terms have been used to classify this condition, including prolonged grief, traumatic grief, and persistent complex bereavement disorder (American Psychiatric Association, 2013). For consistency with the majority of the extant literature, the present article will refer to this condition as CG.

**Common Grief and Complicated Grief**

The loss of a loved one can be a distressing life event. Although there is no single way to grieve that is “normal,” the majority of bereaved individuals respond to bereavement adaptively, with grief symptoms that may include, but are not limited to, sadness, shock, guilt, anxiety, and loneliness (Zisook et al., 2010). However, a small but notable subset of bereaved individuals experiences CG, a prolonged and psychologically immobilizing grief response. Fundamentally, CG is an event-related, relationship-based, maladaptive attachment condition with symptoms that are severe enough to cause long-term psychological disequilibrium and distress if left untreated (McDevitt-Murphy et al., 2012; Ott, Sanders, & Kelber, 2007). CG is characterized by a period of overwhelming grief that persists for at least six months following the death of the loved one and is marked by profound yearning and powerful longing to be reconnected with the deceased, intense separation distress, intrusive thoughts about the loved one, disturbing images of the deceased or of the death event, avoidance of reminders that the loved one has died, and proximity seeking to feel closer to the deceased (Shear et al., 2011). In addition, individuals with CG may experience a sense of meaninglessness about life, difficulty acknowledging the reality
of the loss, and an inability to move forward in creating a life without the deceased loved one (Holland et al., 2009). CG also is distinguished by confusion about one’s role in life, inability to trust others, numbness and shock, and bitterness or anger surrounding the loss (Lichtenthal, Cruess, & Prigerson, 2004; Prigerson et al., 1995; Prigerson et al., 1999). Most notably, this profoundly debilitating response to loss has potentially life-threatening consequences, such that individuals with CG have a statistically higher propensity toward suicidality (Latham & Prigerson, 2004), poor quality of life, impaired social functioning, and higher rates of cancer, heart disease, immune dysfunction, substance abuse, and sleep disturbances compared with those who experience a more adaptive grief response (Prigerson et al., 1997; Prigerson et al., 2009). In light of these troubling consequences, it is critical that counselors can distinguish between common grief reactions and CG.

**Complicated Grief Risk Factors**

Both predisposing characteristics of the bereaved person as well as circumstantial factors surrounding the death event and end-of-life care can put individuals at risk for CG (Burke & Neimeyer, 2012; Neimeyer & Burke, 2012). Burke and Neimeyer (2012) conducted an empirical review, examining 43 studies that explored antecedents and predictors of CG. Using stringent criteria, the authors created a systematic algorithm that identified confirmed risk factors of intense grieving, those that were potential risk factors in forecasting grief outcomes, and isolated other factors that consistently prove non-significant in a majority of studies and, hence, can be ruled out as factors affecting bereavement. Risk factors that emerged as most salient and, therefore, were considered “confirmed” based on their review of the literature included: (1) low levels of social support; (2) avoidant/anxious/insecure attachment style; (3) discovering the body (in cases of violent death) or dissatisfaction with death notification; (4) being a spouse or a parent of the deceased; (5) high levels of pre-death marital dependency; and (6) high levels of
Other studies highlight potential risk factors for CG. Such risk factors include gender, with women being at greater risk for separation distress than men (Keese, Currier, & Neimeyer, 2008; Lang & Gottlieb, 1993; Prigerson et al., 2002); kinship, with studies showing higher levels of grief and CG for immediate family members compared to distant kin (Laurie & Neimeyer, 2008) and for spouses and parents (Prigerson et al., 2002); and race and ethnicity, with some studies identifying ethnic minority groups as reporting higher levels of grief and CG compared to Caucasians (e.g., Laurie & Neimeyer, 2008; Neimeyer, Baldwin, & Gillies, 2006; Tarakeshwar, Hansen, Kochman, & Sikkema, 2005). Furthermore, some studies investigating attachment styles indicate that avoidant (van der Houwden et al., 2010), insecure (Brown, Neese, House, & Utz, 2009), or avoidant/anxious (Wijngaards-de Meij et al., 2007a; 2007b) attachment styles may predict CG, particularly in bereaved individuals who reported pre-loss spousal dependence (Bonanno et al., 2002). Awareness of factors that are prospectively linked to CG could help counselors remain alert to clients who may be at greater risk for complicated bereavement outcomes and anticipate when treatment is warranted (Currier et al., 2008).

**Assessment and Diagnosis of Complicated Grief**

CG stands apart as a serious psychiatric condition that mental health professionals struggle to distinguish and identify correctly (Shear, Frank, Houck & Reynolds, 2005). Although CG shares symptoms with other psychiatric disorders, such as “emotional numbing” that is present in posttraumatic stress disorder (PTSD), and “diminished sense of self” that is found in major depressive disorder (MDD), research demonstrates that CG has a distinctly adverse trajectory and consists of a specific cluster of symptoms (Horowitz et al., 1997; Kersting, Brähler, Glaesmer, & Wagner, 2011; Parkes, 2007; Prigerson et al., 1995; Prigerson et al., 1999; Prigerson & Maciejewski, 2006; Shear et al., 2011). Typically, a protracted and incapacitating
reaction to loss has been classified as MDD (Prigerson et al., 1999) or PTSD because of symptom overlap (Shear et al., 2006). While both MDD and PTSD have symptoms that overlap with CG, CG symptoms represent the cardinal features of the pathological grief experience, namely the intense feeling of emotional detachment and relational severance that comes from the death-related dissolution of a core attachment (Neimeyer, 2008; Prigerson et al., 1997). With CG, regardless of the quantity or quality of one’s social network, often the primary sense is that the individual is alone in life based on the death of a primary attachment figure (Stroebe, Stroebe, Abakoumkin, & Schut, 1996).

Although numerous evidence-based arguments have sought to substantiate CG’s inclusion as a distinct mental disorder (Dell'Osso et al., 2012; Prigerson et al., 2009; Shear et al., 2011), a lack of consensus remains regarding diagnostic criteria, the timeframe for making a diagnosis of CG, and the name for the condition (Carmassi et al., 2014). Thus, the work group for the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) designated the condition as persistent complex bereavement disorder (PCBD) in Section 3 of the DSM-5, along with other conditions requiring further study. Ongoing research is being conducted on the proposed criteria for this condition; however, Shear, Ghesquiere, and Glickman (2013) note that all proposed criteria include key features of prolonged acute grief (e.g., profound yearning for the deceased, overwhelming agony, avoidance of reminders of the loss, a sense of meaningless or purposelessness) and assert that a consensus on the criteria for prolonged acute grief likely will be reached soon. Until then, it may be advisable for counselors to continue conceptualizing and referring to this condition as CG over other terms, consistent with the majority of the existing empirical literature.

By assessing for CG using only psychiatric disorders that are presently listed in the DSM-5, CG sufferers may be overlooked or forced into an inappropriate diagnostic category. In the
absence of a distinct diagnostic category for CG, counselors may find it helpful to refer to clinical assessment tools for identifying clients with CG and their symptoms. A number of such tools exist, with examples included here. The *Inventory of Complicated Grief-Revised* (ICG-R; Prigerson et al., 1995) is a 19-item self-rated assessment that measures the severity of CG symptoms, with scores ranging from 25 to 30 indicating a clinically significant level of bereavement distress. Because the ICG-R (Prigerson et al., 1995) measures grief symptom severity, it may be a useful tool for counselors who are struggling to differentiate between common grief and CG. The *Brief Grief Questionnaire* (BGQ; Ito et al., 2012) is a 5-item instrument used to assess CG symptoms in clinical and research settings (Simon, 2013). Although Ito and colleagues (2012) recommend that the BGQ be further examined in a broader population, this instrument may be useful as an initial CG screener. The *Prolonged Grief Disorder Scale* (PG-13; Prigerson, Vanderwerker, & Maciejewski, 2008) is a 13-item diagnostic scale that has been used as both a self-report and a clinician-administered tool to evaluate CG, and has been modified for use with caregivers prior to the loss of their terminally ill loved one, and also with patients who have experienced traumatic brain injury to assess their own grief reactions. Because standard bereavement support may be insufficient treatment for CG (Shear et al., 2011), counselors are urged to assess bereaved clients for CG symptoms. Furthermore, counselor educators are encouraged to address CG symptomatology in psychopathology courses so that counselors-in-training will be aware of the distinctions between common grief and CG.

**Treatment Approaches for Complicated Grief**

Although most individuals are able to adapt to bereavement without professional support, treatment is indicated for individuals who experience CG symptomatology (Currier et al., 2008). Both self-report (Keesee et al., 2008) and neurophysiological (O’Connor et al., 2008) data indicate that time alone is not sufficient in diminishing CG symptomatology; however, once
identified, CG is responsive to appropriate treatment interventions (Wittouck, Van Autreve, De Jaegere, Portzky, & van Heeringen, 2011). The fictional case of Ms. A, shown below, illustrates key features of CG. Counselors working with bereaved clients are advised to remain alert to the grief reactions depicted here, particularly those that indicate lethality, such as purposelessness and suicidal ideation. CG treatment approaches are also discussed.

**The Case of Ms. A**

Ms. A is a 51-year-old paralegal who lost her father to lung cancer several years ago. Ms. A adored her father, a former Navy SEAL, who raised Ms. A and her sisters after the untimely death of their mother when Ms. A was fourteen years old. As her father’s health declined, Ms. A made a bedroom for him in her home and served as his primary caregiver during the final years of his life. Now, nearly three years after his death, she continues to feel profound agony and intense longing for her father. She often finds herself visiting the bedroom she made for him, lying on his bed and sobbing in anguish as she holds his picture close to her heart. Ms. A is troubled with painful memories of how her father looked during his final days and remains so preoccupied with thoughts of her father that she has found it nearly impossible to carry out her duties at work. Friends and close relatives have told her that it is time to “let go” of her father and accept that he is gone. However, Ms. A continues to yearn for him and is plagued by unfounded guilt for not doing more to help him while he was ill. Without her father to care for, Ms. A feels as though her life has little purpose and, at her lowest moments, she finds comfort in the thought of dying so that she may be reunited with her father.

**Complicated Grief Treatment**

Complicated Grief Treatment (CGT; Shear et al., 2005) was specifically designed to ameliorate the symptoms of CG. CGT addresses the inability to accept the loss through use of techniques similar to prolonged exposure, such as imaginal revisiting, in which the bereaved
verbally recounts the story of the death in an effort to face aspects of the event that prevent acceptance. Simultaneously, the counselor assists the client in recognizing the areas of avoidance that keep the individual from living fully in the present and making plans for the future. Another CGT technique is situational revisiting, in which the counselor challenges behaviors and cognitions that reinforce the bereaved individual’s avoidance of people, places, and situations that were once enjoyed but now trigger bereavement-related distress following the loss. The counselor may also utilize imaginal conversation, a figurative dialogue between the griever and the deceased loved one, for the purpose of addressing issues that trouble the bereaved individual, such as guilt or an ambivalent relationship with the deceased. For instance, Ms. A’s counselor might facilitate a conversation between her and her father so that she may address the regret she feels for not doing more to care for him during his illness. Using Ms. A’s own voice, “her father” can then respond in return with words of comfort and understanding that might serve to alleviate her guilt feelings. CGT also involves emotional memory work, in which the survivor attends to both positive and negative memories of the deceased loved one, as well as future planning, which involves revising life goals and engaging in meaningful relationships.

A key component of CGT is the use of a grief monitoring diary (Turret & Shear, 2012), in which clients make a daily rating of the intensity of their grief on a scale of 0-10, with 0 indicating an absence of grief symptoms and 10 indicating the highest intensity of grief. Clients also are instructed to record the moments of highest and lowest levels of grief each day. The counselor and client then discuss the diary in session, exploring the client’s various grief symptoms and processing the situations that were associated with a fluctuation in grief intensity. In a randomized, controlled trial of grievers (N = 95), CGT was found superior to interpersonal psychotherapy (an intervention that is used successfully for depression) in treating CG and was particularly effective for treating violently bereaved individuals (Shear et al., 2005).
Restorative Retelling

*Restorative Retelling* (RR; Rynearson & Geoffrey, 1999) is a time-limited group therapy designed to target symptoms of trauma and grief associated with intense violent dying imagery, which has been used to treat over 2,000 griever (Rynearson & Correa, 2008). RR is predicated on the theory that before dealing with separation distress, individuals who are highly traumatized by violent dying need to be stabilized. The intervention is comprised of two-hour sessions, spanning 10 weeks, focusing on strategies to restore resilience, exercises to retell and commemorate the living memory of the deceased and self, and exercises of exposure and retelling of the death story to help griever re-engage life beyond the stories of the violent dying (Rynearson, 2001). Rynearson (2001) conducted a 10-session open trial outcome study with 64 adults bereft by homicide, suicide, or fatal accident, all of whom received RR in a group setting. Rynearson’s (2001) pilot study demonstrated that participation in a RR intervention was associated with significant and fairly swift improvement on standardized measures of depression, death imagery, and trauma and grief symptomatology. Although RR is typically used following violent death loss, Ms. A’s counselor might utilize RR exercises to retell and commemorate the living memory of Ms. A’s father.

Cognitive Behavioral Therapy for Complicated Grief

Cognitive behavioral therapy (CBT) for CG (Boelen, van den Hout, & van den Bout, 2006) posits that griever must assimilate the loss into their existing personal narrative, modify deleterious thinking patterns, and replace unhelpful avoidance behaviors with adaptive coping strategies. Similar to CGT, a primary tool of CBT for CG is *exposure*, in which clients confront the most challenging and painful aspects of their bereavement by verbally recounting or writing about the loss. Clients are also encouraged to refrain from engaging in compulsive behaviors (e.g., habitually visiting places that remind the survivor of his or her deceased loved one).
CBT for CG also involves cognitive restructuring, in which the griever identifies deleterious cognitions and replaces them with more constructive ones (Boelen et al., 2006). For example, a counselor might challenge Ms. A’s unfounded notion that she did not do enough to care for her father by asking her, “What evidence do you have to support your belief that you did not provide good care for your father?” or, “In what ways were you a good caregiver?” Such exposure and cognitive restructuring techniques facilitate tolerance to grief distress and demonstrate to clients that experiencing loss-related distress ultimately tempers their sorrow rather than intensifying it (Neimeyer & Burke, 2012). Furthermore, behavioral activation can help clients address grief-related avoidance that may be hindering them from engaging in enjoyable and adaptive activities (Neimeyer & Burke, 2012). CBT has been found to be more effective than supportive counseling in treating CG (Boelen, de Keijser, van den Hout, & van den Bout, 2007).

**Meaning Reconstruction Approaches for Complicated Grief**

Grounded in constructivist theory, meaning reconstruction posits that cultural influences and past personal experiences shape belief systems that inform how individuals respond to significant life events. However, the loss of a loved one can challenge these belief systems, sometimes causing individuals to question their fundamental worldviews and self-narratives (Neimeyer, 2000). From this perspective, grief involves attempts to reaffirm or rebuild worldviews that have been challenged by bereavement, often provoking a search for meaning in the griever’s effort to make sense of the loss and a life without their loved one. Meaning reconstruction approaches to grief counseling may be especially appropriate for targeting the sense of meaninglessness that many mourners with CG have following the loss, which is a key feature of CG (Prigerson et al., 2009).

Meaning reconstruction approaches to grief counseling involve helping the griever to
process the event story of the death and to rebuild a secure attachment with the deceased by addressing the back story of their relationship (Neimeyer, 2011). Rather than relinquishing the relationship with the deceased, meaning reconstruction concentrates on assisting the client in renegotiating a modified relationship with the deceased that can serve as an enduring resource for the bereaved (Neimeyer, 2012; Neimeyer & Sands, 2011). Whereas Ms. A’s family and friends urged her to “let go” of her father’s memory, a counselor using meaning reconstruction might utilize a number of experiential techniques to assist Ms. A in reconstructing a continuing bond with her father. For instance, Ms. A’s counselor may utilize chair work (Neimeyer, 2012), inviting Ms. A to imagine that her father is in her presence and positioned near her in another chair. The counselor would then facilitate an imaginal dialogue between Ms. A and her father, with Ms. A speaking on behalf of both herself and her father. Ms. A might also engage in a symbolic exchange of written correspondence with her father, writing some of her heretofore unspoken thoughts and emotions in a letter to her father. Furthermore, a key component of meaning reconstruction is the use of creative writing to assist the client in making sense of the event story of the death and to facilitate an ongoing relationship with the deceased (Neimeyer & Burke, 2012). (See also Neimeyer, 2012; 2015a; 2015b, for brief descriptions of additional grief therapy techniques, many of which are suitable for treating CG.)

**Conclusion**

Grief is a common presenting issue for psychotherapy clients, and also one that often surfaces in tandem with other co-morbidities or life struggles. It is predicted that the demand for grief counseling will increase in coming decades as baby boomers encounter successive losses (Maples & Abney, 2006). Therefore, helping clients with end-of-life and bereavement issues is a critical skill for mental health counselors to have (Ober, Granello, & Wheaton, 2012), as well as an ethical mandate they are expected to uphold (American Counseling Association, 2014).
However, there remains a need for counseling literature to reflect current developments in grief research and treatment and to address the implications of CG for practitioners and counselor educators. In Ober and colleagues’ (2012) survey on grief counseling competence of licensed professional counselors ($N = 369$) over half of respondents (54.8%, $n = 190$) reported that they had not completed any coursework specific to grief and loss. Furthermore, in the same study, respondents reported lack of familiarity with current, empirically supported theories of grief counseling, identifying the Kübler-Ross (1969) stage theory of grief as the model with which they were most familiar (Ober et al., 2012). These findings underscore the need for literature and training that reflects current developments in grief research and addresses implications for counselors and counselor educators.

Most bereaved individuals are able to adjust to the death of their loved one without professional support; however, individuals with CG face considerable challenges in adapting to loss. Although there remains disagreement about terminology and diagnostic criteria, mounting evidence supports the existence of a protracted and debilitating acute grief response, most commonly referred to in the empirical literature as CG. CG is marked by chronic, profound, and debilitating grief that is associated with poor quality of life, impairment in social, occupational, and family functioning, suicidality, and a number of other troubling outcomes. Once identified, however, CG symptoms often are amenable to treatment. Thus, it is recommended that counselors be trained to distinguish between common grief and CG so that they can provide appropriate treatment for their bereaved clients. Given the prevalence of grief and the potentially dire consequences of CG, counselor educators should alert trainees to the symptoms of CG and introduce them to appropriate screening and assessment instruments. This article suggests several evidence-based interventions for facilitating adaptation to loss that offer counselors substantial hope for mitigating the sorrow and anguish experienced by individuals with CG.
References


Prigerson, H. G., Shear, M. K., Jacobs, S. C., Reynolds, C., Maciejewski, P. K., Davidson, J. R., 

prolonged grief disorder in *DSM-V*. In M. Stroebe, R. Hansson, H. Schut, & W. Stroebe 
(Eds.), *Handbook of bereavement research and practice: Advances in theory and 

Prigerson, H., Ahmed, I., Silverman, G. K., Saxena, A. K., MacIejewski, P. K., Jacobs, S. C., ... 
& Hamirani, M. (2002). Rates and risks of complicated grief among psychiatric clinic 
patients in Karachi, Pakistan. *Death Studies, 26*(10), 781-792. 
doi:10.1080/07481180290106571

retelling and support*. Seattle: Virginia Mason Medical Center.

treatment. In Charles R. Figley (Ed.), *Traumatology of grieving*, (pp.109- 


10.1002/da.21963

Shear, M. K., Frank, E., Houck, P. R., & Reynolds, C. F. (2005). Treatment of complicated grief: 
A randomized controlled trial. *Journal of the American Medical Association, 293*, 2601-


