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Grief and bereavement in adults: Clinical features

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INTRODUCTION — Grief is the response to bereavement, which is the situation in which a loved one has died [[1](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/1)]. Natural acute grief reactions are often painful and impairing with emotional and somatic distress, but should not be diagnosed as a mental disorder. However, bereavement is a stressor that can precipitate or worsen mental disorders (eg, unipolar major depression). In addition, complications (maladaptive thoughts, feelings, or behaviors) may occur, such that acute grief becomes intense, prolonged, and debilitating. This condition is called complicated grief, which is viewed as a unique and recognizable disorder that requires specific treatment.

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

●(See ["Grief and bereavement in adults: Management"](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-management?topicRef=14684&source=see_link).)

●(See ["Complicated grief in adults: Epidemiology, clinical features, assessment, and diagnosis"](https://www.uptodate.com/contents/complicated-grief-in-adults-epidemiology-clinical-features-assessment-and-diagnosis?topicRef=14684&source=see_link).)

●(See ["Complicated grief in adults: Treatment"](https://www.uptodate.com/contents/complicated-grief-in-adults-treatment?topicRef=14684&source=see_link).)

●(See ["Palliative care: The last hours and days of life"](https://www.uptodate.com/contents/palliative-care-the-last-hours-and-days-of-life?topicRef=14684&source=see_link).)

●(See ["Benefits, services, and models of subspecialty palliative care"](https://www.uptodate.com/contents/benefits-services-and-models-of-subspecialty-palliative-care?topicRef=14684&source=see_link).)

●(See ["Hospice: Philosophy of care and appropriate utilization in the United States"](https://www.uptodate.com/contents/hospice-philosophy-of-care-and-appropriate-utilization-in-the-united-states?topicRef=14684&source=see_link).)

TERMINOLOGY — The terms bereavement, grief (acute and integrated), complicated grief, and mourning describe different aspects of experiencing the death of a loved one [[1-4](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/1-4)]:

●Bereavement – The situation in which someone who is close dies (rather than the reaction to that loss). (See ['Bereavement'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H11410500) below.)

●Grief – Grief is the natural response (including thoughts, feelings, behaviors, and physiologic reactions) to bereavement. Although grief can occur in response to other meaningful (non-bereavement) losses, this topic focuses primarily upon grief in response to the death of a loved one.

The pattern and intensity of grief varies over time as bereaved individuals adapt to the loss. The experience of grief is influenced by 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 eventually integrated. Progress from acute to integrated grief is often erratic and hard to discern as it is happening. (See ['Typical acute grief'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H8568685) below.)

●Complicated grief – Complicated grief is a form of acute grief that is unusually prolonged, intense, and disabling; troubling thoughts, dysfunctional behaviors, dysregulated emotions, and/or serious psychosocial problems impede adaptation to the loss. The syndrome of complicated grief is a unique and recognizable condition that can be differentiated from other mental disorders. Other terms that have been used to describe complicated grief include chronic grief, complex grief, pathological grief, persistent complex bereavement disorder, prolonged grief disorder, traumatic grief, and unresolved grief. (See ["Complicated grief in adults: Epidemiology, clinical features, assessment, and diagnosis"](https://www.uptodate.com/contents/complicated-grief-in-adults-epidemiology-clinical-features-assessment-and-diagnosis?topicRef=14684&source=see_link).)

●Mourning – Mourning is the process of adapting to a loss and integrating grief. Adaptation entails accepting the finality and consequences of the loss, revising the internalized relationship with deceased, and re-envisioning the future such that there is a possibility for happiness 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 and in the background. Like grief, mourning is influenced by cultural and religious rituals that vary widely.

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 in order to restore a meaningful and satisfying life; sometimes there are new responsibilities and roles. Close attachments may possibly be internalized in specific neural networks, and the effects of bereavement may be mediated by changes in these networks [[5](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/5)]. In addition, the stress of bereavement can precipitate or worsen general medical or psychiatric disorders.

Each person who dies leaves behind a variable number of bereaved relatives and friends. 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” [[6](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/6)]. There is no standard definition of bereavement that identifies who should be considered bereaved. However, close relatives and friends are most affected by a person’s death. Usually there are one to five people in the closest group who are most likely to be deeply affected by the person’s death and are most vulnerable to problems with adapting to the loss.

The great majority of deaths occur as a natural consequence of aging-related illness and most bereaved people adapt to loss with support from family and friends, moving from acute to integrated grief. However, circumstances or consequences of a death can slow or even halt this transformation. As an example, the death of a life partner or a child, death of a young person, or death by a violent means can increase the likelihood of unusually prolonged and intense acute grief. (See ['Type of loss'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H11407423) below.)

Bereavement differs from other adverse life events in that a period of intense emotional pain and disruption of daily life activities is expected and socially sanctioned. Although social expectations and ritualizing vary widely across cultures, there is usually an expectation that a person will adapt to loss with appropriate support from family and friends [[7](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/7)].

Frequency — A nationally representative survey in Germany found that the lifetime prevalence of bereavement (loss of a significant person) was 57 percent [[8](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/8)]. The average time since the death was 10 years (range 0 to 71 years).

Death rates — The crude annual death rate (number of deaths per 1000 people per year) in the world is 8, meaning that approximately 107 people worldwide die per minute [[9](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/9)]. Reported annual death rates in different countries are as follows:

●Afghanistan – 14

●Australia – 7

●Brazil – 7

●Canada – 8

●China – 7

●Germany – 11

●India – 7

●Israel – 6

●Japan – 9

●Lesotho – 15

●Mexico – 5

●Romania – 12

●Russia – 14

●Qatar – 2

●Saudi Arabia – 3

●Singapore – 3

●South Africa – 17

●Sweden – 9

●Ukraine – 16

●United Kingdom – 9

●United States – 8

In 2010, worldwide deaths amounted to approximately 53 million [[10](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/10)]. The leading causes of death were ischemic heart disease, stroke, chronic obstructive pulmonary disease, lower respiratory infections, lung cancer, and HIV infection. In the United States, more than 2.5 million people died in 2011, nearly 75 percent of whom were 65 years of age or older [[11](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/11)].

Loss of attachment — According to attachment theory, humans are biologically motivated throughout life to form secure close relationships with a few other people [[12-16](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/12-16)]. These are the people whom a person loves and who reciprocate love. People generally want to be with those they love and enjoy the time spent together. 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. Close adult relationships are reciprocal so that each person provides and receives this support. Representations of attachment relationships are contained in a person’s memory. These mental representations influence many aspects of daily functioning in ways that are both in and out of awareness. Loved ones contribute to one’s sense of belonging and sense of identity.

Bereavement creates a state of acute attachment insecurity, which typically 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 [[13](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/13)]. 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.

Memories about attachment relationships tend to be stable and change slowly with some resistance [[17-21](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/17-21)]. When a loved one dies, internalized representations of them require major revisions. Such revision is a learning process by which information is assimilated about the finality of the loss and its meaning. This process takes time. During the learning period when the internal representations of the deceased are out of alignment with the reality of the loss, acute grief symptoms occur, such as yearning and emotional pain, which is 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. Eventually as the finality and consequences of the loss are fully acknowledged, the mental representation of the attachment relationship is revised, and one’s goals and plans are redefined. There is still an internalized connection to the deceased, but the nature of the connection changes [[13](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/13)].

Caregiving is part of adult love relationships and it too is affected by bereavement [[22-28](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/22-28)]. Just as individuals are biologically motivated to seek comfort under stress, they are also motivated to care for others. In the case of 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 [[25,28](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/25%2C28)]. The death of a loved one is often experienced as a failure of caregiving that manifests with self-blame, guilt, or shame. Mourners may rebuke themselves for inadequately caring for their loved one, being unable to prevent the death, and/or failing to make the death easier. Caregiver self-blame, irrational though it might be, is a common response to bereavement and contributes to dysphoria during acute grief.

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) [[4,29](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/4%2C29)]. In a community sample (n = 120 bereaved individuals), 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 [[30](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/30)]. Other circumstances that can influence the nature of acute grief include the age of the deceased, sudden losses, chronic illnesses, and terminal illnesses.

Type of lost relationship — Loss of a child typically triggers an especially strong sense of caregiver failure. Parents often blame themselves for failure to protect the child, however irrational this may be [[31-33](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/31-33)]. In addition, parents may feel that they have lost their own future by losing their child, and may struggle with survivor guilt that leads them to feel that they should not enjoy their own lives. On average, acute grief for parents is more intense and lasting than other types of loss, and the stress of losing a child is more likely to trigger mental illnesses that require treatment [[34](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/34)]. As an example, a national registry study (n >1,000,000 parents, including n >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 [[35](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/35)]. The risk of hospitalization was highest in the first year after the death of a child, but remained elevated for at least five years after the death.

The persistence of acute grief following the loss of a child may vary internationally, depending upon cultural factors. 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 [[36](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/36)]. 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 very difficult, especially when the relationship was positive and rewarding [[37-40](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/37-40)]. In addition to intense yearning and longing, bereaved spouses may feel guilt about letting their partner down or a sense of failure as a caregiver. They may experience survivor guilt and feel anxious or angry about the loss of the support and comfort of their loved one.

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, violence, or accident is likely to produce intense acute grief. The acutely bereaved person may feel as though they are on autopilot, going through the motions of their lives 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 why they did not cry or experience intense sadness. Although most people bereaved by a sudden loss are resilient, the rates of complicated grief are higher following violent loss. (See ["Complicated grief in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Risk factors'](https://www.uptodate.com/contents/complicated-grief-in-adults-epidemiology-clinical-features-assessment-and-diagnosis?sectionName=Risk+factors&topicRef=14684&anchor=H4668481&source=see_link#H4668481).)

Homicide and suicide can trigger guilt or anger about the death that must be resolved for adaptation to occur. Death of a loved one by homicide or suicide is associated with an increased risk of complicated grief as well as other mental disorders, including depression, posttraumatic stress disorder (PTSD), and substance use disorders [[41](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/41)]. As an example, a study examined parents (n >1400) whose child died by suicide and found that after adjusting for several potential confounds (eg, preexisting mental 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 non-bereaved, matched parents [[42](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/42)]. Death of a loved one by suicide may also be associated with an increased risk of suicide in the bereaved (see ['Suicidality'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H87788111) below). The risk of psychopathology following homicide and suicide seems to remain elevated over many (eg, 8 to 10) years [[41,43](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/41%2C43)].

Additional information about bereavement and mental disorders is discussed elsewhere in this topic. (See ['Associated psychopathology'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H248623) below.)

Chronic illness — When patients 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'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H8569275) 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 post-death [[44](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/44)], and complicated grief occurred in 20 percent over 18 months of follow-up [[45](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/45)]. (See ['Associated psychopathology'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H248623) 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 caregiver bereavement [[46-49](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/46-49)]. 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'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H8569275) 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 complicated grief occurred in 25 percent [[50](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/50)]. (See ["Complicated grief in adults: Epidemiology, clinical features, assessment, and diagnosis"](https://www.uptodate.com/contents/complicated-grief-in-adults-epidemiology-clinical-features-assessment-and-diagnosis?topicRef=14684&source=see_link).)

Hospice use can be beneficial:

●Use of hospice by older adult patients may be associated with decreased bereavement-related mortality among surviving spouses [[51](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/51)].

●Caregivers of spouses with longer hospice enrollment (≥4 days) may have a lower incidence of unipolar major depression [[52,53](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/52%2C53)].

(See ["Hospice: Philosophy of care and appropriate utilization in the United States"](https://www.uptodate.com/contents/hospice-philosophy-of-care-and-appropriate-utilization-in-the-united-states?topicRef=14684&source=see_link).)

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 [[54](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/54)]. 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 [[37](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/37)]. When clinicians are insensitive or avoid their dying patients, caregivers may be at risk for complicated grief and other mental health problems [[55](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/55)]. (See ['Associated psychopathology'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H248623) below.)

The American Hospice Foundation has produced a monograph for caregivers called [The Dying Process: A Guide for Caregivers](https://www.uptodate.com/external-redirect.do?target_url=http%3A%2F%2Fwww.optionsforeldercare.com%2Feldercarebooksandarticles%2Fhospice_end_of_life_manual.pdf&token=6W2ONH2GMrndYOGkoCdiDdGv4YpviH7%2BPFinOV4VuhTH%2BxVZPcACy04y6bxuOqeKKrb8sZOp34KRQIqpPiutowp6yvyVr1ySHLdRC4h3EWavALUkLBSw0hah5bEtTSir&TOPIC_ID=14684), 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"](https://www.uptodate.com/contents/the-initial-interview-in-palliative-care-consultation?topicRef=14684&source=see_link) and ["Benefits, services, and models of subspecialty palliative care"](https://www.uptodate.com/contents/benefits-services-and-models-of-subspecialty-palliative-care?topicRef=14684&source=see_link) and ["Palliative care: The last hours and days of life"](https://www.uptodate.com/contents/palliative-care-the-last-hours-and-days-of-life?topicRef=14684&source=see_link) and ["Communication of prognosis in palliative care"](https://www.uptodate.com/contents/communication-of-prognosis-in-palliative-care?topicRef=14684&source=see_link).)

Adverse general medical outcomes — Bereaved individuals are at increased risk of adverse general medical outcomes. Much of this increased risk may be due to complicated grief. (See ["Complicated grief in adults: Epidemiology, clinical features, assessment, and diagnosis"](https://www.uptodate.com/contents/complicated-grief-in-adults-epidemiology-clinical-features-assessment-and-diagnosis?topicRef=14684&source=see_link).)

Mortality — Bereavement is associated with an increased risk of mortality, after controlling for chronic medical conditions and access to resources, as well as age, sex, and smoking status [[56](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/56)]. Losing a spouse, child, or sibling are each associated with an increased risk of dying [[57](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/57)]. However, the absolute number of bereaved people who die is relatively low [[4](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/4)].

Studies of conjugal bereavement and increased mortality have found the following results [[4](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/4)]:

●A meta-analysis of 14 observational studies found that the risk of death was 11 percent greater in widowed individuals compared with married individuals, and that the risk for widows and widowers was the same; heterogeneity across studies was moderate to large [[58](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/58)]

●A prospective Dutch study of a nationally representative sample of older, married individuals (n = 3107) found that conjugal bereavement resulted in an average loss of residual life expectancy of 12 percent, and this effect persisted for over two years [[59](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/59)]

The greatest cause of bereavement-related deaths is cardiovascular diseases and cancer [[60,61](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/60%2C61)]. In addition, alcohol-related deaths and suicide are each about twice as likely to occur in the bereaved, compared with people who are not bereaved. Mortality is greater when one loses a spouse unexpectedly, compared with losing a spouse with known morbidity [[62](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/62)].

Among parents who lose a child, their increased risk of mortality may 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 [[63](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/63)].

Morbidity — Bereavement is associated with increased rates of somatic symptoms (eg, chest pain, dizziness, gastrointestinal distress, and headaches), especially during the first several (eg, six) months after the loss [[4,59,64](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/4%2C59%2C64)]. In addition, the loss of a loved one may lead to disability [[65](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/65)], as well as deterioration of health behaviors, including worsened nutrition, increased alcohol consumption, poor sleep quality, and involuntary weight loss [[40,66](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/40%2C66)].

Bereavement is also associated with an increased risk of general medical illnesses [[4,59,64](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/4%2C59%2C64)], including stress-induced cardiomyopathy. (See ["Clinical manifestations and diagnosis of stress (takotsubo) cardiomyopathy"](https://www.uptodate.com/contents/clinical-manifestations-and-diagnosis-of-stress-takotsubo-cardiomyopathy?topicRef=14684&source=see_link).)

The risk of acute myocardial infarction is increased soon after bereavement [[67](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/67)]. As an example, 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 [[68](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/68)]. The risk was still elevated 7 to 30 days after the loss (incidence rate ratio 4). The absolute risk was such that one extra myocardial infarction would occur within seven days of bereavement for every 1394 bereaved individuals who had a low baseline risk of myocardial infarction, and one extra myocardial infarction for every 320 bereaved individuals who had a high baseline risk. The increased risk of myocardial infarction may be related in part to the association of early bereavement (eg, first few weeks) with increased heart rate and systolic blood pressure [[69,70](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/69%2C70)] and increased cortisol [[71-73](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/71-73)]. Cardiovascular disease accounts for much of the increased mortality that is observed among the bereaved. (See ['Mortality'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H910944) above.)

Bereavement is also associated with a small risk of stillbirth. A national registry study (n >2,900,000 live births and >11,000 stillbirths) found that loss of a parent, sibling, or older child was associated with an increased risk of stillbirth (hazard ratio 1.2) [[74-76](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/74-76)].

Associated psychopathology — Losing a spouse or child is associated with a small to moderate increased risk of psychopathology [[4,35,38,77](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/4%2C35%2C38%2C77)]. Although most people adjust to the loss of a loved one, bereavement can precipitate or worsen one or more mental disorders such as:

●Complicated grief

●Unipolar or bipolar major depression

●Anxiety disorders

●PTSD

●Substance use disorders

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 [[78](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/78)]. 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 [[77](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/77)].

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 mental disorders in bereaved patients is comparable to that in the non-bereaved [[79](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/79)].

Diagnosing mental 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 [[80,81](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/80%2C81)]; however, understanding the clinical picture of acute grief and diagnostic criteria for mental disorders can help clinicians with the differential diagnosis (see ['Differential diagnosis'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H4908986) below) and reduce the risk of overdiagnosing mental disorders. A systematic review found that clinicians are aware of the challenges, and work to avoid “pathologizing” normal grief [[82](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/82)].

Complicated grief — Bereavement can lead to complicated grief, which is distinguished from typical acute grief. Whereas acute grief is a natural reaction to the loss of a loved one, complicated grief is a disabling condition in which maladaptive thoughts, feelings, and behaviors interrupt the natural adaptive process and acute grief symptoms are intensified and prolonged [[83](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/83)]. The epidemiology, clinical features, assessment, diagnosis, and treatment of complicated grief are discussed separately. (See ["Complicated grief in adults: Epidemiology, clinical features, assessment, and diagnosis"](https://www.uptodate.com/contents/complicated-grief-in-adults-epidemiology-clinical-features-assessment-and-diagnosis?topicRef=14684&source=see_link) and ["Complicated grief in adults: Treatment"](https://www.uptodate.com/contents/complicated-grief-in-adults-treatment?topicRef=14684&source=see_link).)

Major depression — Although diagnosing major depression in the context of bereavement is controversial [[80,84](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/80%2C84)], bereavement does not preclude the diagnosis, according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) ([table 1](https://www.uptodate.com/contents/image?imageKey=PSYCH%2F89994&topicKey=PSYCH%2F14684&source=see_link)) [[83](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/83)], as well as the World Health Organization's International Classification of Diseases-10th Revision (ICD-10) [[85](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/85)]. Rather, bereavement is regarded as a stressor that can trigger a depressive episode. This represents a change from the previous edition of the Diagnostic and Statistical Manual (Fourth Edition, Text Revision; DSM-IV-TR), which did not permit clinicians to diagnose major depression within two months of bereavement (commonly referred to as the “bereavement exclusion”) [[86](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/86)].

The rationale for diagnosing major depression in bereaved individuals is based upon the best available evidence, which indicates that bereavement-related major depression and major depression not related to bereavement are comparable 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 [[3,79,87-92](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/3%2C79%2C87-92)]. Other studies indicate that bereavement-related depression and depression related to other stressors (eg, divorce, impoverishment, or disability) are comparable [[93](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/93)]. 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 [[94,95](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/94%2C95)], the preponderance of the evidence indicates otherwise [[84,90](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/84%2C90)].

Most bereaved people do not endorse symptoms sufficient to diagnose major depression; the estimated prevalence of major depression among the bereaved varies from 10 to 30 percent [[4,34,83,96-98](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/4%2C34%2C83%2C96-98)]:

●In a systematic review that identified eight studies of bereaved spouses (n = 1051), the prevalence of major depression in the first 12 months of bereavement was 22 percent, and major depression was 4 to 10 times more likely to occur in widowed individuals than non-widowed controls [[38](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/38)].

●A study examined parents (n >1200) who lost a child and found that after adjusting for several potential confounds (eg, preexisting mental 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 non-bereaved, matched parents [[34](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/34)].

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 [[77](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/77)].

The clinical features, diagnosis, and treatment of unipolar major depression are discussed separately. (See ["Unipolar depression in adults: Clinical features"](https://www.uptodate.com/contents/unipolar-depression-in-adults-clinical-features?topicRef=14684&source=see_link) and ["Unipolar depression in adults: Assessment and diagnosis"](https://www.uptodate.com/contents/unipolar-depression-in-adults-assessment-and-diagnosis?topicRef=14684&source=see_link) and ["Unipolar major depression in adults: Choosing initial treatment"](https://www.uptodate.com/contents/unipolar-major-depression-in-adults-choosing-initial-treatment?topicRef=14684&source=see_link).)

Anxiety disorders — The bereaved are at increased risk of anxiety disorders; the estimated prevalence of anxiety disorders among the bereaved varies from 10 to 30 percent:

●A study found that the prevalence of anxiety disorders in bereaved parents (n >1200) who lost a child was 22 percent, which was 70 percent greater than what was found in non-bereaved, matched parents, after adjusting for several potential confounds [[34](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/34)].

●A study of 102 bereaved spouses found that the prevalence of [[38](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/38)]:

•Generalized anxiety disorder was 31 percent

•Panic disorder was 10 percent

Each of these prevalence rates exceeded the prevalence rate in a separate community sample of non-widowed controls.

A community survey found that at nearly every age across the lifespan, unexpected bereavement is associated with an increased risk of suffering panic disorder [[77](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/77)].

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

Posttraumatic stress disorder — Bereavement can trigger the onset of PTSD [[97,99-102](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/97%2C99-102)], and PTSD may occur more often in response to bereavement than other traumas and stressors.

The prevalence of PTSD among the bereaved is approximately 10 percent, but varies depending upon the type of loss and nature of the death; the prevalence of PTSD is higher following violent deaths (eg, homicide, suicide, or accident), compared with natural causes (eg, cardiac disease and cancer). A community-based sample of bereaved individuals (n = 309) found that PTSD was present in 7 percent [[96](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/96)], and in a systematic review (n = 5 studies with 772 bereaved spouses), the prevalence of PTSD was 12 percent [[38](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/38)].

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 [[77](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/77)].

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) [[103](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/103)]. 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 manifestations, course, assessment, and diagnosis"](https://www.uptodate.com/contents/posttraumatic-stress-disorder-in-adults-epidemiology-pathophysiology-clinical-manifestations-course-assessment-and-diagnosis?topicRef=14684&source=see_link) and ["Psychotherapy for posttraumatic stress disorder in adults"](https://www.uptodate.com/contents/psychotherapy-for-posttraumatic-stress-disorder-in-adults?topicRef=14684&source=see_link) and ["Pharmacotherapy for posttraumatic stress disorder in adults"](https://www.uptodate.com/contents/pharmacotherapy-for-posttraumatic-stress-disorder-in-adults?topicRef=14684&source=see_link).)

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

●Eating disorders [[104-107](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/104-107)]

●Mania [[77](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/77)]

●Psychotic disorders [[35](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/35)]

●Sleep disorders [[37,66,108](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/37%2C66%2C108)]

●Somatoform disorders [[109,110](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/109%2C110)]

●Substance use disorders [[35,111](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/35%2C111)]

For mania, psychotic disorders, sleep disorders, and substance use disorders, the prevalence was greater in bereaved individuals than controls.

Additional 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"](https://www.uptodate.com/contents/eating-disorders-overview-of-epidemiology-clinical-features-and-diagnosis?topicRef=14684&source=see_link) and ["Evaluation and diagnosis of insomnia in adults"](https://www.uptodate.com/contents/evaluation-and-diagnosis-of-insomnia-in-adults?topicRef=14684&source=see_link) and ["Clinical manifestations, differential diagnosis, and initial management of psychosis in adults"](https://www.uptodate.com/contents/clinical-manifestations-differential-diagnosis-and-initial-management-of-psychosis-in-adults?topicRef=14684&source=see_link) and ["Somatic symptom disorder: Epidemiology and clinical presentation"](https://www.uptodate.com/contents/somatic-symptom-disorder-epidemiology-and-clinical-presentation?topicRef=14684&source=see_link) and ["Somatic symptom disorder: Assessment and diagnosis"](https://www.uptodate.com/contents/somatic-symptom-disorder-assessment-and-diagnosis?topicRef=14684&source=see_link) and ["Clinical assessment of substance use disorders"](https://www.uptodate.com/contents/clinical-assessment-of-substance-use-disorders?topicRef=14684&source=see_link).)

Suicidality — Bereavement is associated with suicidal ideation and behavior. However, the risk of suicidality may in part be accounted for by complicated grief. (See ["Complicated grief in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Suicidality'](https://www.uptodate.com/contents/complicated-grief-in-adults-epidemiology-clinical-features-assessment-and-diagnosis?sectionName=Suicidality&topicRef=14684&anchor=H15816177&source=see_link#H15816177).)

Several studies have found that bereavement is associated with suicidal ideation and behavior that is independent of psychopathology such as major depression or PTSD [[7,96,112-114](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/7%2C96%2C112-114)]. 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 [[115](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/115)]. The risk of suicide was approximately three times greater among bereaved males than females.

The risk of suicidal ideation and behavior among the bereaved is increased by factors that include [[96](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/96)]:

●Prior psychiatric history

●Current psychopathology (complicated grief, PTSD, or unipolar major depression)

●Less social support

●Female sex

●Non-Caucasian race

●Death of a loved one by suicide

Losing a loved one through suicide appears to increase the risk of suicide in the bereaved. A national registry study found that the risk of suicide was 22 times greater among individuals whose spouse committed suicide in the prior two years, compared with individuals whose spouse was alive [[115](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/115)]. The dataset did not indicate whether complicated grief was present in the individuals whose spouse committed suicide, and complicated grief may have accounted for the increased risk of suicide in the surviving spouses.

General information about suicide is discussed separately. (See ["Suicidal ideation and behavior in adults"](https://www.uptodate.com/contents/suicidal-ideation-and-behavior-in-adults?topicRef=14684&source=see_link).)

TYPICAL ACUTE GRIEF — The hallmark of acute grief is the 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 (non-bereavement) losses, including an interpersonal loss (eg, separation from a loved one through divorce) or loss of a pet, job, property, or community. In a study of survivors of a natural disaster who showed signs of unusually prolonged, intense, and disabling grief (ie, complicated grief), the large majority of survivors suffered non-bereavement losses [[116](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/116)].

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 [[3,117](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/3%2C117)]. These positive experiences during bereavement reflect resilience and foretell better outcomes [[13,118](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/13%2C118)].

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 [[3,4,14](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/3%2C4%2C14)]. 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'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H11407423) above), and the experience of prior losses [[4](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/4)].

The symptoms of acute grief are typically related to either separation from the deceased or to stress and trauma [[1,3,4,119-122](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/1%2C3%2C4%2C119-122)]:

●Symptoms of separation distress

•Yearning for and seeking proximity to the deceased

•Loneliness

•Crying, sadness, and other painful emotions (eg, anger, guilt, and anxiety) that occur upon confrontation with reminders of the loss

•Somatic symptoms including distressing physical sensations and disrupted sleep or appetite

•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 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 [[123](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/123)].

Despite wanting and needing other people, the bereaved often find it difficult to feel connected to them and may thus withdraw from others [[14](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/14)]. Bereavement may leave people uncertain about changes in their identity.

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 be taken seriously, and warrant assessment for suicidal thoughts, plans, intent, and acts. (See ['Suicidality'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H87788111) above and ["Suicidal ideation and behavior in adults", section on 'Patient evaluation'](https://www.uptodate.com/contents/suicidal-ideation-and-behavior-in-adults?sectionName=PATIENT+EVALUATION&topicRef=14684&anchor=H16&source=see_link#H16).)

Thoughts and images 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. Patients may be frightened by these experiences and can be reassured that hallucinations are a means of seeking proximity to the deceased and are not abnormal.

Bereaved people may consult clinicians because they are surprised and alarmed by the intensity of their acute grief. It can be helpful to provide information about grief to promote a better understanding of the experience, and to provide patients an opportunity to talk about their loved one. Management of grief is discussed separately. (See ["Grief and bereavement in adults: Management"](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-management?topicRef=14684&source=see_link) and ["Grief and bereavement in adults: Management", section on 'Management'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-management?sectionName=MANAGEMENT&topicRef=14684&anchor=H427654&source=see_link#H427654).)

Course — The evolution of acute grief does not proceed according to a predictable series of stages; rather, symptoms vary as bereaved people adapt to the loss and acute grief is transformed and integrated [[1,3,14](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/1%2C3%2C14)]. The course of acute grief varies depending upon the circumstances and consequences of the death, as well as social and cultural expectations [[1,83](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/1%2C83)].

Some individuals cope better with losses than others [[4](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/4)]. 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 [[118](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/118)]. These are likely people who have lost someone to whom they were not so close or someone whose death they had anticipated (see ['Anticipatory grief'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H8569275) below). Many people ultimately find that bereavement leads to psychological growth [[4](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/4)].

Acute grief is usually time-limited [[36](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/36)]. For most people, considerable progress in adapting to the loss occurs within six months and restoration of ongoing life is well underway within 6 to 12 months [[122](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/122)]; in some cases, adjustment occurs more quickly (eg, within weeks of the loss) [[124](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/124)]. As a person adapts to the loss, grief becomes more subdued and thoughts and memories of the deceased recede to the background and are no longer insistent. Grief becomes integrated as the finality and consequences of the death are understood. 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. 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.

In some instances, acute grief does not abate because certain kinds of thinking and behavior derail and impede the process of adapting to the loss. One such thought is second-guessing oneself or someone else in relation to the death, thinking “if only” someone had done something different, the loved one would still be alive or would have lived longer. In addition, excessive avoidance or frequent prolonged proximity seeking can also complicate grief.

Grief complications can lead to the distressing and disabling syndrome of complicated grief. Other types of psychopathology may arise as well, such as major depression, anxiety disorders, and PTSD, even when grief is not intense or prolonged. (See ['Associated psychopathology'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H248623) above.)

Delayed or absent grief has not been found in systematic, community-based studies of bereaved individuals [[125](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/125)]. 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 yearning for past health and/or a more hopeful future, sadness, anxiety, anger, and disbelief. 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. Discussing death and bereavement with caregivers is usually helpful, and a study (n = 893) found that interview questions about this topic provoked little or no distress in nearly 90 percent [[126](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/126)].

Anticipatory grief may occasionally be severe and disabling [[127](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/127)]. 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 [[128](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/128)]. Clinicians can help by identifying suicidal thinking, evaluating the risk of suicidal behavior ([algorithm 1](https://www.uptodate.com/contents/image?imageKey=PSYCH%2F94491&topicKey=PSYCH%2F14684&source=see_link)), 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'](https://www.uptodate.com/contents/suicidal-ideation-and-behavior-in-adults?sectionName=PATIENT+EVALUATION&topicRef=14684&anchor=H16&source=see_link#H16).)

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

●Complicated grief

●Major depression

●PTSD

Acute grief includes symptoms that overlap with those of common mental disorders. 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.

Complicated grief — A subgroup of bereaved people experience complicated grief, which is marked by maladaptive thoughts, dysregulated emotions, and dysfunctional behaviors. The distinction between typical acute grief and complicated grief is based upon the presence of complicating symptoms and the prolonged time frame of complicated grief [[83](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/83)]. Complicated grief is diagnosed in patients with each of the following:

●Ruminative preoccupation with troubling aspects of the circumstances or consequences of the death

●Excessive avoidance of reminders of the loss

●Excessive difficulty regulating emotions

●Complicated grief symptoms persisting for at least six months after the death and interfering with functioning

Additional information about diagnosing complicated grief is discussed separately. (See ["Complicated grief in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Diagnosis'](https://www.uptodate.com/contents/complicated-grief-in-adults-epidemiology-clinical-features-assessment-and-diagnosis?sectionName=DIAGNOSIS&topicRef=14684&anchor=H4668577&source=see_link#H4668577).)

Major depression — Typical acute grief and major depression ([table 1](https://www.uptodate.com/contents/image?imageKey=PSYCH%2F89994&topicKey=PSYCH%2F14684&source=see_link)) 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 [[83](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/83)]:

●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 [[3,129-131](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features/abstract/3%2C129-131)]. 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, for example, not having prevented the death, not having made the deceased person’s life easier, not having professed love enough, or other caregiving missteps. 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 feel hopeless and cannot imagine being happy.

●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 and more pervasive worries.

●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.

Additional information about the clinical features of depression is discussed separately. (See ["Unipolar depression in adults: Clinical features"](https://www.uptodate.com/contents/unipolar-depression-in-adults-clinical-features?topicRef=14684&source=see_link).)

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. Grief symptoms may include frequent insistent images of the deceased person 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 fear of recurrent danger. (See ["Posttraumatic stress disorder in adults: Epidemiology, pathophysiology, clinical manifestations, course, assessment, and diagnosis"](https://www.uptodate.com/contents/posttraumatic-stress-disorder-in-adults-epidemiology-pathophysiology-clinical-manifestations-course-assessment-and-diagnosis?topicRef=14684&source=see_link).)

SUMMARY

●Bereavement is the situation in which a loved one has died, and grief is the distress that occurs in response to bereavement. Acute grief can be intense and disruptive, but usually is integrated over time. Complicated grief is a form of acute grief that is abnormally prolonged, intense, and disabling; as such, complicated grief is a unique and recognizable mental disorder. (See ['Terminology'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H12189335) above.)

●Reactions to bereavement can 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. The intensity and course of acute grief is also influenced by the circumstances of the death, including the age of the deceased, and whether the loss is sudden or violent, or the result of a chronic or terminal illness. (See ['Type of loss'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H11407423) above.)

●Bereavement is associated with an increased risk of mortality, general medical illnesses (eg, cardiovascular disease), and mental disorders (eg, unipolar or bipolar major depression, anxiety disorders, and posttraumatic stress disorder [PTSD]), as well as suicidal ideation and behavior that is independent of psychopathology. Some bereaved individuals develop complicated grief, which may account for most of the increased risk for each of these negative health outcomes. (See ['Adverse general medical outcomes'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H11726306) above and ['Associated psychopathology'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H248623) above.)

●Although diagnosing major depression in the context of bereavement is controversial, bereavement does not preclude the diagnosis. The rationale for diagnosing major depression in bereaved individuals is based upon the best available evidence, which indicates that bereavement-related major depression and major depression not related to bereavement are comparable with regard to risk factors, symptoms, impaired functioning, comorbidities, course of illness, and response to treatment. (See ['Major depression'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H1951779) above.)

●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'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H8568114) 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, 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'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H119191330) above.)

●Typical 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 complicated grief, major depression, and PTSD. (See ['Differential diagnosis'](https://www.uptodate.com/contents/grief-and-bereavement-in-adults-clinical-features?csi=cd232ff7-97f4-4e24-9775-22ffefe38b5f&source=contentShare#H4908986) above.)

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