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## **Fostering Resiliency After a Loss: A Focus on Adjustment Disorder Related to Bereavement**

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Fostering Resiliency After a Loss:  
A Focus on Adjustment Disorder Related to Bereavement

Lydia M. Greis

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### Fostering Resiliency After a Loss:

#### A Focus on Adjustment Disorder Related to Bereavement

The word bereavement is derived from an ancient Germanic root word meaning “to rob” or “to seize by violence.” After the death of a loved one, a void takes the place of a once vibrant life. This experience can be devastating for the survivor, who must find a way to adapt to this new reality. Bereavement refers to the period of mourning and grief following a death (“Bereavement,” n.d.). Grief is a universal emotion; nonetheless, the experience of grief is highly personal. Bereavement is a relatively slow and uneven process, and individual responses often reflect personal variables such as personality, cultural practices, and the symbolic magnitude of the death (Love, 2007). Therefore, it is impossible for health care providers to place a prescriptive timeline on the process. Bereavement should be viewed as a normal, natural human experience, one which can be overcome with time.

While most people do not require special interventions, a minority will struggle with their grief, and a debilitating disorder may ensue. Adjustment Disorder Related to Bereavement is a new diagnosis that identifies a subgroup of mourners who are not likely to improve simply with time and informal support (American Psychiatric Association [APA], 2011). This disorder is characterized by unrelenting grief, and is associated with serious long-term health consequences, significant morbidity, and ultimately contributes to increasing health care costs (Prigerson, 2009). For this reason, bereavement is a concern not only for preventive care but also for clinical practice.

This leads to an investigation surrounding the root of this disorder. Much research effort has been directed at identifying risk factors to understand why people are affected by bereavement in different ways; why some have extreme and lasting outcomes while others are

resilient and actually thrive in the face of adversity. The ability to cope is multifactorial in nature; a review of the literature unveils a complex interplay between genetics, life history, and personality. Certain factors are learned and can be modified by behavioral intervention and personal awareness, while others are inherited. Health care providers are in a unique position to care for bereaved patients during this critical time. Understanding these risk and protective factors will allow clinicians to search for individual strengths in patients and nurture them, while simultaneously identifying those at risk for maladaptive coping. Timely intervention for an adjustment disorder can be implemented in the primary care setting, and can reduce the personal toll that results from grief. Because of the frequency of bereavement in the outpatient population and the possible need for intervention in these patients, the clinician should have a thorough understanding of Adjustment Disorder Related to Bereavement, including its clinical features, risk and protective factors, and treatment options.

### **Grief**

While reactions to loss are tremendously variable (Maciejewski, Zhang, Block, & Prigerson, 2007), it is important to distinguish between grief reactions that can be considered 'normal' and those that are debilitating. Immediately following a death, survivors often experience feelings of numbness, shock, and disbelief; the reality of the death has not been fully comprehended. These feelings of intense sadness, yearning for the deceased, anxiety of the future, disorganization, and emptiness are common in the weeks after the death (Love, 2007).

Grief often comes in waves that are precipitated by reminders of the deceased. Birthdays and anniversaries may cause overwhelming sadness. Similar to the stages of grief in dying described by Kubler-Ross (1969), the resolution of grief, to some degree, occurs in stages

(Maciejewski et al., 2007). In the early phases after a loss, the intensity and symptoms of the various stages of grief may overlap (Prigerson & Maciejewski, 2008).

Over time, the distressing feelings gradually diminish for those experiencing normal grief. The individual slowly comes to accept the reality of the loss, and reestablishes mental and physical balance, usually over a period of several months. The bereaved person becomes able to remember the deceased without being overwhelmed by grief, can work productively, and can carry on with pleasure and enjoyment. The sadness will diminish over time, but the grief may never completely go away (Love, 2007).

### **Morbidity of Bereavement**

Bereavement can be detrimental to health, and prolonged grief can lead to mental and physical deterioration. Research correlates bereavement with an increased risk of mortality (Li, Precht, Mortensen, & Olsen, 2003; Manor & Eisenbach, 2003). Rates of completed suicide (Erlangssen, Jeune, Bille-Brahe, & Vaupel, 2004) and suicidal ideation (Stroebe, Stroebe, & Abakoumkin, 2005; Szanto et al., 2006) are significantly increased in the bereaved population. One study found this risk to be over 6.5 times greater in bereaved individuals (Latham & Prigerson, 2004). Grieving individuals have a greater occurrence of physical health complaints, ranging from headaches, dizziness, indigestion, and chest pain (Stroebe, Schut, & Stroebe, 2007), to insomnia (Hardison, Neimeyer, & Lichstein, 2005) and anxiety (Miyabayashi & Yasuda, 2007). One example of a physical manifestation of stress is Takotsubo Cardiomyopathy, or “Broken Heart Syndrome.” This is a transient condition that mimics an acute coronary syndrome and typically is precipitated by acute emotional stress, such as a death (Virani, Nasser Khan, Mendoza, Ferreira, & de Marchena, 2007). Clearly the toll of bereavement can have direct and lasting physiologic consequences.

**Protective Factors**

Not everyone who experiences a loss will develop psychological distress. Individual differences can moderate this response. Certain variables of personality, life history, and genetics may act as buffers to stress (see Table 1). Although most people do not require special interventions, health professionals can facilitate the grieving process by identifying and encouraging positive coping mechanisms. Likewise, screening for the absence of these protective factors can identify vulnerable patients at risk for a grief disorder.

**Personality.**

A substantial body of evidence links personality to health status (Hampson, Goldberg, Vogt, & Dubanoski, 2007). Moreover, personality traits can be predictive of coping behavior. Extraversion is strongly linked to adaptive coping (Campbell-Sills, Cohan, & Stein, 2006; Pai & Carr, 2010; Taga, Friedman, & Martin, 2009). Bonanno and colleagues (2002) assessed personality a few years prior to spousal loss and found that extraversion was predictive of an individual's pattern of grief, with pre-bereavement extraversion representing the lowest levels of chronic depression. In another study, researchers explored the relationship between pre-bereavement personality traits and post-widowhood mortality risk in 784 adults. Results linked the stress of bereavement to serious health risks, and confirmed that personality can moderate grief reactions. In this study, both conscientiousness (e.g. self-disciplined, deliberate) and agreeableness (e.g. friendly, compassionate) were protective traits. Furthermore, conscientiousness was associated with decreased mortality risk (Taga et al., 2009). Individuals who are flexible, energetic, assertive, and possess a sense of humor are more likely to have positive adaptation (Richardson, 2002). Possessing an internal locus of control (or the belief that one has command over his or her life) and high self-esteem are associated with lower levels of

cortisol, a stress hormone, during psychosocial stress (Simeon et al., 2007). Seemingly, a person who feels he or she is able to influence outcomes by his or her own actions is more likely to adapt effectively.

### **Genetic variables.**

In addition to personality, there appears to be a genetic basis of behavior. Inherited differences may predispose individuals to respond to stress in one way or another. Some believe these genetic influences account for up to one-third the variance of adaptation to stress (Hansson et al., 2008). Several brain regions and a number of neurochemicals and hormones have been linked with response to stress, positive coping, and vulnerability (Charney, 2004). For instance, increased levels of plasma neuropeptide Y, a neurotransmitter, and dehydroepiandrosterone levels, a natural steroid prohormone, are linked to resilience (Yehuda & Flory, 2007). Small hippocampal volume has been associated with maladaptive coping. Gilbertson and colleagues (2002) compared hippocampal size in identical twins and discovered the twin pairs with a psychological stress disorder had, on average, a 10% smaller hippocampus. Interestingly, this finding was inversely associated with resilience.

### **Prior stress exposure.**

It is well known that exposure to early life stressors increases the risk for development of mood, anger, anxiety, and substance abuse disorders (Heim, Plotsky, & Nemeroff, 2004). At the same time, however, overcoming adversity early in life may contribute to positive adaptation in the future. Variously referred to as the toughening or steeling effect, this hypothesis has not been widely examined in humans, although findings from several animal studies have supported this theory. For example, Lyons and Parker (2007) researched the link between early life stressors in squirrel monkeys and the development of resilience. Baby monkeys who were exposed to the

repeated stress of separation from their mothers demonstrated significantly more curiosity and exploratory behavior than the control group. These monkeys showed enhanced cognitive control and emotional regulation consistently over time and across situations, and ultimately were more resilient. The evidence suggests that stressors which are challenging, but not overwhelming, may actually foster the development of resilience.

**Table 1. Protective Factors**

	Boelen (2010)	Bonanno (2004)	Campbell-Sills, Cohan, & Stein (2006)	Campbell-Sills, Forde, & Stein (2009)	Hansson et al. (2008)	Lyons & Parker (2007)	Ott, Lueger, Kelber, & Prigerson (2007)	Pai & Carr (2010)	Richardson (2002)	Simeon et al. (2007)	Taga, Friedman, & Martin (2009)
<b>Protective Factors</b>											
<b>Positive Emotion</b>											
Laughter		X			X						
Humor					X				X		
Optimism					X				X		
<b>Personality Traits</b>											
Extraversion			X					X			X
Conscientiousness			X					X			X
Agreeableness											X
Adaptable									X		
Creative									X		
Tolerant									X		
Curious						X					
Responsible					X				X		
<b>Positive Identity</b>											
Internal locus of control					X		X		X		
High self-esteem					X		X		X		
Confidence					X						
Self discipline									X		
Self determination									X		
<b>Coping Style</b>											
Task-oriented			X								
<b>Independent Variables</b>											
High level of education	X			X							
<b>Life History</b>											
Social support							X		X	X	
Challenging (but not overwhelming) early life stressor						X					

**Resiliency.**

Many believe that recover from a loss falls along a continuum, with adjustment disorder on one end, and resiliency on the other. Loss is not necessarily harmful. In contrast to normal recovery, some individuals are resilient after a traumatic loss and emerge with a greater sense of strength, emotional stability, and appreciation for life. Evidence suggests resilience is more

common than once believed. Large numbers of people seem to manage traumatic events remarkably well (Bonanno et al., 2002). One study found, of 141 bereaved widows, 34% were considered to be resilient. This group maintained below average levels of grief and depression, and higher mental health levels than other participants. Furthermore, their mental health scores were higher than the population norms (Ott et al., 2007).

### **Adjustment Disorder Related to Bereavement**

Unfortunately for a significant few, the loss of a loved one may precipitate a mood or adjustment disorder. While most individuals eventually adapt after a loss, a minority experience chronic and disabling grief (Prigerson et al., 2009). A study of 306 bereaved widows found that chronic and disabling grief predicts a variety of mental and physical health problems, and persists over time for a minority (Prigerson et al., 1999). This population is more likely to suffer from symptoms of impaired role performance, low self-esteem, suicidal ideation, and heart attacks (Jacobs, Mazure, & Prigerson, 2000).

Chronic grief has been the subject of considerable research. Phrases such as “prolonged grief” (Prigerson et al., 2009), “complicated grief” (Boelen & Van den Bout, 2008; Dillen, Fontaine, & Verhofstadt-Deneve, 2008), and “traumatic grief” (Beolen, Van den Bout, & De Keijser, 2003; Prigerson et al., 1999) have been used in the literature to describe a state of abnormal mourning. These terms refer to the same concept: a prolonged state of bereavement that is pathological in nature may develop after a death. Presently, the APA does not recognize this as a mental disorder as it is not included in the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 2000). However, “Adjustment Disorder Related to Bereavement” is a new diagnosis that will be included in the revised DSM-V. The revision will be included in a group of Trauma and Stress-Related Disorders (APA, 2011).

Currently, Post Traumatic Stress Disorder (PTSD) is the only diagnosis in the DSM-IV for any grief-related disorder (APA, 2000). However, this diagnosis fails to capture the pathological form of grief that may develop after a loss. A person with PTSD is more likely to feel fear, whereas a grieving person may experience a feeling of aching void, almost as though a part of themselves has been amputated. It is the absence of the deceased that is the source of the trauma with bereavement, rather than fears that the traumatic event will be re-experienced (Prigerson et al., 2009). Multiple studies have confirmed this difference, and found symptoms of Adjustment Disorder Related to Bereavement to be significantly distinct from those of depression, anxiety, and PTSD (Boelen & Van den Bout, 2008; Beolen et al., 2003; Dillen et al., 2008; Prigerson, et al., 2009).

### **Diagnosis.**

Adjustment Disorder Related to Bereavement is characterized by the following criteria: For at least 12 months following the death of a close friend or relative, the individual experiences on more days than not intense longing/yearning for the deceased, intense sorrow and pain, or preoccupation with the deceased or the circumstances of the death. The individual may also display intense anger over the loss, difficulty accepting the death, a diminished sense of self, feelings that life is empty, or difficulty planning the future or engaging in activities or relationships (see Table 2). As mourning shows substantial variation, the bereavement reaction must be out of proportion or inconsistent with cultural or religious norms. Finally, the disorder must cause significant impairment in important areas of functioning and not be better accounted for by other mental disorders (e.g., major depressive disorder, generalized anxiety disorder, or PTSD [APA, 2011]).

**Table 2. Criteria for Adjustment Disorder Related to Bereavement proposed for DSM-V**

Category	Definition
A.	The person experienced the death of a close relative or friend at least 12 months earlier.
B.	Since the death at least 1 of the following symptoms is experienced on more days than not and to a clinically significant degree: <ol style="list-style-type: none"> <li>1. Persistent yearning/longing for the deceased</li> <li>2. Intense sorrow and emotional pain because of the death</li> <li>3. Preoccupation with the deceased person</li> <li>4. Preoccupation with the circumstances of the death</li> </ol>
C.	Since the death at least 6 of the following symptoms are experienced on more days than not and to a clinically significant degree: <p><u>Reactive Distress to the Death</u></p> <ol style="list-style-type: none"> <li>1. Marked difficulty accepting the death</li> <li>2. Feeling shocked, stunned, or emotionally numb over the loss</li> <li>3. Difficulty in positive reminiscing about the deceased</li> <li>4. Bitterness or anger related to the loss</li> <li>5. Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame)</li> <li>6. Excessive avoidance of reminders of the loss (e.g., avoiding places or people associated with the deceased)</li> </ol> <p><u>Social/Identity Disruption</u></p> <ol style="list-style-type: none"> <li>7. A desire not to live in order to be with the deceased</li> <li>8. Difficulty trusting other people since the death</li> <li>9. Feeling alone or detached from other people since the death</li> <li>10. Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased</li> <li>11. Confusion about one's role in life or a diminished sense of one's identity (e.g., feeling that a part of oneself died with the deceased)</li> <li>12. Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities)</li> </ol>
D.	The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
E.	The bereavement reaction must be out of proportion or inconsistent with cultural or religious norms

(American Psychiatric Association, 2011)

### Clinical Implications: Identifying Patients at Risk

Adjustment disorders often go undetected in initial assessments. Assessment time is limited, and many clinicians may choose to focus on the immediate physical ailments of their patients and overlook mental health issues (Piper, Ogrodniczuk, & Weideman, 2005). However, detection of high-risk individuals early in bereavement can lead to decreased morbidity and an increased quality of life.

#### Population.

Screening should focus on individuals with risk factors for developing a grief disorder (see Table 3). Lack of social support is one of the most significant risk factors for prolonged grief (Bonanno, 2004; Neria & Litz, 2003). Simeon and colleagues (2007) found that secure attachment in childhood, or the presence of one good parent-child relationship, comprises a protective mechanism against stress later in life. Another study demonstrated that widows who

have at least one close relationship with another adult tend to be more resilient after the loss of their spouse (Ott et al., 2007). Lack of support may particularly impact college students who may be geographically distant from their usual support systems (Schnider, Elhai, & Gray, 2007). Careful assessment should be routine for such high-risk populations.

Prior psychiatric history is a strong correlate to the development of an adjustment disorder. Patients who have had past suicidal threats or attempts are especially vulnerable. Anyone with a history of depression, anxiety, or hospitalization for mental health issues should be thoroughly evaluated after a loss (Simeon et al., 2007). Prior childhood trauma is also a significant risk factor. Abuse and neglect early in life may contribute to poor coping skills (Campbell-Sills, Forde, & Stein, 2009).

Neuroticism (emotional instability) is associated with maladaptive coping strategies (Campbell-Sills et al., 2006). Bush and colleagues (2007) reveal that rats with neurotic tendencies have stronger fear responses and decreased resilience. Coping styles such as escape, avoidance, and suppression, are also thought to be maladaptive. Although initially reducing distress, thought suppression may actually maintain symptoms of stress (Tull, Gratz, Salters, & Roemer, 2004). Deliberate attempts to try to avoid the trauma may actually amplify the problem and hinder one's ability to heal.

Circumstances of the death itself may contribute to a grief disorder. A loss that occurs suddenly or under violent circumstances is referred to as traumatic loss (Prigerson et al., 2009). This type of loss is associated with greater functional impairment and more intrusive symptoms when compared to an anticipated death. The difference between traumatic loss and anticipated loss lies in the preoccupation with the death. With traumatic loss, the fixation is the scene of the trauma, whereas with anticipated loss, the intrusions are of the lost person (Green, 2000).



### Screening tools.

Two simple questions, which are appropriate to use in initial interviews, can be asked in the outpatient setting to identify patients at risk (see Table 4). These questions may be more practical than requesting clinicians to conduct a thorough assessment for a grief disorder. The questions are: “Do you feel that you have not really grieved, or that you are not functioning as well as before the death?” and “Do pictures of the death pop into your mind, or do you try not to think about it?” Nearly 90% of study participants with and without a grief disorder were identified using these questions (Piper et al., 2005). If a patient answers “yes” to any of the above questions, the clinician should inquire further about the loss and/or refer the patient for treatment. Because Adjustment Disorder Related to Bereavement is a new diagnosis, screening tools are limited. Future research is needed to create a screening tool specific for identifying traumatic grief.

**Table 4. Screening Questions for Adjustment Disorder Related to Bereavement**

- |    |  |
|----|--|
| 1. | Do you feel that you have not really grieved, or that you are not functioning as well as before the death? |
| 2. | Do pictures of the death pop into your mind, or do you try not to think about it?                          |

(Piper, Ogrodniczuk, & Weidman, 2005)

### Treatment

Treatment of the bereaved ideally begins before the death takes place. Attention to family members during the dying process offers the clinician an opportunity to assess for coping resources and vulnerabilities of these individuals. Psychosocial support should be considered for those with poor coping resources and risk factors for poor bereavement outcomes. Because a grief disorder can lead to prolonged dysfunction, patients with this disorder should be referred to a psychiatrist for evaluation.

**Grief counseling.**

Interventions targeted to adults who are experiencing normal bereavement are not beneficial in terms of diminishing grief-related symptoms (Jordan & Neimeyer, 2003). In general, the efficacy of grief therapy for the bereaved is distressingly low, with findings of either insignificant (Jordan & Neimeyer, 2003; Neimeyer, 2000; “Report,” 2004) or no reduction in grief symptoms (de Groot et al., 2007). Neimeyer (2000) conducted a meta-analysis of 23 studies of grief therapy and found that counseling for normal grievers had essentially no measurable positive effect. Not only did grief therapies tend to be ineffective, 38% of individuals receiving grief treatments actually got worse compared to no-treatment controls. This raises the sobering possibility that some interventions may actually do more harm than good. One possible explanation is that uncomplicated grief is naturally self-limiting; grief counseling may not be needed by most mourners. Many individuals will show a genuine resilience that should not be interfered with or undermined by clinicians (Bonanno, 2004).

In contrast, individuals at risk for complications of bereavement respond well to formal intervention (Jordan & Neimeyer, 2003; Neimeyer, 2000; “Report,” 2000). In one randomized controlled clinical trial, researchers compared two therapeutic interventions for patients experiencing a grief disorder. Both treatments produced improvement of grief symptoms (Shear, Frank, Houck, & Reynolds, 2005). A pilot study specifically targeting individuals with prolonged grief found significant improvements in symptoms of grief, anxiety, and depression after grief therapy (Shear et al., 2001).

Generic grief counseling interventions targeted toward the general population of the bereaved are unnecessary. Instead, interventions that are tailored to individuals at high risk for poor outcomes, or those with prolonged grief, are likely to be more beneficial. Those who meet

criteria for adjustment disorder related to bereavement, survivors of sudden losses, and individuals with previous psychiatric or abuse histories, are likely to have elevated risk. More research is needed to confirm these findings and improve treatment response.

### **Pharmacotherapy.**

Studies targeting bereavement-related depression have found minimal effects of medication on grief (Simon, et al., 2008; Zisook, Shuchter, Pedrelli, Sable, & Deaciuc, 2001). Zisook and colleagues (2001) treated individuals who met criteria for a major depressive episode 6 to 8 weeks after a loss of a spouse with bupropion, and found a significant reduction in depression. Nonetheless, only a modest reduction in grief symptoms was produced with treatment (Zisook et al., 2001). Unlike depression, grief itself is not effectively treated with antidepressants.

Medications, however, can be used to target concurrent symptoms of grief. For instance, anxiolytics for symptoms of anxiety may be helpful. Depression, anhedonia and hopelessness, which often accompany a traumatic loss, can be successfully treated with medication (Charney, 2004). The American College of Physicians recommends selecting second-generation antidepressants (selective serotonin reuptake inhibitors [SSRIs], serotonin norepinephrine reuptake inhibitors [SNRIs], and selective serotonin norepinephrine reuptake inhibitors [SSNRIs]) for the treatment of depression and anxiety. The current guidelines recommend a treatment of 4 to 9 months after a satisfactory response in patients with a first episode of major depressive disorder, and an even longer duration of therapy in patients with subsequent episodes (Quaseem, Snow, Denberg, Forcica, & Owens, 2008). In conclusion, bereaved individuals should not immediately be prescribed a medication for grief, instead, pharmacologic therapy should only be considered for those with debilitating behavior patterns or depression.

**Alternative therapy.**

There is a growing interest in non-pharmacologic therapy for treatment of depression that often accompanies grief. Studies have found Vitamin D supplementation may decrease symptoms of depression (Barnard & Colon-Emeric, 2010). The Institute of Medicine (IOM) currently recommends 600 IU of Vitamin D per day for adults under age 70, and 800 IU for adults 70 and older (IOM, 2010). There is increasing evidence that omega-3 fatty acids are beneficial to mental health as well. Of the two main omega-3 fatty acids found in fish oil, eicosapentaenoic acid (EPA) has shown the greatest effect on mood. Adjunctive use of omega-3 fatty acids with EPA is recommended for treatment of depression (Peet & Stokes, 2005). Finally, research clearly indicates a positive association between physical activity and mental health. Regular physical activity contributes to emotional well-being and positive-self esteem, and has been found to decrease rates of depression, hopelessness, and suicidal behavior (Taliaferro, Rienzo, Pigg, Miller, & Dodd, 2008). Recommending regular physical activity, along with Vitamin D and omega-3 nutritional supplements, may help alleviate symptoms of depression in a bereaved patient.

**Patient education and counseling.**

If counseling and medications are only effective for a minority, what interventions are available for the entire population of grief sufferers? The answer is patient education. Knowledge of the complicating factors associated with death can enhance therapeutic guidance and intervention, and promote successful bereavement.

Often bereaved individuals wonder if they are grieving normally. Remind survivors that grief is a very individual response, and it is not unusual for grief reactions to vary among family members. Grief responses are not 'wrong' or 'bad.' Educating patients of the range of possible

bereavement reactions can help validate their feelings. A helpful first step is to encourage the survivor to talk about the loss. Acknowledgement of the death and its irreversibility is needed before healing can begin. Avoid using metaphors such as “passed on,” or “in a better place,” when speaking of the death. Instead, use clear language-- words such as “dead” or “died”-- to verify that the family member has died (Hobgood et al., 2009).

A common myth of grieving family members is that there is an established timetable for grief. Remind survivors that grief is a continuum, and it may take a long time to feel “normal” again. Symptoms may come and go, some days the survivor may have outbursts of anger, and other days, withdraw in sadness. Explain that these symptoms are common. Rather than needing encouragement to ‘move on’ or to ‘let go’, patients need support and reassurance; it is “ok” to feel sad for a very long time (Love, 2007). Practitioners can assist in the process of recovery by providing constructive education, and showing tolerance and acceptance.

### **Conclusion**

Helping a bereaved individual through the grieving process is truly an opportunity to heal the body and the mind. Most people recover from grief over time, and do not require a special intervention. There are several ways to identify functional grieving. The survivor may display an ability to talk about the death without feeling overwhelmed or bursting into tears. Energy levels may improve. Sleep and dietary patterns may begin to normalize. Confidence will return and survivors will be able to make decisions without second-guessing themselves. There may be a visible return of a sense of humor. As the pain subsides, there is a renewed interest in life (Clements, DeRanieri, Vigil, & Benasutti, 2004). Only when grief becomes so overwhelming that it begins to impair function should the provider intervene. Adjustment Disorder Related to Bereavement is a severe and debilitating condition that may result after the death of a loved one.

Timely intervention is necessary, as this disorder will not simply resolve over time, but progress if left untreated. The patient will likely present to primary care for initial diagnosis. Therefore, an understanding of the predisposing risk factors will be helpful for clinicians during the identification process. Likewise, encouragement and support can be offered for traits that are protective in nature. Grief is a process, not an endpoint. The goal of grief is neither to forget about nor to “get over” the loss, but to remember the deceased, to understand the changes created by the loss, and determine how to reinvest in life.

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