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Articles

Grief and the new DSM-5 clinical category: A narrative review of the literature

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Abstract

Aim: Grief is a common reaction to loss and it is considered a physiological and instinctive response. The "normal" grief evolves into an "integrated" phase within one year from death, and it is a non-pathological condition, that does not require specific therapeutic interventions. When this "integrated phase" does not occur, the subject could reach pathological manifestations related to the grief. The Persistent Complex Bereavement Disorder (PCBD) was proposed as a new category in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition. PCBD is a new clinical category characterized by symptoms related to the detachment and to the post-traumatic distress and it differs from normal and uncomplicated grief, for the disability caused by these reactions and their persistence and pervasiveness.

Method: We examined reviews and studies of different researches done in the last twenty years, concerning the issues of loss, "normal" and "complicated" mourning that led to the diagnostic category of PCBD. For this review, we based our consideration starting from those pathological conditions that preceded PCBD, as "pathological", "complicated" and "traumatic" grief.

Results: PCBD results a new important clinical category showing specific symptoms, diagnostic criteria and treatment. It presents many differences with other pathologies, which goes into differential diagnosis with PCBD, and it can be treated with targeted therapeutic approaches.

Conclusions: Diagnostic criteria for PCBD could allow early diagnosis and a correct treatment avoiding underdiagnosis and misdiagnosis. Further researches could focus on the evaluation of more neurobiological aspects, new psychometric tools, for assessing susceptibility to this pathology, and on the cultural aspects that may influence mourning reactions, in an ethno-psychiatric perspective.

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1. Introduction

The experience of loss and the consequent reaction of grief is experienced by the majority of human beings in their lifetime course; although most of them adequately address loss, a significant percentage of subjects encounters difficulties and troubles in dealing with this painful path. According to Carmassi et al. (2016), a terminological definition can be useful in order to

achieve a better comprehension, since in English three different terms are usually used for describing processes and reactions to loss: grief, mourning, and bereavement.

“Grief” refers to the emotional suffering concerning the loss, “mourning” is the external expression of grief, including rituals and being influenced by spiritual, religious, and cultural beliefs and practices; “bereavement” refers to the event of loss per se (Morgan, 2005; Morgan & Laugani, 2002). However, current literature uses all these terms to indicate the phenomenon of loss, as we will do in the present work; in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition - DSM-5 (American Psychiatric Association, 2013), and in the International statistical classification of diseases and related health problems, tenth revision - ICD-10 (World Health Organization, 2004), “bereavement” and “grief” are used for indicating conditions that overlap in terms of symptoms, prevalence, and health correlates.

In the greatest number, people adequately address loss, but a significant percentage of subjects develops a syndrome characterized by a prolongation of the psychological suffering related to the loss (Lee, 2015). For this reason, the Persistent Complex Bereavement Disorder (PCBD) appears as a separate pathological entity in the third section of the DSM-5 (2013), that contains some diagnostic categories that require further research. A slightly different diagnostic entity, named Prolonged Grief Disorder (PGD), has been introduced in the 11th edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-11, Maercker et al., 2013; Prigerson et al., 2009).

PCBD and PGD strongly overlap in terms of symptoms, prevalence, and health correlates (Maciejewski et al., 2016); in this article, the phenomenon of pathological grief will be addressed using PCBD and PGD constructs in an interchangeable manner.

The first question is: what is the difference between normal and pathological grief?

Grief is often a dramatic event that alters the psychic balance and the well-being of the subject, especially in the acute phase, and it is considered a physiological and instinctive response (Carmassi et al., 2016). It is difficult to judge as pathological the reactions of a subject in the early stages of mourning due to the fact that the experience of detachment is different from one to another, and it can also change in relation to the cultural group of belonging (Silver et al., 2007).

It could be useful to analyze the differences between "normal" and "pathological" grief in order to understand where the research that led to the definition of Persistent Complex Bereavement Disorder has started. "Normal" grief is a process that develops through different phases. It has been studied in psychology and there are several theories derived from different authors (Freud, 1917; Bowlby, 1973). "Normal" grief could present severe psychological reactions (anguish,

anger, shock, etc.), but it evolves into an "integrated" phase within about one year from the loss, configuring itself as a non-pathological condition that does not require specific therapeutic interventions (Jordan & Neimeyer, 2003). As observed by Lombardo et al., (2014) the integrated grief is a condition characterized by a serene memory of the deceased; when this "integrated phase" does not occur, the subject could reach pathological manifestations related to the grief.

In the last twenty years the scientific debate has led to a gradual definition of diagnostic criteria for various pathological patterns, named from time to time as "pathological grief" (Horowitz et al., 1993), "complicated grief", (Stroebe et al., 2000) and "traumatic grief" (Jacobs et al., 2000; Prigerson & Jacobs, 2001), up to the Persistent Complex Bereavement Disorder present in the DSM- 5 as a new clinical category which deserves further studies.

PCBD should differ from normal and uncomplicated grief for the distress and disability caused by these reactions, and their persistence and pervasiveness (Prigerson et al., 2009).

The purpose of this article is the analysis of the path that led to this new definition, through a narrative review of the main studies published in the last twenty years, with the aim to clarify the clinical utility of this new diagnostic category.

2. Method

This article reviews studies published in the last twenty years on the topics of loss, "normal" and "complicated" grief, with attention to those studies that led to the diagnostic category of Persistent Complex Bereavement Disorder.

The selected studies are been identified through a research carried out in Medline/PubMed, Scopus, Google Scholar and Science Direct using the following key-words: "loss", "bereavement", "grief", "mourning" ,"complicated grief", "traumatic grief", "pathological grief", "prolonged grief disorder", "persistent complex bereavement disorder".

3. Persistent complex bereavement disorder: general aspects

The influent studies from the groups of research of Horowitz et al. (1993) and Prigerson et al. (1999) led to the nosological definition of PCBD; thanks to their works, a precise definition of the disorder was included in the third section of DSM 5.

Horowitz et al. (1997) assessed subjects at 6 and 14 months after loss, using the Complicated Grief Module- CGM, a 30-item scale exploring three categories of symptoms related to the loss: intrusive symptoms, avoiding behavior, and difficult to adapt to the loss. Prigerson & Jacobs

(2001) first developed the Inventory of Complicated Grief-ICG, further revised as the Inventory of Traumatic Grief - Revised - ITG-R, in order to elaborate other diagnostic criteria.

In a second step, the two working groups established a commission of experts, with the purpose of approving a common consensus list of symptoms for defining the construct of a new grief-related nosographic entity to be proposed for DSM-5 classification (Prigerson et al., 2009).

3.1 Symptomatology and diagnostic criteria

Psychiatric disorders related to grief have been variously described; however, main symptoms include disorganized behavior (Monk et al., 2006), abnormal sleep-wake rhythm (Hardison et al., 2005), substance abuse, self-destructive, and anti-conservative behaviors (Latham & Prigerson, 2004). Moreover, complications in the grieving process have been associated with an increase in the risk to develop a medical illness such as cancer, cardiovascular diseases, and hypertension (Zhang, El-Jawahri, & Prigerson, 2006).

The diagnostic category of "Persistent Complex Bereavement" proposed in DSM-5 (APA, 2013) includes the diagnostic criteria reported in Table 1.

Table 1 - Persistent Complex Bereavement?: DSM-5 diagnostic criteria (APA, 2013).

<p>A. The individual experienced the death of someone with whom he or she had a close relationship.</p> <p>B. Since the death, at least one of the following symptoms is experienced on more days than not and to a clinically significant degree and has persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:</p> <ol style="list-style-type: none"> 1. Persistent yearning/longing for the deceased. In young children, yearning may be expressed in play and behavior, including behaviors that reflect being separated from, and also reuniting with, a caregiver or other attachment figure. 2. Intense sorrow and emotional pain in response to the death 3. Preoccupation with the deceased 4. Preoccupation with the circumstances of the death. In children, this preoccupation with the deceased may be expressed through the themes of play and behavior and may extend to preoccupation with possible death of others close to them.
<p>C. Since the death, at least six of the following symptoms are experienced on more days than not and to a clinically significant degree, and have persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:</p> <p>Reactive distress to the death</p> <ol style="list-style-type: none"> 1. Marked difficulty accepting the death. In children, this is dependent on the child’s capacity to comprehend the meaning and permanence of death. 2. Experiencing disbelief or emotional numbness over the loss. 3. Difficulty with positive reminiscing about the deceased. 4. Bitterness or anger related to the loss. 5. Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame). 6. Excessive avoidance of reminders of the loss (e.g., avoidance of individuals, places, or situations associated with the deceased; in children, this may include

<p>avoidance of thoughts and feelings regarding the deceased).</p> <p>Social/identity disruption</p> <p>7. A desire to die in order to be with the deceased.</p> <p>8. Difficulty trusting other individuals since the death.</p> <p>9. Feeling alone or detached from other individuals since the death.</p> <p>10. Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased.</p> <p>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).</p> <p>12. Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities).</p>
<p>D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.</p>
<p>E. The bereavement reaction is out of proportion to or inconsistent with cultural, religious, or age-appropriate norms.</p>
<p><i>Specify if:</i></p> <p>With traumatic bereavement: Bereavement due to homicide or suicide with persistent distressing preoccupations regarding the traumatic nature of the death (often in response to loss reminders), including the deceased’s last moments, degree of suffering and mutilating injury, or the malicious or intentional nature of the death.</p>

This new construct encompasses symptoms related to separation, and to post-traumatic distress; the attention of the individual is focused on the mental representation of the lost loved one, the bereaved subject could assume maladaptive behaviors consisting in a hyper-involvement in activities in some way related to the missing person.

For diagnostic purposes, the symptoms must persist for at least 12 months after the loss in adults, and for at least 6 months for children, eventually altering subjective quality of life.

3.2 Epidemiology and risk factors

Epidemiological studies on the prevalence of complicated grief show heterogeneous data. About 7-10% of bereaved subjects experience a grieving process that does not evolve towards resolution over a period of about 6-12 months (Shear, 2012). The prevalence of complicated grief in general population varies between 3.7% (Kersting et al., 2011) and 4.8% (Newson et al., 2011). According to DSM-5, the prevalence of PCBD is approximately 2.4% - 4.8%.

However, there are special populations in which the rates of prevalence and incidence of the disorder and its previous definitions could be higher. A recent study by Areia et al. (2018) showed that 25.9% of family caregivers of patients with terminal cancer presented a high risk of complicated anticipatory grief. A prospective study by Schulz et al. (2006) reported that 20% of caregivers of patients affected by dementia exhibited complicated grief, along with high levels of depressive symptomatology after the death of the patients. Data suggested that the incidence

of complicated grief was high among individuals bereaved by suicide, and that survivors of suicide were at higher risk of developing complicated grief (Jordan, 2008; Shear et al., 2011). A systematic review and a meta-analysis performed in 2017 showed as the prevalence of PGD (ICD-11) among bereaved adults was 9.8% (95% CI 6.8–14.0), thus suggesting that one out of ten experiencing bereavement in adulthood will exhibit clinically significant levels of PGD symptoms (Lundorff et al., 2017). Regarding gender differences, PCBD, similarly to other internalizing disorders, such as anxiety and depression, is more prevalent in females than in males (Merlo et al., 2018; Shulla & Toomey, 2018).

Several studies have tried to identify two major areas of risk factors. The first area includes demographic variables. In particular, caregivers of terminal patients, female gender, the condition of wife or daughter, and the lack of family support expose people to the risk of developing PCBD (Chiu et al., 2010). The second area includes individual differences in personality traits, defense mechanisms and attachment styles, and the quality of the relationship with the dying person (Stroebe, Schut, & Stroebe, 2007; Chiu et al., 2011). Alexithymia, low levels of self-esteem, poor tolerance to frustrations, the presence of a close and exclusive relationship with the deceased person, intolerance of uncertainty, and emotional distress increase the risk of developing pathological bereavement (Boelen, 2010; Boelen et al., 2012; Lombardo et al., 2012); moreover, the inability to make sense of the loss, associated with spiritual and existential problems and rumination are other important risk factors (Eisma et al., 2015; Neimeyer et al., 2006).

Based on the literature, early diagnosis of PCBD could take advantage of specific screening methods for the assessment of risk predictors. In a cohort study by Mai-Britt et al. (2011) the Beck's Depression Inventory - BDI has been proven effective for assessing risk factors; it was used eight weeks after loss in combination with a single item question (inspired by the literature on risk factors) for evaluating the risk of developing complicated grief after six months.

It is also important to consider cultural and religious factors in the context of the risk of developing a PCBD. The evaluation instruments could be different if we consider samples of people belonging to cultures different from the western one. A study by Ito et al. (2012) suggested that the Brief Grief Questionnaire - BGQ) was a reliable and valid instrument for screening complicated grief in non-clinical population from a non-Western Country. The questionnaire is a 5-items self-report or interview instrument for screening complicated grief; however, it has not been validated in a broader population. In the same way, a study conducted by Kim et al. (2017) assessed the need for adaptations of the DSM-5 criteria for PCBD, as well as the validation of a culturally relevant grief scale, for cultural groups in Nepal.

3.3 Psychological mechanisms and neurobiology of grief

Grief was analyzed by many authors during the last century, according to psychological, historical and anthropological points of view. Freud (1917) examined the work of mourning, recognizing two mutually exclusive responses to loss: mourning (Trauer), and melancholia (Melancholie); this firm distinction between the two responses has long since become nearly identical to the consideration of a normal versus a pathological reaction to loss, with a clear border between them. Nevertheless, the two phenomena are not representative of two different kinds of reaction to loss, but they are distinct psychic entities: whereas mourning is regularly the reaction to the loss, in melancholia a loss has occurred, but it is unclear who or what was actually lost and, since loss is internalized and unconscious, the melancholic experiences a peculiar kind of loss, that of the Ego.

Another important contribution to the topic of loss comes from Bowlby (1972), who derived from different sources, such as object relations theory, psychoanalysis, ethology, and evolutionary biology, a model on the function and course of mourning, including “disordered” mourning, highlighting the role of attachment system and styles in determining the way an individual responds to loss. More recently, three main models have attempted to explain the onset and the development of the grief symptomatology: the Biobehavioral attachment-based model (Shear & Shair, 2005), the Cognitive-behavioral model (Boelen et al., 2006), and the Dual-process model (Stroebe, Schut & Boerner, 2010). Although apparently different, these three models converge in identifying the attachment system, cognition (cognitive evaluations based on negative thinking) and, finally, alterations of the emotional system (autobiographic memory, suppression and rumination) as contributing factors to normal and pathological grieving processes, opening new perspectives of study and therapy (Maccallum & Bryant, 2013). Post-traumatic theory by Horowitz (1993), finally, asserts that mourning is one of the most stressful events in life, associated with mental and physical discomfort.

From a neurobiological point of view, research aimed at identifying specific brain centers that are involved in the modulation of grieving processes has shown that grief is mediated by a distributed neural network connecting structures, such as the posterior cingulate cortex (PCC), cerebellum and the medial/superior frontal gyrus, involved in affect processing, visual imagery, autonomic regulation, memory retrieval, processing of familiar faces (Hardison et al., 2005).

Eisenberger (2012) examining social pain, and social loss, by a neurobiological point of view, observed that experiences of social loss predominantly activated the dorsal anterior cingulate cortex (dACC) and anterior insula (AI). This also could be extended to the phenomenon of grief, according to neurobiological substrates.

Silva et al. (2014) across a review of different studies, highlighted the activation of the anterior cingulate cortex (ACC), posterior cingulate cortex (PCC), prefrontal cortex (PFC), insula and amygdala in bereaved subjects. Also reward pathways in the brain may play a role in PCBD and in complicated grief, as shown by a study documenting that yearning predicted greater activation in the subgenual anterior cingulate cortex (sgACC) (McConnell, 2017), congruently with previous data from functional magnetic resonance (fMRI) studies showing increased activation of the nucleus accumbens in complicated grief (O'Connor et al., 2008). O'Connor (2012) highlighted the importance of immunological and neuroimaging biomarkers in complicated grief, since these variables could help in discriminating grief from other disorders, such as post-traumatic stress disorder (PTSD), and acute grief from complicated grief. Moreover, a number of biomarkers may also improve early diagnosis and prevention of complicated grief disorders.

3.4 Differential diagnosis and comorbidity

Persistent and Complex Bereavement Disorder, and “pathological grief” in general, imply differential diagnosis with numerous other disorders (Simon et al., 2007). In particular, the differences with Major Depressive Disorder (MDD) and PTSD are suggestive, because these disorders exhibit partially overlapping symptoms. Comorbidity with MDD is present in a percentage between 52% and 70% of PCBD cases (Simon et al., 2007; Gesi et al., 2017), although the two disorders need to be accurately differentiated.

Compared to MDD, grief is shaped with a dysphoric mood entangling feelings of guilt that are not generalized but centered on the deceased one. In bereaved subjects, thought content is polarized on the deceased, whereas in MDD ruminations are usually self-centered.

In PCBD, suicidal ideation is present, sustained by the strong desire to reunite with the loved one, and accompanied by obsessive ideation with intrusive thoughts focused on loss, with significant symptoms of separation anxiety (Carmassi et al., 2015).

In addition, neurobiological data seem to confirm the differences between the two disorders: complicated grief symptoms were associated with mild subjective sleep impairment but electroencephalographic (EEG) sleep measures did not show disrupted sleep architecture, and, differently from depression, no changes of EEG sleep physiology were documented (McDermott et al., 1997; Settineri et al., 2012). One of the most relevant symptoms that define the difference between these PCBD and MD is the absence of psychomotoric disturbs in PCBD; moreover, in PCBD there is no impairment of basic neurocognitive functions (Carmassi et al., 2016).

It is also important to consider how these studies led to the so-called Bereavement Exclusion in the DSM-5, with the elimination of the E criterion in the diagnosis of Major Depressive

Episode (MDE), distinguishing between MDE and physiological and/or pathological mourning reaction (APA, 2013).

Contrarily, it has been observed that in case of traumatic and/or sudden death, PCBD should be accurately discriminated from PTSD (Dell'Osso et al., 2012). In this case, mourning is configured as a trauma, and the subject could experience avoidance behaviors, numbing, depersonalization, derealization, estrangement, alterations of sleep and cognitive impairment. However, where in PTSD trauma consists of a circumscribed event in time and space, the loss of the loved one becomes part of the existential sphere of the individual.

From the point of view of the emotional involvement, fear and anxiety are prevalent in PTSD, whereas in mourning sadness and nostalgia of the deceased are the central affective dimensions. It should be borne in mind that sudden and traumatic deaths are a risk factor for the comorbidity between PBCD and PTSD (Marques et al., 2013). PCBD should also be differentiated from Adjustment Disorder; however, Adjustment Disorder occurs within three months, the stressful event (loss) (Carmassi et al., 2016).

3.5 Assessment: diagnostic tools

For diagnostic purposes, Complicated Grief Module, Inventory of Complicated Grief and Inventory of Traumatic Grief-Revised are the instruments that Prigerson et al. (2009) used to validate their diagnostic criteria.

A psychometrically sound, self-report measure of PCBD symptoms is the Persistent Complex Bereavement Inventory – PCBI (Lee, 2015; 2018), recently developed to facilitate research into the Persistent Complex Bereavement Disorder (PCBD) construct.

The PCBI consists of 16 items corresponding to the diagnostic criteria described in section B and C of the DSM-5. Each PCBI items represent one of three symptom clusters used to define PCBD:

1. Items 1-4 reflect attachment-related response (core grief factors)
2. Items 5-10 assess the reactive distress factors (difficult reactions)
3. Items 11-16 measure the impact of grief on interpersonal and personal domains (social identity disruption factors).

The PCBI is able to predict levels of distress and impairment, and it is a useful tool in the assessment of psychological phenomena of grief.

3.6 Treatment

As stated earlier, many of the symptoms of PCBD are very similar to the symptoms first experienced by bereaved persons who are experiencing normal uncomplicated grief during the first few months following their loss (Zhang, El-Jawahri, & Prigerson, 2006).

However, many studies have found that PCBD is associated with heightened risk of physical and mental diseases such as cancer, hypertension, cardiac events, suicidal ideation, disability, functional impairments (Prigerson et al., 1995; 1999), thus increasing rates of hospitalization, and reducing quality of life (Silverman et al., 2000). For these reasons, early recognition and appropriate treatment strategies for PCBD are needed, and both pharmacological and psychotherapeutic therapies have been proposed (Zhang, El-Jawahri, & Prigerson, 2006; Hensley et al., 2009; Smid et al., 2015).

Antidepressant treatments do not seem to be entirely appropriate for PCBD; combined nortriptyline and interpersonal psychotherapy (IPT) have proven effective for the reduction of bereavement-related depression, although this treatment did not show efficacy on grief symptoms (Zhang, El-Jawahri, & Prigerson, 2006). Selective serotonin reuptake inhibitors (SSRIs) reduced grief-related symptoms (Zhang, El-Jawahri, & Prigerson, 2006), but it seems necessary to improve psychological cares. An open pharmacotherapy trial found that escitalopram improved depressive, anxiety and grief symptoms (Hensley et al., 2009).

Cognitive Behavioral Therapy - CBT and Brief Eclectic Psychotherapy - BEP-TG have been applied in PCBD (Smid et al., 2015). CBT resulted quite effective in the treatment of children with disturbing grief (Spuij, Dekovic, & Boelen, 2015); BEP-TG could be indicated in patients with traumatic grief, whereas it seems not to be helpful, rather contra-indicated, in patients with psychotic depression, cognitive impairment, psychotic disorders, bipolar disorders, substance dependence, and severe personality or eating disorders. The aim of treatment is learning to live with the loss (or in case of ambiguous loss, with ambiguity), that finally may lead to relief symptoms of PCBD. It consists of a 16-session protocol based on three stages with different emphasis on processes and influencing factors of the cognitive stress model (Smid et al., 2015).

4. Conclusions and future perspectives

Bereavement is a common life experience that becomes pathological when it does not evolve in an integrated grief. This happens in an important percentage of cases (Kersting et al., 2011; Newson et al., 2011), and for this reason, the recognition of a new nosographic entity in the sphere of mourning provides dignity to a disorder that can be otherwise underestimated.

This could allow, in a medical perspective, to focus attention on the problems related to grief in a clear and precise way, and therefore may help clinicians to consider it not only as a physiological, but sometimes exasperated, reaction to the loss.

For decades, the topic of “pathological” grief has been faced by numerous perspectives (Freud, 1917; Bowlby, 1973), but in the last twenty years research has brought more specific contributions. This led to the definition of a new clinical entity: the Persistent and Complex Bereavement Disorder (PCBD) that is different from “normal” and “uncomplicated” mourning for its persistence and pervasiveness (Prigerson et al., 2009; APA, 2013).

A certain terminological confusion in the years preceding the systematization of this new category may have prevented a full understanding of this pathological dimension. The use of various and different clinical definitions to indicate the same disorder (complicated grief, traumatic grief) has created dispersion in intercepting patients with problems related to grief.

The less accurate concepts of "pathological grief" (Horowitz et al., 1993), “complicated grief” (Stroebe et al., 2000) and “traumatic grief” (Prigerson & Jacobs, 2001), which preceded PCBD, have hindered diagnostic issues, including differential diagnosis with similar disorders. PCBD (and PGD, in the same way) organize and systematize in a clear way grief-related symptoms and abnormal/pathological reactions to loss, allowing a better and easier diagnostic process. Also, a correct diagnosis permits focused treatments, although studies on specific treatment strategies for PCBD are still sparse.

Further research should add new insight into the neurobiological and psychological correlates of complicated mourning, along with sustained attention towards early diagnosis and prevention of the disorder. The awareness that mourning is closely related to cultural aspects should also lead to include an ethno-psychiatric dimension in this field of research, along with the validation of culturally sensitive grief scales, as well as the adaptation of DSM-5 criteria to different cultural groups. Finally, a complex topic such as “grief” should be investigated with substantial attention to all the involved dimensions, and clinicians need to be attentive to all problematic responses to loss, for helping bereaved subjects to reshape their existential experience that has been shattered by loss, and to restore a sense of direction, promoting new insight and personal growth.

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