

Concepts and Controversies in Grief and Loss

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Although grief is a universal experience, the ways in which it occurs are not universally agreed upon. In fact, there is considerable controversy about the "normal" duration of grief, its expected outcome, and its course. Although most grieving adults will achieve a sense of normalcy at some point, others seem not to do so. Continuing impairment by grief raises a question: Is the experience qualitatively different from normal grief or is it different only in degree? This article discusses grief conceptualizations, including that of complicated grief, and approaches to grief counseling.

Loss is a universal human phenomenon, but people respond to it with varying degrees of grief and mourning. Although the experience is common, its expression varies across individuals. People grieve in different ways, for different durations, and with manifestations that range from depression to rage to avoidance. Working with their clients and within their communities mental health counselors are often faced with issues of grief. Although it has been widely studied, there is still disagreement about the definition of grieving, as is clear from the diagnostic criteria issued by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders* ([DSM-IV-TR], APA, 2000).

The loss of a loved one is one of the most distressing emotional experiences people face, yet virtually everyone will deal with grief at some point. Despite the emotional difficulty associated with loss, most people experience a "normal" grieving process in which they endure a period of sorrow, numbness, and even guilt or anger, followed by a gradual fading of these feelings as the griever accepts the loss and moves forward.

In the literature many terms have been used to describe aspects of grief and loss. Bereavement is understood to be the experience of having lost a loved one to death; grief to be various emotional, physiological, cognitive, and behavioral reactions to the loss; and mourning to be the cultural practices through which

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bereavement and grief are expressed (Brown & Goodman, 2005). Finally, the term complicated (or traumatic) grief (Prigerson & Jacobs, 2001) describes grief that appears to deviate from the norm in duration and symptom intensity. Some defining aspects of both normal and complicated grief presented here provide a context for the articles that follow.

Uncomplicated Bereavement

According to the DSM-IV-TR (APA, 2000), a bereavement v-code can be used when the focus of treatment is a client's reaction to the death of a loved one. The normal grieving process is considered to be characterized by feelings of great sadness and anger, physical symptoms such as weight loss and insomnia, a preoccupation with the death, and difficulty with concentration (Cohen, Mannarino, Greenberg, Padlo, & Shipley, 2002). The clinical presentation of bereavement responds to individual, family, environmental, and cultural variables, although there are common tasks an individual likely goes through to successfully navigate the grieving process (Lin, Sandler, Ayers, Wolchik, & Luecken, 2004).

Uncomplicated bereavement involves reconciliation, which has been defined as "the process that occurs as the bereaved individual works to integrate the new reality of moving forward in life without the physical presence of the person who died" (Cohen et al., 2002, p. 309).

Reconciliation is achieved through specific tasks that take place during bereavement. Cohen, Mannarino, and Knudsen (2004) suggest that these tasks include (1) accepting the reality of the death; (2) fully experiencing the pain associated with the loss; (3) adjusting to life without the loved one; (4) integrating aspects of the loved one into one's own self-identity; (5) converting the relationship from one of ongoing interactions to one of memory; (6) finding meaning in the loved one's death; and (7) recommitting to new relationships with other adults. Similarly, Worden (1991) proposes that adaptation to loss involves navigating specific tasks that include (1) acceptance of the reality of the loss; (2) working through and experiencing the negative emotions associated with the loss; (3) adjusting to an environment in which the deceased is no longer physically present; and (4) establishing continuing bonds with the deceased.

Although most people are able to cope with and navigate the normative grieving process without complication (Boelen, van den Hout, & de Keijser, 2003; Bonanno, 2004), some are unable to do so successfully. When people are prevented from moving through the tasks adequately, the normal bereavement process is interrupted, grief reactions become much more painful and debilitating (Mayo Clinic, 2007), and complicated grief may develop.

Complicated Grief

Among the terms that have been used in the bereavement literature to describe atypical grief are complicated grief (CG); traumatic bereavement; childhood traumatic grief; and prolonged grief disorder (PGD). In this article, for consistency we use the term complicated grief. Although the specific definitions for these conditions may differ, the common defining characteristic is that the bereavement process is interrupted and there is no resolution.

CG has been conceptualized as the development of trauma symptoms following a death that interfere with the ability to grieve (Cohen et al., 2002). People may experience trauma reminders, which remind them that death is traumatic; loss reminders—thoughts, memories, or people that are reminders of the deceased; or change reminders, which remind the person of changes that have taken place as a result of the death. All of these lead to intrusive and distressing thoughts, memories, and images about the trauma (Cohen et al., 2002). These trauma-related thoughts then prompt the person to experience physiological reactions and extreme psychological distress similar to those experienced during the original loss (Cohen et al., 2002). Individuals with CG may use avoidance and numbing strategies to protect themselves against unpleasant feelings associated with the death. As a result, these individuals are overwhelmed and cannot become reconciled to the loss (Brown & Goodman, 2005). Essentially, complicated grievers get “stuck” in the course of their grief, concentrating on the traumatic aspects of the death and unable to proceed through the normal bereavement process.

Symptoms. Although mental health experts continue to analyze how CG symptoms differ from normal grief reactions, signs and symptoms identified as characterizing CG include extreme focus on the loss and reminders of the loved one; intense longing for the deceased; problems accepting the death; numbness or detachment; preoccupation with feelings of sorrow; bitterness about the loss; an inability to enjoy life; depression or deep sadness; difficulty carrying out normal routines; withdrawing from social activities; irritability or agitation; and a lack of trust in others (Mayo Clinic, 2007).

Symptoms associated with traumatic loss have been found to constitute a distinct form of bereavement-related emotional distress independent of bereavement-related depression and anxiety (Boelen et al., 2003). The onset and course of symptoms is important for differentiating CG from the normal grief process and other psychiatric disorders. Though it may be normative for symptoms of posttraumatic stress disorder (PTSD) to arise immediately after a traumatic death, they typically last no longer than a month (Cohen et al., 2002). However, when the grieving individual has difficulty progressing through the normative tasks and cannot positively reminisce or talk about the loved one, it becomes clear that something more clinically significant is causing the interference

(Cohen et al., 2002). The presence of PTSD-like symptoms and their impingement on the ability to fully grieve the loss of a loved one is what makes CG unique (Cohen et al., 2004).

Characteristic trauma symptoms present in CG resemble symptoms of acute stress disorder and PTSD: intrusive and distressing thoughts, memories, and images about the trauma; exaggerated avoidance symptoms; and traumatic estrangement (Parkes, Relf, & Couldrick, 1996). The trauma-related thoughts then prompt the person to experience physiological reactions and extreme psychological distress (Cohen et al., 2002; Goodman, Cohen, Epstein, et al., 2004). For people with CG, reminders of trauma, loss, and recent changes cause emotional numbing and avoidance, whereas such reminders facilitate the healing process for those whose bereavement is uncomplicated.

Complicated or pathological grief reactions are maladaptive extensions of normal bereavement. Maladaptive reactions may overlap with symptoms of other psychiatric disorders and typically require more complex, multimodal therapies than do uncomplicated grief reactions (National Cancer Institute, 2008). Adjustment disorders (especially depressed and anxious mood or disturbance of emotions and conduct); major depression; and substance abuse are among the more common psychiatric sequelae of CG (Rando, 1993).

Diagnosis. In recent years CG has been the topic of several studies (Cohen et al., 2002); the findings suggest that if not treated appropriately the condition may cause negative long-term mental health consequences (Melhem, Day, Shear, Day, Reynolds, & Brent, 2004). As a result, researchers are making attempts to define CG, understand its relation to various adaptive responses and desired mental health outcomes, and identify efficacious interventions (Brown & Goodman, 2005).

Although mental health providers do not yet recognize CG as an actual disorder, there is a growing consensus that it should be included in the DSM, and some researchers have proposed specific diagnostic criteria (Forstmaier & Maercker, 2007; Horowitz, Siegel, Holen, Bonanno, Milbrath, & Stinson, 2003). Prigerson and Jacobs (2001) posit that CG is distinguishable from other disorders currently covered by the DSM-IV-TR by features of separation distress as well as traumatic distress. Separation distress refers to a preoccupation with the deceased accompanied by cognitions and behaviors such as longing and searching; traumatic distress is a feeling of disbelief coupled with mistrust, anger, and other symptoms resulting in clinically significant impairment.

Horowitz and colleagues (2003) contend that the symptoms of some CG reactions differ from the DSM-IV-TR criteria for major depressive disorder. Hence, they suggest such diagnostic criteria as experience of intense intrusive thoughts, pangs of severe emotion, distressing yearnings, feelings of extreme emptiness and loneliness, excessive avoidance of tasks reminiscent of the

deceased, unusual sleep disturbances, and significant loss of interest in activities more than a year after the loss. Symptoms must last at least six months and disrupt daily functioning.

Most recently, Prigerson, Vanderwerker, and Maciejewski (2008) presented a case for changing the terminology from CG to PGD. In addition to proposing specific diagnostic criteria, the authors present descriptive features, risk factors, outcomes, and differential diagnoses for PGD. Clearly, the development of specific diagnostic criteria for CG is an important direction for future research.

Treatment. Given that as yet there are no consistent definition and specific diagnostic criteria for CG, few randomized trials for treating it have been conducted. Studies testing various types of treatment have had mixed results; additional research is needed to help determine which treatment options may be best (Piper, Ogrodniczuk, Joyce, & Weideman, 2009).

Shear, Frank, Houck, and Reynolds (2005) conducted a randomized controlled trial with adults to compare the efficacy of a novel approach, complicated grief treatment (CGT), with interpersonal therapy (IPT), a standard psychotherapy. CGT specifically addresses trauma symptoms and combines loss-focused cognitive-behavioral techniques with restoration-focused IPT strategies. Both treatments produced improvement in CG symptoms, although CGT demonstrated higher response rates and faster time to response.

Some studies have also examined the use of cognitive-behavioral therapy (CBT; Boelen, de Keijser, van den Hout, & van den Bout, 2007; De Groot et al., 2007). CBT has been used to treat a variety of psychiatric conditions, and recently treatment models have also been extended to address aspects of adjustment to grief and loss (Mathews & Marwit, 2004). CBT helps bereaved individuals identify and change maladaptive cognitions and behavior patterns, which researchers suggest are at the core of traumatic grief.

Other forms of therapy, such as IPT, may also be effective (Klerman et al., 1984). Although IPT was originally designed as a short-term therapy for depression, the foci of grief and role transitions seem particularly relevant for bereaved individuals with depressive symptoms (Miller et al., 1994). Grief is typically the most common problem area focused on when addressing the loss of a loved one, although it may be necessary to examine other areas to determine how they might be influencing management of the client's grief reactions (Miller et al., 1994). As noted, researchers have demonstrated the usefulness of incorporating IPT strategies into CG treatment (Shear et al., 2005).

Researchers have also examined effective treatments specifically for bereaved children. According to Stubenbort and Cohen (2006), treating children who have CG requires treatment of both trauma and grief symptoms. Similarly, successful outcomes are associated with bringing surviving family members into the treatment process. Additional studies are needed to examine

the appropriateness of current options for treating grieving individuals, including children, who present with CG symptoms.

Bereavement and grieving are considered normal processes when an individual is coping with a major loss (APA, 2000). As noted, grief reactions may vary as a result of factors such as culture, age, and time since loss. Although grieving individuals experience a period of significant emotional distress after a loved one dies, usually the ability to engage in new interests, pleasurable activities, and healthy relationships will eventually return (Tomita & Kitamura, 2002). In some cases, however, grief reactions are more chronic and long-standing, resulting in clinically significant impairment in social, occupational, or other major areas of functioning. Such CG needs significantly more examination by clinicians and researchers if the nature of this disorder and its treatment are to be fully understood.

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