"Special issue on bereavement: Contemporary scientific perspectives for researchers and practitioners"

Zech, Emmanuelle ; Stroebe, Margaret S
BEREAVEMENT: CONTEMPORARY SCIENTIFIC PERSPECTIVES FOR RESEARCHERS AND PRACTITIONERS

Emmanuelle ZECH & Margaret STROEBE
Université catholique de Louvain & University of Utrecht, The Netherlands

The death rate within the European Union is 9.6/1000, which is about the same as it is in North America (8.4 for 2009 in the United States of America, see CIA World Factbook, 2010). In concrete terms, this means that about 100,000 of the total population of 10 million Belgian people die each year (in fact, the death rate in Belgium is a bit higher, 10.5/1000). The 2001 Belgian Health Interview Survey indicated that the relationship or social support network of Belgian citizens is composed of a mean number of 9 persons (Gisle, Buziarsist, Van der Heyden, Demarest, Miermans, Sartor et al., 2002). As a consequence, a rough estimation of the number of persons who become bereaved each year in Belgium is 945,000 (i.e., 9.5% of the Belgian population). In fact, the death of a loved one is an experience that occurs sometime or other in nearly everyone’s life. Many of us will suffer multiple losses long before we reach old age, when such events occur with increasing frequency. We will lose our grandparents, parents, siblings, or close friends and romantic partners through death. Bereavement is a very frequent phenomenon, and as the contributions to this Special Issue will make amply clear, it is a personally impactful life event for most people.

Before presenting this Special Issue, it is useful to distinguish and define some basic terms and concepts that pertain to this area of research. In English, bereavement refers to the objective situation of having lost someone significant through death. Bereavement leads to two types of reactions: grief and mourning reactions. Grief refers to the emotional response to one’s loss. It involves psychological (behavioural, cognitive-experiential, social) as well as physical (physiological, immunological, and somatic) responses that have widely been described in the literature (e.g., Shuchter & Zisook, 1993; Stroebe & Stroebe, 1987). The term mourning denotes the actions and manner of expressing grief, the public display of grief, which often reflect the mourning practices or rituals.
of one’s culture (for a review, see Parkes, Laungani, & Young, 1997). In the psychoanalytic tradition, mourning has also been used interchangeably with grief.

Although bereavement is a frequently encountered situation, it has costs that are intrinsically related to the need to affiliate and relate to other human beings. These costs can be said to be developmentally determined. Indeed, the survival of human beings depends on attachment processes that take place between the infants and their caregivers, mostly their parents (Archer, 2001). Infants would not survive if they were not taken care of and loved and if they were not displaying signs of distress when in danger and separated from their caregivers. Attachment processes thus bear a fundamental survival value. However, the benefits and adaptive value of attachment lead one to have costs when definitive or irrevocable loss arises (Bowlby, 1980). In evolutionary terms, grief reactions represent the necessary costs of the adaptive separation reaction (Bowlby, 1980). “Grief is a cost incurred in pursuit of something that has an important adaptive consequence” (Archer, 2001, p. 268).

The purpose of this Special Issue is to provide not only researchers across different areas of psychology and related disciplines but also practitioners and clinicians with a number of key scientific contributions to enable them to consolidate or extend their knowledge of contemporary bereavement research. This kind of research overview has been lacking in the literature available in Belgium and surrounding European countries. So far, scientific information on bereavement has mainly been available in American journals, which are not so easily accessible in these countries and which are also spread across diverse sources (e.g., Death Studies, Omega, Journal of Loss and Trauma). Thus, the first purpose of this special issue is to make a selection of this rich body of literature easily available. Psychologica Belgica represented a good outlet since it has now become electronically accessible free of charge by Academia Press on the Ingenta website.

The second purpose of this Special Issue on bereavement is to reach researchers and health care professionals alike. The contributions represent state-of-the-art knowledge about the manifestations and phenomena associated with bereavement as well as intervention guidelines with bereaved people. Persons of top international repute were asked to contribute and the range of topics is significantly different from other recent reviews such as the 2008 Handbook of Bereavement published by the American Psychological Association (Stroebe, Hansson, Schut, & Stroebe, 2008). To this end, this issue includes 7 articles which address questions of major scientific interest and relevance to contemporary society. Articles either review the literature, presenting a synthesis of advances on a specific topic, or they present new research findings. As will become evident, contributors present many novel and challenging ideas based on their scientific reviews and empirical research within the bereavement field.
The issue is divided into two parts. The first deals with the manifestations of grief and the second deals with adjustment and addresses matters related more directly to coping and interventions for the bereaved.

Part I. Manifestations of grief: scientific understandings

As indicated above, in this first part, a major aim is to illustrate the scope of research on phenomena and manifestations associated with the loss of a loved person. The first article is by the well-known pioneer and leading scholar in bereavement research, the English psychiatrist Colin Murray Parkes. He provides a comprehensive historical overview of the way grief has been conceived over time, as well as tracing back the origin of contemporary bereavement research, theory, and intervention. This contribution provides the reader with an overview on how grief is conceptualised, and how different areas, such as the research field on stress and trauma, have fuelled and are still fuelling contemporary views on bereavement. Parkes stresses the fundamental role of attachment security and bonding in responses to bereavement. He calls for a less prejudiced view on mental illness and thus of conceptions of pathological reactions (e.g., “Prolonged Grief Disorder”) and calls for a society where each bereaved person can receive the right help and support, be it – if necessary (most bereaved people adjust without formal or professional help) – through volunteer counselling and support, recently-developed internet-based interventions, or face-to-face professional grief treatment.

In the second paper, the German psychologists Birgit Wagner and Andreas Maercker address the important question of the distinction between normal and pathological grief reactions and the question of whether a new diagnostic category of pathological grief reactions (called Complicated or Prolonged Grief Disorder, CG or PGD) should be included in the next edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). They provide a critical appraisal of the literature and overview of the challenges that such an inclusion entails. In doing so, they review the complex issues raised by this proposed new diagnostic category, including conceptual matters (What is pathological grief? Should it be defined as a set of prolonged and intense or chronic reactions? How can one distinguish between trauma and bereavement?) and methodological questions relating to the validation of the diagnosis (e.g., the inclusion or exclusion of avoidance and sleep disturbances as diagnostic criteria). They also stress the importance of considering the bereaved person’s past and present relationship or attachment to the deceased in conceptualising and intervening with bereaved individuals. They call for more research before the inclusion of this diagnostic category in the DSM, because too many important issues remain to be answered.
In answer to the need for better conceptualisation and finer-grained understanding of PGD, the Dutch psychologists Paul Boelen and Jan van den Bout have conducted extensive research and here provide a unique perspective on the importance of distinguishing between anxious and depressive avoidance of grief and their causal relationships in the development and maintenance of PGD. They show that the avoidance of confrontation with the reality of the loss (anxious avoidance) and the avoidance of engaging in activities that could foster adjustment (depressive avoidance) both play a role in mediating the effects between personality variables such as neuroticism and attachment insecurity on grief outcomes. This cognitive-behavioural perspective enables them to develop intervention guidelines for countering the avoidance that may be responsible for PGD.

Shifting the focus from close personal losses (e.g., those within one’s family and friendship circle) to those in professional settings, the fourth contribution to this special issue provides a novel, contemporary perspective focusing on professionals. Janice Genevro and Therese Miller, two American researchers, address whether the death of a patient in health care settings (i.e., hospitals) leads to emotional reactions among health care professionals. They then go on to review whether the impact of death of patients could have economic costs for the health care system. This is particularly relevant for health care policy makers and persons who would like to provide the best quality end-of-life care, considering how limited health care resources are and how these demands will increase as populations become older. Since this is a new topic that has rarely been investigated, they then propose a theoretical framework that allows one to address these questions systematically in forthcoming research.

Part II. Adjustment to bereavement: coping and interventions

While the first part of this Special Issue includes a variety of approaches to understanding grief and grieving, the second part turns to issues relating to how people deal with bereavement, and the role of others (including professionals) in the process of adjusting to a personal loss. The fifth manuscript, by Henk Schut and Margaret Stroebe from the University of Utrecht, The Netherlands, examines whether bereaved individuals can be helped by others. For the first time, their review of the literature addresses this question before as well as after the loss of a loved one. It covers the provision of help by professionals (or trained volunteers) as well as natural social support networks (e.g., family members and friends). Schut and Stroebe conclude that most bereaved persons manage to adjust to their loss in the course of time – albeit frequently with considerable suffering – without intervention beyond
that provided within their own informal network. Therapeutic interventions provided to specifically-targeted, high-risk groups, such as those presenting complicated grief reactions, have proven more effective than those open to all bereaved persons. They conclude that further research addressing moderators and mediators underlying the efficacy of intervention should be conducted, particularly since “one size does not fit all”.

This conclusion fits well with the next manuscript by Emmanuelle Zech, Anne-Sophie Ryckebosch, and Emily Delespaux from the Université catholique de Louvain, Belgium, who address the question why therapeutic interventions for the bereaved are not as effective as one could expect. They propose a number of reasons for this, relating to the fact that help is sometimes given to those who do not need and will not benefit from it; to the use of inappropriate types of intervention; to giving too much or too little intervention; or to the incorrect timing of intervention. Furthermore, in contrast to previous analyses which have focused on the difficulties or symptoms which bereaved clients present, they propose that effective intervention requires identifying and working on underlying processes that cause or maintain the difficulties presented by the bereaved person. A fundamental message is that bereaved people need to get individualised intervention that will address these specific emotional, cognitive, existential, and affective processes. They also stress the importance of flexibility on the part of the therapist and thus the role of the therapeutic relationship in helping bereaved individuals cope with their difficult grief.

Finally, Lawrence Calhoun, Richard Tedeschi, Arnie Cann, and Emily Hanks of the University of North Carolina, U.S.A., provide a different approach from the one usually taken by behavioural scientists of the 20th century. Investigators in the past typically focused on the negative psychological consequences of bereavement. By contrast, Calhoun and his colleagues address positive aspects associated with bereavement. They argue the need to pay more attention to positive changes such as personal or “posttraumatic” growth that occur during bereavement for many bereaved individuals. They show that, because the loss of a significant other can challenge the individual’s assumptive world, the struggle with negative responses can also lead to positive changes in self-perception, in relationships with other persons, in new possibilities, in appreciation of life, and in existential meaning making. They also propose a model that addresses the shattered assumptive beliefs and distinguishes between deliberate and intrusive ruminations. The model of intervention that they propose can guide clinical work with bereaved individuals. They suggest that the therapist adopts the role of “expert companion”, focusing on the reconstruction of the client’s beliefs, sense of meaning and life narrative. This approach integrates cognitive, humanistic-existential and narrative-constructionist approaches.
Taken together, we hope that these seven contributions to our Special Issue give a sense of the exciting lines of research that are currently being conducted, as well as an indication how this scholarship is embedded in historical context. It can also hopefully be seen how the results and conclusions reported by the authors of this volume will lead to an accumulation of further knowledge about bereavement, grief, and mourning across forthcoming decades of the 21st century. Furthermore, we hope that the link with practice has become amply clear, that it is evident how scientific analysis not only of the manifestations and phenomena of bereavement, but also of ways of coping and possibilities for intervention, will enable better understanding and support for those who have lost a loved one. For ultimately, a major goal of bereavement researchers and practitioners alike must be to understand and, where possible, to ease the suffering of bereaved persons.

References


GRIEF: LESSONS FROM THE PAST, VISIONS FOR THE FUTURE

Colin Murray PARKES  
St Christopher’s Hospice, Sydenham, UK

Over the last millennium patterns of mortality have changed and have determined who grieves and how. At all times grief has been recognised as a threat to physical and mental health. More recently the scientific study of bereavement has enabled us to quantify such effects and to develop theoretical explanations for them. This paper reviews our evolving understanding of grief, focusing especially on the developments in research, theory and practice that have taken place during the twentieth century. Wars and similar conflicts are associated with repression of grief but methods of helping by facilitating its expression, which were introduced during the two World Wars are less needed and effective at other times. In recent years more attention has been paid to the social context in which grief arises and, particularly, to the nature of the attachments which precede and influence the reaction to bereavement and to other traumatic life events. At the same time a range of caring resources have become available and acceptable to bereaved people and the results of scientific evaluation of these give promise that we are moving towards an era in which more sensitive and appropriate care will be provided to the bereaved by both voluntary and professional caregivers.

Grief in the last millennium

Written over a millennium ago, the poem ‘Beowulf’ records the reaction of his subjects to the death of the hero/king, Beowulf, who died of wounds after slaying the Firedrake, a dragon 50 feet long.

“The people of the Geats then made ready for him on the ground, a firm-built funeral pyre, hung round with helmets, battle shields, bright corselets as he had bid them do. Then mighty men, lamenting, laid in its midst the famous prince, their beloved lord. …the roaring flame mingled with the sound of weeping. Depressed in soul, they uttered forth their misery, and mourned their lord’s death… Heaven swallowed up the smoke.

Then the people of the Geats raised a mound upon the cliff, which was high and broad and visible from far by voyagers on sea… the warriors, brave in battle, …rode round the barrow; they would lament their loss, mourn for their king, utter a dirge and speak about their hero. They reverenced his man-
liness, extolled highly his deeds of valour – so it is meet that man should praise his friend and lord in words, and cherish him in heart when he must needs be led forth from the body” (Hall, 1950).

It seems that, in the late 8th century, even warriors could cry when their great chief died and that it was seen as right and proper for them to talk of him and praise his great deeds. Many barrows were raised in Britain above the dead to ensure that they were not forgotten.

Of course, this was the privilege of the great and important dead. Humble folk had humble graves then, as they do now. We tend to think of it as normal to die in old age, but the first millennium was a time of strife and early death. Few people survived to old age and the greatest mortality was in the first year of life. This melancholy fact remained true until the last hundred years in the West and is still the case in the so-called Third World. During most of the millennium many deaths took place in infancy and it was sometimes said that you were not a woman until you had lost your first child. In this day and age the death of a child is recognised as one of the most traumatic experiences and we all view the very thought with horror.

Were our predecessors psychologically scarred by all these horrors? I think not. Very little was written about the death of children and essayists, such as Montaigne (1603), in 1580, can write “I have lost two or three children in their infancy, not without regret, but without great sorrow”. One is reminded of the recent research of Nancy Sheper-Hughes (1992) among the poor people of North-East Brazil, where the infant mortality rate is still very high. She entitles her book *Death Without Weeping* and records her own sense of shock when, in great distress, she told a mother that the baby she had been taking to hospital had died. The mother, surprised at her distress, reassured her “It’s only a baby!”. In such cases there is no funeral. The baby is entrusted to a procession of children who carry the body to the cemetery for burial. It is believed that the souls of dead babies are immediately promoted to become cherubs in heaven and it is they who welcome their mother when she comes to join them. Some mothers boast of the number of cherubs they have contributed.

But we would be wrong to assume that the deaths of infants inoculated people against the effects of other griefs. There is plenty of evidence that other types of bereavement, including the death of older children, could have devastating effects. Montaigne (1603) also describes the reaction of John, King of Hungaria, to the death of his son: “He only, without framing word or closing his eyes, but earnestly viewing the dead body of his son, stood still upright, till the vehemence of his sad sorrow, having suppressed and choked his vital spirits, fell’d him stark dead to the ground”.

The idea that you can die of a broken heart goes back to Biblical times and we find ‘griefe’ listed as a cause of death in Heberden’s (1657) statistics of
causes of death for the city of London in 1657. But it was not until my own statistical study with Benjamin and Fitzgerald was published in 1969 that clear evidence of an increased mortality rate from heart disease was found among widowers during the first year of bereavement (Parkes, Benjamin, & Fitzgerald, 1969). Since then several other studies have confirmed the finding and indicate that men are more likely than women to die of a ‘broken heart’.

In 1621, when Robert Burton published his influential *Anatomy of Melancholy*, he adopted the classical humoral system which attributed Depression or ‘Melancholy’ to an excess of ‘Black Bile’. But the flow of bile could also be caused by grief and Burton (1621) describes grief or sorrow as “The epitome, symptome and chief cause of melancholy”. In this he preceded Freud and Lindemann by 200 years.

Vogther in Altdorf (1703) published a Ph D thesis entitled *De Morbis Morerentium*, which translates as ‘The Illnesses of Grief’ or, to use modern language, ‘Pathological Grief Reactions’. He lists a number of prescriptions for grief. It seems that the idea that bereavement can cause mental illness goes back a long way.

Coming closer to the present day, in 1835 we find the American physician Benjamin Rush, one of the signatories to the Declaration of Independence, describing dissection of the body of persons who had died of grief. He found “Inflammation of the heart, with rupture of its auricles and ventricles” (Rush, 1835). This alarming finding caused him to recommend that “Persons afflicted with grief should be carried from the room in which their relatives have died, nor should they ever see their bodies afterwards.” He went on to prescribe “liberal doses of opium”.

Rush’s recommendations do not seem to have deterred bereaved people from adopting ever more flamboyant customs of mourning during Queen Victoria’s reign. In 1853 there were no less than four ‘Mourning Warehouses’ in London’s Regent Street (Morley, 1971, p. 73). Victoria’s own grief for the death of her husband Prince Albert was severe and protracted.

### Grief in the twentieth century

According to Geoffrey Gorer (1965), it was the rising death rate in the trenches during the first World War that put paid to shows of mourning. By the time the war ended the ‘stiff upper lip’ had become the ideal and grief was under firm control. Repression of grief is not uncommon among warriors and other people at time of war.

And so we come to Sigmund Freud, whose classical paper, ‘Mourning and Melancholia’, written in 1917, proposed that grieving or ‘mourning’, as it was inaccurately translated, is a job of work in the course of which emotional en-
ergy, or libido, is withdrawn from a loved person before it can be re-directed elsewhere. “When the work of mourning is completed,” he wrote, “the ego can become free and uninhibited again.” He also compared grief to clinical depression, or ‘melancholia’, and suggested that, although depression resembles grief, its causes are symbolic rather than real losses and that their roots are to be found in earlier traumatic experiences (Freud, 1953).

Freud’s paper had much influence on the psycho-analytic theory of depression but it was not until the end of the second World War that its relevance for bereavement was given further attention. At this time two important papers were written. The first, in 1944 by Eric Lindemann, described ‘The Symptomatology and Management of Acute Grief’ and provided a clear account of the reaction to bereavement, its short-term course and the treatment of the problems that arise when it is delayed or distorted. Lindemann was a psycho-analyst and he found confirmation in his work with bereaved people for Freud’s theory of repression. In his view “The essential task of the psychiatrist is that of sharing the patient’s grief work.” This, he claimed, could be done in 8-10 interviews. He also acknowledged the possibility that this work could be done by non-psychiatrists and, in doing so, sewed the seeds of bereavement counselling (Lindemann, 1944).

Lindemann’s approach led to great enthusiasm for Bereavement Counselling, most of it based on the naïve assumption that all the counsellor needed to do was to encourage the bereaved person to express grief, or ‘do the grief work’. In recent years, however, a number of random allocation studies have shown that most bereaved people do not need and will not benefit from such counselling (Currier, Holland, & Neimeyer, 2007; Forte, Hill, Pazder, & Feudtner, 2004; Schut, Stroebe, van den Bout, & Terheggen, 2001). Fortunately they also show that, for the minority who are at special risk, appropriate interventions can be successful.

From the outset it was apparent that there were limitations to Lindemann’s theory. In 1949 Anderson, in the UK, published an account of the psychiatric consequences of bereavement in which he described a type of problem that had not been given weight by Lindemann and which was not so easily explained. This was the Prolonged Grief Disorder (PGD) and it was, and remains, the most frequent diagnosis among people seeking psychiatric help. People with PGD do not show any signs of repressing their grief, rather they grieve intensely from the start and continued to do so long after they are expected to stop grieving. Anderson’s work did not have the same impact as Lindemann’s, perhaps because it did not come up with a simple solution to the problem.

Lindemann’s work triggered a great deal of interest in the topic of bereavement, which has continued to this day. Any attempt to summarise the research that has followed must pick and choose between a large number of
contenders and I apologise if my own review is highly selective and misses out your favourite paper.

My own interest in the subject arose when, as a trainee psychiatrist, I met two people who had been admitted to the Maudsley Hospital for treatment of depression following bereavement. Reading what literature there was on the subject alerted me to the possibility that the study of bereavement might make a useful contribution, not only to our understanding of bereavement but of the many other stresses that contribute to cause mental illness.

My first study was focused on people seeking psychiatric help after bereavement and was published in 1965. It showed that bereavement could trigger a wide range of psychiatric disorders, of which affective disorders were the most frequent. It also showed that a minority of these patients were suffering from the forms of pathological grief which had been described by Lindemann and by Anderson. It confirmed Anderson’s claim that PGD was more frequent than delayed grief.

Part of the problem faced by researchers at this time was the absence of any systematic studies of normal or uncomplicated grief. What was the range of normality, how long did grief last, was there a pattern to it? In 1962 John Bowlby, who was studying the reactions of small children to the experience of separation from their mothers, invited me to join his unit at the Tavistock Institute of Human Relations. Here I was able to study a relatively unselected sample of young women who had lost their husbands through the course of their first year of bereavement.

Robertson and Bowlby (1952) had observed that young children separated from their mothers expressed a distinctive pattern of grieving moving in sequence from a phase of acute Separation Anxiety, in which they cried a great deal, to a period of Disorganisation and Despair to a final phase of Recovery in which they began to reach out to others and make new relationships. I found something very similar in my own study of young widows, the only difference being that many widows reported an initial phase of Blunting or Numbness which preceded the phase of crying and yearning. From the start Bowlby and I recognised that there was a great deal of individual variation in the response to bereavement and that not everybody went through these phases in the same way or at the same speed (Bowlby & Parkes, 1970).

It was in 1964 that I visited the United States for the first time. I had read a paper on ‘The Dying Patient’s Grief’ by Prof. Knight Aldrich (1963) in Chicago and he invited me to speak about my own studies of bereavement at Billing’s Hospital. Here I met a remarkable young trainee working, in his department, on the problems of cancer patients. Her name was Elizabeth Kubler Ross and she subsequently adapted Robertson, Bowlby and Parkes’s (Bowlby & Parkes, 1970; Robertson & Bowlby, 1952) Phases of Grief to describe the Phases of Dying (Ross, 1970). I mention this because Kubler Ross has some-
times been credited with discovering the Phases of Grief as well as the Phases of Dying. Both of these concepts have subsequently given rise to a fair amount of controversy and several alternative models have been described.

While working at the Tavistock I had met Gerald Caplan who played a large part in the development of Community Psychiatry in the USA. His name is associated with Crisis Theory and he was a friend and colleague of Eric Lindemann. Gerald invited me to join his unit at Harvard for a year in order to direct the Harvard Bereavement Project. This was a systematic short longitudinal study of unselected widows and widowers over the first four years of their bereavement. Its aim was to discover why some people did well after bereavement and came through without the need for help from outside their families while others did not. It enabled us to identify risk indicators, which could be used to recognise people before or at the time of a bereavement who were at risk of problems later. We also described the characteristic reactions that followed sudden, unexpected and untimely deaths, the deaths of partners on whom the bereaved person had been very dependent and the conflicted grief of people whose relationships were highly ambivalent (Parkes & Weiss, 1983).

Since that time many other researchers have contributed to our understanding of bereavement risk. The current thinking is summarised in the table below. Of particular note is Doka’s category of Disenfranchised Grief (1989). This arises in situations in which, for various reasons, grief is discouraged and social supports are absent.

Table 1
_Risk factors in bereavement_

<table>
<thead>
<tr>
<th>Mode of Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden or Unexpected Losses for which people are unprepared.</td>
</tr>
<tr>
<td>Multiple Losses.</td>
</tr>
<tr>
<td>Violent or Horrific Losses.</td>
</tr>
<tr>
<td>Losses for which the person feels responsible.</td>
</tr>
<tr>
<td>Losses for which others are seen as responsible.</td>
</tr>
<tr>
<td>Disenfranchised Losses (i.e. losses that cannot be acknowledged or mourned).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal Vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent on Deceased Person (or vice versa).</td>
</tr>
<tr>
<td>Ambivalence to Deceased Person.</td>
</tr>
<tr>
<td>Persons lacking in self-esteem and/or trust in others.</td>
</tr>
<tr>
<td>Persons with previous history of psychological vulnerability.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lack of Social Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family absent or seen as Unsupportive.</td>
</tr>
<tr>
<td>Social Isolation.</td>
</tr>
</tbody>
</table>
While in the USA I received a visit from a physician whom I had previously met in London. She was Cicely Saunders and she brought with her the plans of a new kind of therapeutic community for people with late-stage cancers. I was most impressed by her work and delighted when, in 1966, she invited me to join her in setting up support services for the families of her patients.

St Christopher’s Hospice provided a test bed in which I was able to make use of the findings from the Harvard Study to identify family members at risk and to offer them the help of a carefully trained and selected volunteer counsellor. The idea of sending volunteers into the homes of newly bereaved people proved controversial, even at St Christopher’s. It was only after the suicide of a young widow of one of our patients that I was able to persuade the staff to let me carry out a random-allocation study in order to find out if we were doing good or harm. Fortunately for me the results of this study confirmed the value of our intervention (Parkes, 1981). The effect of the counselling was to improve outcome as measured by a shortened version of the Health Questionnaire used in the Harvard Bereavement Study to about the same level as that of a low risk group who received no counselling. Looked at more closely, it was the males who benefited most significantly from a type of intervention that, at that time, was influenced by Lindemann’s model.

Figure 1

*Outcome study by risk by intervention results of the Harvard Bereavement Study*

*Note.* The score was measured by a shortened version of the Health Questionnaire used in the Harvard Bereavement Study.
None of this work was taking place in a vacuum. A colleague who was also working in Caplan’s unit was David Maddison. He returned from Boston to Australia where he carried out a study of risk factors in bereavement and came up with similar results (Maddison, Viola, & Walker, 1969; Maddison & Walker, 1967). One of his trainees, Beverley Raphael, set up her own Bereavement Service and carried out an evaluation of the effects of intervention in high-risk bereaved people using a very similar method to my own and also with very similar results (Raphael, 1977). The main differences between her study and mine were that we were in different continents and that, in her case, all of the interventions were provided by a highly trained psychiatrist specialising in bereavement problems, herself, whereas mine were provided by volunteers.

Under Raphael’s influence the Australian National Association for Loss and Grief has developed training courses for professionals who provide a high standard of care for bereaved people. In recent years many of these have been employed by firms of funeral directors who are able to offer counselling as part of the package of services provided when somebody dies.

In the UK it is voluntary services for the bereaved that have flourished, some of them linked with Hospices and others based in the community. The best organised of these is Cruse Bereavement Care which has branches in most parts of the UK and which publishes the journal Bereavement Care. This has now become an international journal for all who work with bereaved people. It is published by Routledge on line and in print.

In the USA things seem to have taken a rather different turn. Death education has come to play a major part in the training of the caring professions under the aegis of the Association for Death Education and Counseling (ADEC) and a variety of excellent professional services are now available including some run by funeral directors. The use of trained volunteers is largely confined to hospices and palliative care units but it is mutual help groups that have come to dominate the scene. These owe much to another of Caplan’s protégées, Phyllis Silverman, who has devoted her working life to developing Widow-to-Widow and other projects aimed at bringing bereaved people together (Silverman, 1969). Unfortunately there have been few attempts to demonstrate, by scientific means, the value of this work, and those that have been carried out, such as Mary Vachon’s comparative study, have not shown clear-cut benefits (Vachon, Lyall, Rogers, Freedman, & Freeman, 1980).

Important contributions to teaching have also been made by William Worden whose ‘Tasks of Grieving’ constitute a check-list which has been found very useful by counsellors (Worden, 1982, 4th edition 2009).
Related topics – psychological trauma

While these approaches were being developed other research was taking place which, although not primarily focused on bereavement, has come to overlap with this field and to have triggered important developments. This is the field of stress studies which developed largely independently of the field of loss and grief. There is no space here to go into this in detail but the work of Horowitz and his colleagues in San Francisco, who developed the Impact of Event Scale, has done much to bridge the gap between these overlapping areas of study (Horowitz, 1986; Horowitz, Wilner, & Alvarez, 1979).

A landmark event whose influence is still not fully appreciated was the inclusion of Post-Traumatic Stress Disorder (PTSD) in the 3rd and subsequent editions of the Diagnostic Statistical Manual of Psychiatric Disorders (American Psychiatric Association, 1994). This is the Bible of psychiatric diagnosis and the inclusion of PTSD acknowledged that a particular psychiatric disorder could follow a particular life event. This has opened the door to the possibility that other life events will be recognised as causes of other syndromes.

Raphael and Martinek (1997) and Horowitz, Bonanno, and Holen (1993) have tried to formulate criteria for the diagnosis of pathological grief but the most impressive work in this field stems from Holly Prigerson, Vanderwerker, and Maciejewski (2008) whose systematic studies have established clear diagnostic criteria for Anderson’s Prolonged Grief Disorder (previously known as ‘Chronic Grief’, ‘Traumatic Grief Disorder’ and ‘Complicated Grief Disorder’). The distinctive feature of PGD, which distinguishes it from other disorders, is pining for a person who is lost. This places it in the category of attachment disorders, a concept which owes much to attachment theory.

Note that these criteria allow for the inclusion of grief that has been delayed provided that it then becomes prolonged.

Related topics – attachments

Attachment theory stems from the seminal work of John Bowlby whose magnum opus Attachment and Loss was published in three volumes in 1969, 1973 and 1980. He greatly extended our understanding of the bonds which tie people to each other and of the consequences when separations and losses occur. He highlighted the dangers of separating small children from their mothers and the influence of such separations on later relationships. My own studies have confirmed that high scores of separation in childhood correlate significantly with high anxiety and a tendency to cling after bereavements in adult life (Parkes, 2006). Bowlby formulated the concept of the ‘secure base’. In childhood this is provided, or should be provided, by a secure relationship
with one or both parents and by the familiar home in which the child grows up. Given a secure base children learn to explore their world and cope with the challenges which they meet. Lack of a secure base, however, can give rise to serious problems which interfere with cognitive and emotional development. Bowlby went on to show how therapists and counsellors can provide a secure base within the therapeutic relationship (Bowlby, 1988).

The further development of this field owes much to the American psychologist, Mary Ainsworth. She developed a systematic way of studying the

### Table 2

**Proposed criteria for the diagnosis of Prolonged Grief Disorder in the DSM**  
*Prigerson, Vanderwerker, & Maciejewski, 2008*

<table>
<thead>
<tr>
<th>A. <strong>Event Criterion:</strong></th>
<th>Bereavement (loss of a loved person)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. <strong>Separation Distress:</strong></td>
<td>The bereaved person experiences at least one of the three following symptoms which must be experienced daily or to a distressing or disruptive degree:</td>
</tr>
<tr>
<td>1. Intrusive thoughts related to the lost relationship</td>
<td></td>
</tr>
<tr>
<td>2. Intense feelings of emotional pain, sorrow, or pangs of grief related to the lost relationship</td>
<td></td>
</tr>
<tr>
<td>3. Yearning for the lost person</td>
<td></td>
</tr>
<tr>
<td>C. <strong>Cognitive, Emotional, and Behavioural Symptoms:</strong></td>
<td></td>
</tr>
<tr>
<td>The bereaved person must have five (or more) of the following symptoms:</td>
<td></td>
</tr>
<tr>
<td>1. Confusion about one’s role in life or diminished sense of self (i.e., feeling that a part of oneself has died)</td>
<td></td>
</tr>
<tr>
<td>2. Difficulty accepting the loss</td>
<td></td>
</tr>
<tr>
<td>3. Avoidance of reminders of the reality of the loss</td>
<td></td>
</tr>
<tr>
<td>4. Inability to trust others since the loss</td>
<td></td>
</tr>
<tr>
<td>5. Bitterness or anger related to the loss</td>
<td></td>
</tr>
<tr>
<td>6. Difficulty moving on with life (e.g., making new friends, pursuing interests)</td>
<td></td>
</tr>
<tr>
<td>7. Numbness (absence of emotion) since the loss</td>
<td></td>
</tr>
<tr>
<td>8. Feeling that life is unfulfilling, empty, and meaningless since the loss</td>
<td></td>
</tr>
<tr>
<td>9. Feeling stunned, dazed or shocked by the loss</td>
<td></td>
</tr>
<tr>
<td>D. <strong>Duration:</strong></td>
<td>Duration at least six months from the onset of separation distress</td>
</tr>
<tr>
<td>E. <strong>Impairment:</strong></td>
<td>The above symptomatic disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (e.g., domestic responsibilities)</td>
</tr>
<tr>
<td>F. <strong>Medical Exclusion:</strong></td>
<td>The disturbance is not due to the physiological effects of a substance or a general medical condition</td>
</tr>
<tr>
<td>G. <strong>Relation to Other Mental Disorders:</strong></td>
<td>Not better accounted for by Major Depressive Disorder, Generalized Anxiety Disorder, or Posttraumatic Stress Disorder</td>
</tr>
</tbody>
</table>
attachments between parent and child in her Strange Situation Test (Ainsworth, Blehar, Waters, & Wall, 1978). As a result she distinguished between secure and insecure attachments and, with the help of her colleague Mary Main (Main & Hesse, 1990; Main & Solomon, 1990), identified three main types of insecure attachment, the Anxious/ambivalent pattern, Avoidant pattern and Disorganised/disoriented pattern.

Anxious/ambivalent children have anxious, overprotective parents who are insensitive to their needs for autonomy. The children tend to become anxious and clinging. Avoidant children have parents who are intolerant of closeness. They learn to inhibit attachment but their apparent independence masks underlying anxiety. Each of these types of children have learned to cope with their parents, the former by staying close, the latter by keeping their distance. Children in the Disorganised/disoriented category have no such strategies for survival. They grow up in families in which high levels of stress and depression make their parents unpredictable and inconsistent in their parenting. The children grow up unhappy and helpless. These patterns have turned out to be remarkably stable and, indeed, to predict attachment problems later in life.

This work has initiated a lot of new studies in all parts of the world; as a result the field is developing very rapidly. Among other things is the identification of similar categories of attachment in adult life (Bartholomew & Perlman, 1994). My own work in recent years has included an attempt to map out the attachment patterns of people who seek psychiatric help after a bereavement. I have developed a retrospective questionnaire which confirms that people who report having had secure attachments to their parents show less grief and have lower scores on distress than those who have had insecure attachments (Parkes, 2006). Among those with insecure attachments predictions based on attachment theory have mostly been confirmed. To summarise a large number of statistical correlations:

Adults who describe themselves as having been anxious/ambivalent children tended, in later life, to have conflicted relationships with their partners. Following bereavement they suffer protracted grief and a continued tendency to cling. They are most vulnerable to PGD. Adults who, as children, learned to avoid attachments remain aggressive and assertive in adult life. They have difficulty in expressing both affection and grief. Adults who grew up with family rejection, violence, danger and depression describe themselves as deeply unhappy children. They exemplify Main’s disorganised/disoriented pattern of attachment. As adults they lack trust in themselves and others. Under stress they turn in on themselves and may even harm themselves. Following bereavement they become anxious, panicky and/or depressed. They may turn to alcohol for escape. I have dwelt on these findings because I believe that they reconcile some of the arguments that have arisen in recent years between exponents of various approaches to bereavement care.
Attachment theory emphasises the importance of the family as our main source of security and support at times of trouble. Indeed it is the possession of a supportive family that explains why most bereaved people do not need counselling. By the same token, the absence of such support makes bereavement hard to bear. Kissane, McKenzie, Bloch, Moskowitz, and McKenzie (2006) have developed ways of assessing support and a method of intervention that has passed the test of a random allocation study. Their Family-Focused Grief Therapy enables families to resolve conflicts, solve problems and share grief in ways that benefit them all.

Controversies and recent developments

In recent years psychologists and sociologists have challenged several of the assumptions made by the pioneers. Freud’s concept of ‘grief work’ has been questioned by Wortman and Silver (1989) and by the Stroebes (1991). Wortman and Silver based their argument on the observation that people who show the most distress before bereavement are more, not less, distressed afterwards. They equate high initial distress with ‘grief work’. This argument only holds water if we assume that distress is the same thing as ‘grief work’ and that lack of ‘grief work’ is the only or main cause of problems in bereavement. My studies suggest that this type of severe reaction is to be expected in people whose attachments are anxious/ambivalent or disorganised.

More constructive than Wortman and Silver’s approach is the Dual Process Model of Bereavement put forward by the Margaret Stroebe and Henk Schut at the University of Utrecht (1999). They point out that, in the acute phase of grief, people tend to oscillate between the so-called ‘pangs’ of grief, when they are focused on thoughts of loss and pining for the lost person, and periods when they put their grief aside, are less distressed and able to begin to look forward and make plans. They term these loss orientation and restoration orientation. Both facing loss and turning away are appropriate responses so long as they do not last too long. Some people, however, become preoccupied with the loss orientation others with restoration. The former equates with PGD, the latter with avoided or delayed grief (the delayed form of PGD).

This model does seem to correspond reasonably well with the observed evidence and with my own research which, as we have seen, explains why it is that some people find it hard to stop grieving, while others avoid it. In both cases it would seem likely that the provision of a secure base in which people can feel safe enough, either to let go of the person ‘out there’ and move into the restoration mode or to relinquish avoidance and begin to face the pain of loss orientation.

The Dual Process Model also conforms with the findings of another study
by the Utrecht group (Schut, Stroebe, van den Bout, & de Keijser, 1997). They assigned people with problematic bereavements, at random, to one of three groups, an Emotion-focused group which employed Lindemann’s traditional method of helping people to express grief, a Problem-focused group who adopted a more cognitive, forward-looking approach and a third waiting list control group. When all three groups were followed up they found that both of the counselled groups did rather better than the control group. Looking more closely they found that, as in my own study at St Christopher’s Hospice, men, who in most societies are more inclined to avoidance of grief, had responded best to emotion-focused help while women did best with problem-focused help. It is worth noting that, if they had been given a free choice, the men would probably have chosen the problem focus and the women the emotion focus. What our clients want is not necessarily what they need.

Another sacred cow that has come under attack is the concept of stages of grief (Wortman & Silver, 1989). A recent study showed that, although the features described by Bowlby and Parkes tend to peak in the predicted
order, they do not replace each other (Maciejewski, Zhang, Block, & Prigerson, 2007). Many bereaved people accept the reality of loss from the start while others are able to accept the loss as time passes. Yearning is often present from the start and remains prominent while declining over the first year. Numbness is not always present but when present is most pronounced at the outset and declines fairly rapidly thereafter. Anger is less common, it often coexists with yearning. Critics have suggested that it is inappropriate for counsellors to attempt to impose this model on their clients. Each person will grieve in their own way and their own time. I am inclined to agree that the phases have been misused but I think that they served their purpose in providing us with the idea of grief as a process of change through which we need to pass on the way to a new view of the world.

My own studies of the reaction to amputation of a limb (Parkes, 1975) and Fitzgerald’s studies of blindness (Fitzgerald, Ebert, & Chambers, 1987) gave rise to the concept of Psycho-Social Transitions (Parkes, 1996). They showed how people faced with change need to let go of redundant assumptions about the world if they are to learn to live as an amputee or a blind person. The same applies to bereaved people. Many habits of thought and behaviour which depended on the presence of the person now lost have to be given up if we are to find new ways of living in a world without the person who has died.

It is the match between our assumptive world and the world that we meet that gives direction, purpose and meaning to life. After bereavement there arises a disjunction between the world that is and the world that should be. This is experienced as a loss of meaning and recent work has paid attention to the importance of helping bereaved people to discover new meanings as they rebuild their assumptive world. Neimeyer (2000; 2001) speaks of this as a change in the narrative of our lives.

But letting go of obsolete assumptions does not mean forgetting the dead. In fact there are many people who find that they feel closer to the dead person when they give up trying to force them to return ‘out there’. Only then do they realise that there is a literal truth in the saying ‘He (or she) lives on in my memory’. The concept of continuing bonds is a useful one which has been explored by Dennis Klass, Silverman, and Nickman (1996) in the book of that name.

Another contribution to our understanding of Psycho-social Transitions comes from Janoff-Bulman (1992), who points out that the assumptive world includes basic assumptions regarding our security, worth and the protection of others. In her book Shattered Assumptions she described how traumatic life events can easily shatter these assumptions and leave us feeling insecure, unworthy and unprotected. This concept has been found helpful in the understanding of many traumatic stresses (Kauffman, 2002).

One other area of controversy is Engel’s notion of grief as a disease (Engel,
Engel pointed out that grief is a cause of great mental pain, it produces a variety of bodily and psychological symptoms and it interferes with our ability to function effectively. Bereaved people find that their concentration, memory and judgement are impaired and a period of time off work is often needed. These are the criteria normally thought of as evidence of illness. Yet, the consequences of severe grief are not covered by health insurance and bereaved people receive no medical help or legal compensation for the suffering which they undergo.

Most of those who work with bereaved people prefer to reserve the term ‘pathological’ for the minority of bereaved people whose grief fails to follow the course which, in Western society, is regarded as ‘normal’. They see it as unfair to bereaved people to stigmatise them with a psychiatric diagnosis and they see no reason to believe that doctors are the best people to treat grief.

Perhaps the problem lies in our prejudice about mental illness. By excluding grief from our diagnostic categories we may collude with those who see all mental illness as permanent and shameful and, in doing so, we may perpetuate the prejudice. Yet, if we are honest, we should admit that there are times when most of us need to be relieved of our responsibilities, to take a break, unload our problems onto others and even take a drug (such as alcohol) which will relieve some of our feelings of distress.

Given current prejudice, it seems wise to reserve attributions of psychiatric disorder for the minority who meet DSM criteria for psychiatric disorders and, in addition, to include Prigerson’s criteria for PGD.

Contrary to popular belief, most psychiatric disorders respond well to treatment and this includes PGD. A recent random allocation study has shown significant benefits from what Shear, Frank, Houck, and Reynolds (2005) call ‘Complicated Grief Therapy’. They treat people with PGD by focussing attention on the loss and restoration components of grieving, use ‘Revisiting Exercises’ to treat trauma symptoms (including role played conversations with the deceased person), use a ‘memory questionnaire’ to identify positive and negative memories, and ‘Motivational Enhancement Therapy’ to identify goals and monitor progress. Techniques of this kind constitute an amalgam of the emotive and cognitive approaches that are now recognised as most likely to benefit bereaved people.

Visions for the future

So what of the future? It is possible that the inclusion of ‘Prolonged Grief Disorder’ within the orbit of psychiatric diagnosis and its inclusion in the Diagnostic Statistical Manual of the American Psychiatric Association (DSM) will pave the way to a greater recognition of the fact that losses of one sort or
another impair the lives of many of us. By widening the range of mental disorder to include the temporary impairment of function that follows many of the traumatic life situations that we face, we may eventually reduce the stigma. People may come to see grief as an injury for which help may be needed in much the same way that we now view the consequences of a bodily injury.

Regardless of this, in a world in which many people can no longer rely on their own families to provide them with emotional support, non-judgemental acceptance and tolerance, there will continue to be a need for counsellors who will do just that and who understand about grief.

Recent years have seen a steady increase in the numbers of such counsellors and a similar increase in the willingness of bereaved people to seek their help. The internet enables those who prefer to remain anonymous to do so and must create its own safeguards against the unscrupulous minority who abuse it. However some encouraging results are already being obtained from on-line help for people suffering depression, anxiety disorders (Proudfoot, Ryden, Everitt, Shapiro, Goldberg, Mann et al., 2004) and PGD (Wagner, Knaevelsrud, & Maercker, 2006), all of which are common after bereavement. With the rapid deployment of low-cost computers across the world, it seems likely that these will become the most popular sources of help.

Help is needed by people of all races and status but especially by those who are at the bottom of the pile, who are likely to be most at risk and least likely to afford to pay for therapy. Sadly the ‘Inverse Care Law’ currently implies that those in most need of support are least likely to get it.

Paradoxically this also applies to those at the top of the hierarchy. Most support systems work downwards. That is to say, the people at the top of the hierarchy are expected to support those below them. But who supports the people at the top? As attitudes to counselling continue to change we may find that people in positions of power will come to recognise their own needs for support.

Anger, we know, is a part of grieving. It can also bring about cycles of violence, which can become self-perpetuating. How many times in history have terrible deeds been done because people in power were overwhelmed with grief and acted out their rage? How easily a delicate political balance can be destroyed by an act of violence. I have a dream of a cadre of specially-trained ‘counsellors’ whose role would be to monitor the needs of people in positions of leadership, to ensure that they are supported as they struggle to fulfill their roles as leaders at times of crisis. Such counsellors would themselves carry great responsibility and would need to be incorruptible and properly supported.

I am not pessimistic. In my life time I have seen a new science and art of hospice and palliative care arise for families faced with death. I have seen training in bereavement become a part of the curriculum of many doctors and
nurses and, although there has never been enough money to do things in an ideal way, I have seen important progress made whenever people who care have come together to work with each other to achieve change. Above all I have come to respect the potential of the many people who volunteer to help the dying and the bereaved.

Perhaps my most heartening experience was in Rwanda. Visiting that poor country a year after the genocidal killings that devastated that land I had little hope that the small group of psychologists and social workers employed by UNICEF under the leadership of the American psychologist, Leila Gupta, would achieve anything worthwhile. Yet, over the months that followed, that little group recruited and trained groups of volunteer counsellors, those volunteers each went out and trained another group until they had 21,156 teachers, caregivers, social workers, community and religious leaders, health workers and local associations who reached out and supported over 200,000 children and surviving families (Gupta, 2000). If anything can break the cycle of violence and restore peace in Rwanda and elsewhere it must be ventures of this kind.

So my vision for the future is of a world where Beowulf’s dragons are extinct; no-one needs to resort to terrorism or violence to assuage their grief; where the global village, with all its soap operas and other trivia, brings everyone who needs it within reach of proper and effective help; where parents as well as children, leaders as well as followers, receive the cherishing and support that they need; where the griefs that are a necessary part of life are recognised as such and those who suffer them receive understanding and wise counsel.

References


Maddison, D.C., & Walker, W.L. (1967). Factors affecting the outcome of conjugal

Main, M., & Hesse, E. (1990). Parents’ unresolved traumatic experiences are related to infant disorganised attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. Greenberg, D. Cicchetti, & M. Cummings (Eds.), *Attachment in the preschool years* (pp. 161-182). Chicago: Chicago University Press.


Vogther, C.B. (1703). *Disputatio de morbis moerentium altdorfii*. (British Library Shelfmark 7306.i.9).


Received October 24, 2008
Revision received December 22, 2008
Accepted February 2, 2009
THE DIAGNOSIS OF COMPLICATED GRIEF AS A MENTAL DISORDER: A CRITICAL APPRAISAL

Birgit WAGNER & Andreas MAERCKER

University Hospital Leipzig, Germany & University of Zurich, Switzerland

In recent years, research on grief complications has focused on the development and validation of Complicated Grief diagnostic criteria for the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Even though research has shown that complicated grief is a disorder distinct from other psychiatric disorders such as PTSD and MDD, there are still concerns about the validation and conceptualisation of the proposed criteria. In this article, we review findings and different concepts with regard to complicated grief. Key issues are the currently proposed diagnostic criteria, differentiation between traumatic and non-traumatic bereavement, and relational aspects of the grief process.

Introduction

Grief reactions following the loss of a significant person often comprise a set of expected negative reactions involving functional impairment. This process can be considered normal, though depression and trauma-related symptoms might occur during this time of adjustment and working through loss. It is therefore difficult to find consensus with regard to the difference between pathological and normal grief reactions. Normal grief reactions include a combination of mostly negative symptoms, e.g., social retreat, crying, and intrusions, which persist for a certain length of time. Distressing moods and confusing thoughts are common during grief. The mourning process will, in most cases, lead to a restored equilibrium. However, in some cases, the grief can become extreme (Horowitz, Siegel, Holen, Bonanno, Milbrath, & Stinson, 2003). As many as 5-15% of bereaved people seem to develop severe long-term reactions to their loss. These severe reactions may lead to impairments on a physical and psychopathological level (Horowitz et al., 2003): the grief is then usually termed Complicated Grief (CG). Various factors, such as the circumstances of the death, relationship to the deceased, access to social support, and mental health state play a large role in impairment after a loss. Research has demonstrated the multidimensionality of grief reactions.
with different types of emotions, cognitive impairment, health problems, and impaired role functioning (Bonanno, Neria, Mancini, Coifman, Litz, & Insel, 2007). Studies have also shown that bereavement is associated with a higher risk of mortality, especially in the period immediately after the loss, and have shown a relation with the use of medical services (Stroebe, Schut, & Stroebe, 2007). Further, these ailments can include interpersonal problems, substance abuse, physical illness, and even death (Lichtenthal, Cruess, & Prigerson, 2004; Stroebe, Schut, & Finkenauer, 2001).

Yet, CG is still not in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the International Classification of Diseases, 10th revision (ICD-10), though there is now one proposal (Prigerson, Horowitz, Jacobs, Parkes, Aslan, Goodkin et al., 2009) for CG (or alternatively ‘prolonged grief disorder’), which has been developed out of two previously proposed sets of diagnostic criteria (Horowitz, Siegel, Holen, Bonanno, Milbrath, & Stinson, 1997; Prigerson, Shear, Jacobs, Reynolds, Maciejewski, Davidson et al., 1999), to be given official recognition in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders. However, there is still some scepticism and critical discussion concerning the validity of diagnostic criteria for CG. Some researchers claim that the current CG criteria are still not scientifically soundly proven (e.g., Hogan, Worden, & Schmidt, 2003). Diagnostic criteria are helpful for the identification of bereaved individuals who are suffering pathological grief reactions, but they should neither exclude too many cases of bereavement complications nor be over-inclusive.

A number of questions arise regarding the specific diagnostic criteria for CG: first of all, on which conceptualisation will the new diagnostic criteria be based? How can the interface of trauma and bereavement be addressed? Will the diagnostic criteria show a cohesive syndrome for all different groups of bereaved people (loss of a child, loss of a spouse, parental loss, loss of significant others, etc)? How could different pathways of complicated bereavement (delayed, intensive or absent) be assessed with the proposed criteria? Another dilemma is the ongoing relationship of the bereaved person to the deceased and the interpersonal aspects of the loss. The assessment of the cognitive-emotional organisation of the relationship to the deceased can give important insights into possible complications in the grief process (Rubin, Malkinson, & Witztum, 2008). And finally, what are the advantages and disadvantages of including CG in the future DSM-V and ICD 11? The multidimensional complexity of these questions poses a challenge for the diagnostic criteria of CG and grief processes.

A number of complex issues are raised by this proposed new diagnosis. In this article we will give an overview of the challenges associated with the evolution of a DSM diagnosis for CG. We will also introduce important conceptualisations of CG and their relevance to diagnostic criteria. Furthermore,
we will present the historical development of two propositions of diagnostic
criteria (Horowitz et al., 1997; Prigerson et al., 1999), out of which one di-
agnostic category has now been developed (Prigerson et al., 2009). Another
important topic will be the relationship between trauma and bereavement and
its implications for criteria of CG. Finally, in an effort to give a widely ne-
glected aspect of complicated grief processes the attention we think it needs,
we review the impact of the continuing relationship to the deceased.

Conceptualisation of complicated grief

The importance of identifying syndrome criteria for CG with acceptable
reliability is evident and could facilitate research in the field of laboratory
studies, family studies and treatment studies. Diagnostic criteria might serve
to identify individuals in need of treatment. The establishment of diagnostic
criteria for CG therefore asks for a ‘gold standard’, which is not only able to
detect those who are not experiencing ‘normal’ grief, but also those who suf-
fer from distinct disorders. Still, bereavement is a normal, non-pathological
phenomenon, which occurs after the loss of a loved one. In order to define
CG, one would need to know what exactly is understood by “normal grief”.
However, it appears nearly impossible to define ‘normal’ grief, as there are
cultural and individual differences in bereavement reactions. There are com-
mon ways of grieving in one culture which do not fit the traditional idea of
bereavement in another culture. Just as it is difficult to define normal grief, so
is it also difficult to define CG (Dijkstra, 2000; Maercker, 2007).

In DSM-IV, a mental disorder is defined as “a clinically significant behav-
iorial or psychological syndrome or pattern that occurs in an individual and
that is associated with present distress or disability or with a significantly
increased risk of suffering death, pain, disability, or an important loss of
freedom. In addition, this syndrome or pattern must not be merely an ex-
pectable and culturally sanctioned response to a particular event, for exam-
ple, the death of a loved one” (American Psychiatric Association, 1994, xxi).
The DSM-IV categorises the death of a significant person as a stressor with
generally normative and predictable consequences. In the current issue of
the coding system of the DSM-IV, bereavement is included among the “ad-
ditional codes” (V codes) and it is conceptualised as a normal phenomenon,
which is culturally varying among different groups (American Psychiatric
Association, 1994, p. 684). The use of the V code also explicitly avoids the
distinction between normal and complicated forms of grieving. Instead, the
DSM-IV provides for the more pathological cases diagnosis in the form of
existing categories, such as Major Depressive Disorder (MDD) or Posttrau-
matic Stress Disorder (PTSD).
Not only are the diagnostic criteria of CG still at a development and research stage, naming the “not normal” grief reactions has also gone through various changes and developments. In the last years, clinicians and researchers have described CG by using many terms and subtypes such as ‘abnormal’, ‘chronic’, ‘morbid’, ‘pathological’, ‘traumatic’ and ‘prolonged’ grief. Recently, two research teams have focused on establishing specific diagnostic criteria for CG (Horowitz, Bonanno, & Holen, 1993; Horowitz et al., 1997; Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka et al., 1995). Although CG was, from 1997 to 2002, referred to as ‘traumatic grief’ by Prigerson and colleagues in the literature, after the events of 9/11 they reverted to CG due to the upcoming misinterpretation of traumatic grief with PTSD (Lichtenthal et al., 2004). Later, Prigerson, Vanderwerker, and Maciejewski (2008) developed new diagnostic criteria named ‘prolonged grief’ (Prigerson et al., 2009; Prigerson et al., 2008). The authors explain this change of terminology by pointing out that complicated is defined as “difficult to analyze, understand and explain” and does not capture the nature of the bereavement syndrome. Instead, the term prolonged seemed to express the nature of the disorder more clearly. However, the authors state that duration is not the main factor of a dysfunctional bereavement (Prigerson et al., 2008). The frequent change of terminology which has taken place in the past years has not been useful for developing standard diagnostic criteria. The lack of consensus regarding specific terminology for the phenomenon of “not normal” grief reactions also mirrors the lack of consensus regarding the conceptualisation of CG. A conceptualisation of CG is needed to understand how bereavement is processed on an individual level. The future diagnostic criteria of CG in the DSM should be based on a clear conceptualisation of complicated grief, because this will have important implications for both diagnosis and treatment. Recently, a number of conceptualisations of CG have been suggested. In the following, we will describe the most relevant conceptualisations which have also partly influenced the current diagnostic criteria proposed by Prigerson et al. (2009).

Horowitz and colleagues (1997) based their conceptualisation of CG on the stress response theory, which views bereavement as a stressful life event. Horowitz (2006) suggested a general change of the DSM categories, in the sense that PTSD should be removed from the category ‘Anxiety Disorders’ and a new category ‘Stress Response Syndromes’ should be created (Horowitz, 2006). These Stress Response Syndromes would include psychiatric disorders that are caused by the experience of stress: PTSD, Adjustment Disorder, Acute Stress Disorder, Stress Induced Psychosomatic Disorder, and Complicated Grief.

Another approach would be to conceptualise CG in terms of depression (Clayton, 1990). The depression model of bereavement defined CG as ‘con-
continued depressive symptom’, which needed to be treated as a depression (Clayton, 1990). However, a number of studies have shown that CG was distinct from depressive disorders: factor analytic studies have shown a significant distinction between grief and MDD or anxiety disorders (Boelen, van den Bout, & de Keijser, 2003; Bonanno et al., 2007). Furthermore, though research has shown that tricyclic antidepressants have proven to be effective in reducing depressive symptoms following the loss of a loved one, they did not prove to be particularly effective in ameliorating symptoms of CG (Reynolds, Miller, Pasternak, Frank, Perel, & Cornes, 1999). These findings are in line with another conceptualisation of CG which was based on the distinctiveness from other disorders (Stroebe, van Son, Stroebe, Kleber, Schut, & van den Bout, 2000). After the death of a significant person, most people experience a wide variety of symptoms, but also meet criteria for disorders such as MDD (Maercker, Forstmeier, Enzler, Krüsi, Hörler, Maier, & Ehlert, 2008; Zisook, Shuchter, Sledge, Paulus, & Judd, 1994), PTSD (Schut, de Keijser, Bout, & Dijkhuis, 1991) and other anxiety disorders (Jacobs, Hansen, Kasl, Ostfeld, Berkman, & Kim, 1990). Therefore, CG had often been subsumed under other disorders, even though bereavement, depression or trauma did not always overlap, and the unique symptoms of CG (i.e., strong yearning for the deceased) were not captured by the symptom criteria of these disorders (see Lichtenthal et al., 2004). The high comorbidity with these disorders added to the considerable confusion over the precise nature of symptoms that constituted a CG reaction.

An additional conceptualisation of CG was the focus on relational aspects of bereavement (Rubin et al., 2008). The cognitive-emotional organisation of the relationship to the deceased plays an important role in bereavement dysfunction. Therefore, the evaluation of the nature of the continuing relationship might help to explain the grief process. Because of its high relevance to any treatment and diagnoses of CG, the influence of relational aspects will be described in a later, separate section.

In their overview of conceptualisations of CG, Stroebe and colleagues (2000) described how some experts have identified subtypologies of CG. These subtypologies included delayed, absent, unresolved, and chronic forms of grief. In the earlier proposed diagnostic criteria the research groups of Horowitz and Prigerson (Horowitz et al., 1997; Prigerson et al., 1999) mainly focused on grief processes for which the time spans were too long and too intensive. Aspects of delayed or absent complicated grief reactions were not considered at that time. Further, Stroebe and colleagues (2000) were right in saying that the concentration only on the high intensity of grief reactions as indicator for CG is problematic. Those bereaved individuals who avoid grieving or show delayed grief reactions may mask complications in their grief process. Further, if the complication lies in one specific symptom (e.g.,
yearning, guilt), a checklist might not reflect this problem (Stroebe et al., 2000).

A case of a patient illustrates the problem that complications may be masked: A 76-year-old woman lost her husband five years ago. The couple had a very good and close relationship together and enjoyed each other’s company. The husband then died suddenly of a stroke. The patient was shocked, but organised the funeral and described herself during the immediate period after the loss as sad, though she could not cry at the funeral or afterwards. During the first year and a half, she managed very well, travelled a lot, and often visited her family abroad. On one of these trips, she suddenly became fully aware of the death of her husband and started crying. She felt a strong sense of yearning and physical pain with regard to her deceased husband. Subsequently, she experienced strong longing for her deceased husband, and cried every time uncontrollably when she saw a reminder of him in the house or when she talked about him. Even though she had a functioning social life, she felt deeply saddened as soon as she thought of her husband and started to cry. She did not, however, have any feelings of bitterness or anger, she did not feel numb, she could accept the loss, and she did not avoid reminders of the loss. Not until five years after the death did she start looking for therapy. This case illustrated very clearly two problems of the two current diagnostic criteria. First, the delayed/absent form of grief is not considered in the diagnoses, which might exclude a number of individuals who suffer from pathological grief (we will expand on this below). Second, if an individual suffers only of one or two specific symptoms (e.g., yearning) a diagnosis of CG cannot be made, even though the individual may suffer greatly.

The above example suggests that the subgroups of pathological grief processes (delayed, absent, chronic) would require multiple classifications if they were to be taken into account (Stroebe et al., 2000). However, there is so far very little scientific evidence to support the subtypologies of CG, because only a few studies have been conducted to investigate their relevance. In the most recent classifications of CG there has been a stronger focus on high intensity, chronic or prolonged grief. In conclusion, looking at the various conceptualisations, it becomes obvious that there is little agreement: instead, there is a great diversity of different models of CG. Even though there is growing evidence that CG is a distinct disorder, there is a lack of agreement between different researchers.

Diagnostic criteria for complicated grief

In recent years, a great deal of research has been carried out, mainly by Prigerson and colleagues (e.g., Prigerson & Jacobs, 2001) and Horowitz and
colleagues (e.g., Horowitz et al., 1997), with the aim of defining diagnostic criteria for CG for the following edition of the DSM. In 2009 the research groups of Prigerson and Horowitz joined forces and developed a new diagnostic category, combining both criteria. Before we describe the new proposed criteria (Prigerson et al., 2009) in more detail, we would like to describe the original research work of both groups in order to achieve a better understanding of the historical development of the newly proposed criteria.

Prigerson and colleagues (1995) began to evaluate symptoms of CG empirically after they found a distinct cluster of symptoms which forms a unified component of emotional distress that is clearly different from depression and anxiety (Prigerson, Maciejewski et al., 1995). These results were found in three independent samples of widows and widowers (Prigerson, Frank, Kasl, Reynolds, Anderson, Zubenko et al., 1995; Prigerson, Maciejewski et al., 1995). In 1997, a panel of experts led by the Prigerson research group, met to discuss the advantages and disadvantages of establishing diagnostic criteria, and agreed that there is evidence that CG is a symptom cluster which is distinct from depression and anxiety and which can predict mental and physical impairment. Consensus criteria proposed for CG by Prigerson et al. (1995) were formerly defined in two categories: (a) symptoms of separation distress (i.e., preoccupation with thoughts of the deceased person, longing and searching for the deceased, loneliness after the loss); and (b) symptoms of traumatic distress, such as disbelief about the death; anger and feeling shocked, avoiding reminders of the deceased, feeling purposelessness and futility about the future, feeling that life is empty and unfulfilling without the deceased, having a fragmented sense of trust, security and control (Prigerson & Jacobs, 2001). In a preliminary test of the consensus criteria for CG analyses were conducted on data collected from the San Diego widowhood study (Zisook, Shuchter, & Lyons, 1987) with the Widowhood Questionnaire (Zisook et al., 1987), which covered nearly all the symptoms of the consensus criteria of CG. Receiver operator characteristics (ROC) analyses tested the performance of the proposed criteria on 306 widowed respondents at seven months post-loss with a mean age of 61 years ($SD = 10.4$). Each item was evaluated to determine its ability to identify individuals suffering from true cases of CG. Two items (avoidance and ‘difficulty imagining a fulfilling life without the deceased’) were deleted and the internal consistency coefficient improved after deletion (Prigerson & Jacobs, 2001). Originally, a set of symptoms which persist for more than 2 months were taken to give an appropriate marker for dysfunction; later the duration time of disturbance was increased to 6 months (Latham & Prigerson, 2004). The 6-month duration criterion was chosen because it might more easily distinguish bereaved individuals who are suffering more chronic stress from individuals with more temporary stress.
Based on these diagnostic criteria, a widely utilised assessment tool was developed called the ‘Inventory of Complicated Grief’ (ICG), later renamed the ‘Inventory of Traumatic Grief’ (ICG), and after these changes again to the ‘Inventory of Complicated Grief’ and recently into the ‘Inventory of Prolonged Grief’ – a questionnaire which provides a self-report symptom severity score. The study used to test the consensus criteria (Prigerson & Jacobs, 2001) has a number of limitations, which are important to acknowledge. First, the group of elderly widows and widowers were not entirely random or unbiased: only 34% responded to the initial assessment; people who did not participate might have been more distressed than those who participated. Low mean levels of the proposed symptoms of CG support this case. Second, two thirds of the spouses lost their partner after prolonged illness, which so far has not been identified as a risk factor for CG. Therefore the sample used to base the consensus criteria on might report biased results. The sample is typically associated with comparatively low complications; therefore it probably shows low levels of CG and might thus not be the ideal sample to validate the criteria on.

The diagnostic criteria of Prigerson & Jacobs (2001) caused much discussion. Hogan et al. (2003) conducted a study with bereaved parents using the diagnostic criteria of CG (Prigerson & Jacobs, 2001). Bereaved parents (N = 166), who lost their child through automobile accidents (65%), suicide (15%), homicide (9%), illness (7%) or other (4%) participated in this study (Hogan et al., 2003). The results showed that the basic criteria ‘separation distress’ and ‘traumatic distress’ could not be isolated as distinct constructs in confirmatory factor analyses. The conceptualisation as a diagnostic entity did not provide an adequate fit of the model. Hogan and colleagues (2003) suggested that the separation distress and the traumatic distress criteria needed further investigation and refinement with other samples, which also include subtypes of bereavement (e.g., traumatically bereaved, suicide survivors). This argument is important, because both samples on which the algorithms for complicated grief, respectively prolonged grief, are based on were conducted with elderly widowers and widows. However, a rejoinder was published by Prigerson and Maciejewski (2006), where they claim that the examination of the data by Hogan et al. (2003) had not been carried out in accordance with a fair and unbiased standard.

A second group of researchers (Horowitz et al., 1997) have published parallel criteria for CG disorder (Horowitz et al., 1997), based on stress response theory. According to Horowitz, CG disorder has a generic relationship to PTSD and acute stress disorder (ASD), resulting from exposure to a stressful event. In a 1984 study (Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984), they first showed that symptoms of prolonged grieving resulted in the following symptom cluster: intrusion, avoidance, and failure to adapt to the
loss. Later, Horowitz and colleagues (1997) published criteria for CG disorder and constructed operational definitions of these symptoms. This CG module (Horowitz et al., 1997) comprised of 30 items includes the following symptoms: intrusions (e.g., unbidden memories, frequent reminiscences of life with the deceased), avoidance (e.g., avoiding places that evoke the deceased) as well as maladaptive behaviour (feeling alone or empty, trouble sleeping). The symptoms should persist longer than 14 months after the loss. In the event of CG, intrusions manifest themselves in the recurrent realisation of the absence of the lost relationship, leaving a painful reminder of the empty space left by the deceased. An additional form of intrusion has also been identified: the bereaved person may wilfully indulge in positive memories and images of the deceased to the extent that it becomes a problem in the process of re-orientation in the present. Therefore, the positive and negative memories and images of the deceased may interfere with assessment of the grief process. Avoidance manifests itself in various ways: staying away from places or people; avoiding talking about the deceased in the family. Finally, the third criterion, namely failure to adapt, may be observed in feelings of being far too much alone or unusual levels of sleep disturbance. Recent research has found evidence for the stress response operationalization of CG (Langner & Maercker, 2005). Using the stress response model of CG (Horowitz et al., 1997), Langner and Maercker (2005) examined a sample of 75 participants who had lost their children, parents or spouses. The authors could confirm the classification of the symptoms into intrusion, avoidance, and failure-to-adapt categories. ROC analyses indicated high diagnostic accuracy and showed predictive validation to standard measures of distinct disorders and normal grief reactions.

In a joint effort to integrate the previous two approaches, Prigerson and colleagues (2009) determined a new specific algorithm for criteria for Prolonged Grief Disorder (PGD). The main difference to the previous approach by Prigerson et al. (2009) is to include avoidance symptoms in the definition of the disorder. The new criteria involve the experience of yearning and at least 5 of the following 9 symptoms experienced at least daily or to a disturbing degree: avoidance of reality of the loss; emotional numbness; feeling stunned; feeling that life is meaningless; confusion of identity; mistrust; difficulty accepting the loss; bitterness over the loss; and difficulty moving on with life. Symptom disturbance must last at least 6 months from the death and be associated with functional impairment.

The new criteria proposal for PGD still lacks comprehensive validation since it has so far only been tested in a field trial of the Yale Bereavement Study, a study which only included elderly widowed persons. However, any revised version of the diagnostic criteria requires renewed testing with new data and valid inferences across subgroups (e.g., bereaved parents, widows
and widowers, the traumatically bereaved, the elderly), and it is therefore still too early to say if these new and integrated concepts can address the requirements for psychodiagnostic criteria.

**Comparison of the two diagnostic criteria Prigerson and Jacobs (2001) and Horowitz et al. (1997)**

Both Prigerson and Jacobs (2001) and Horowitz et al. (1997) have emphasized the impairment of social functioning, and severe symptoms of separation distress, which Horowitz et al. characterises as intrusive symptoms. The Horowitz group and the consensus panel of experts have proposed a similar set of criteria independently. However, there are differences which are important to acknowledge, such as the symptom of avoidance, sleep disturbances, functional disturbance, and the duration of bereavement. While avoidance is one of the core symptoms of the criteria set of Horowitz et al. (1997), Prigerson and Jacobs (2001) omitted the symptom of avoidance due to low specificity and item-total correlation in order to increase the diagnostic accuracy of the traumatic stress set. Other studies (Raphael & Martinek, 1997) observed that bereaved people wish to avoid reminders of the absence of the deceased person, while people with PTSD avert reminders of the trauma. While some researchers (Kaminer & Lavie, 1993) suggest that avoidance can be an adaptive way of coping with the loss, some theorists (e.g., Horowitz et al., 1993) claim that grief reactions persist if the emotional processing and adjustment is prevented due to avoidance behaviour. The symptom of avoidance can interfere with the integration of the death of a close person into existing schemas and the development of new schemas (Horowitz et al., 1993). Research shows that there is increasing evidence of avoidance processes in CG (Boelen, van den Bout, & van den Hout, 2003; Langner & Maercker, 2005; Schut et al., 1991). Boelen, van den Bout, and de Keijser (2003) evaluated bereaved individuals who had been confronted with the death of a close relative, looking at the role of negative interpretations of grief reactions in emotional problems after bereavement. They reported that avoidance behaviour was significantly related to the severity of CG and depression. The degree to which mourners experienced their grief reactions as distressing influences the degree to which they engage in avoidance strategies that are likely to impede recovery and prolong grief reactions. Therefore, taking the relevance of avoidance behaviour into account, the avoidance item has been added to the algorithm of the new Prolonged Grief Disorder (Prigerson et al., 2009).

Another unique symptom of the diagnostic criteria of Horowitz et al. (1997) is interference with sleep, while sleep disturbances, presumably reflecting hyperarousal, was also omitted from the original consensus criteria (Prigerson et al., 1999). The latter decision was based on a sleep study with
65 recently bereaved people over 60 with varying levels of CG symptoms (McDermott, Prigerson, & Reynolds, 1997). The CG symptoms were associated with mild subjective sleep disturbance but there were no main effects on electroencephalographic (EEG) sleep measures. However, newer studies show that people suffering CG actually show poor sleep quality (Forstmeier & Maercker, 2007; Germain, Caroff, Buysse, & Shear, 2005). In addition to these differences, the two sets of criteria also differ with regard to the time relationship to the death.

Further differences of the two diagnostic criteria could be shown regarding prevalence of CG. In a treatment study for CG (Wagner & Maercker, 2008), in which both diagnostic criteria systems were used (Horowitz et al., 1997; Prigerson & Jacobs, 2001), comparably more patients were diagnosed with CG at pretreatment and posttreatment assessment when the Horowitz Grief Module Scale was applied. Similar findings were found in a study of bereaved family members, who lost a significant person through assisted suicide (Wagner & Maercker, submitted). In this study, 13.4% fulfilled the complicated grief criteria of Horowitz et al. (1997) and 5% met criteria of Prigerson and Jacobs (2001). These findings are in line with results of Forstmeier and Maercker (2007), who assessed the two diagnostic systems in a sample of 570 elderly people using data from the Zurich Older Age Study, and compared the respective findings with regard to prevalence. The prevalence of CG as measured by the two diagnostic systems differed widely: 4.2% (n = 24) when the Horowitz et al. (1997) criteria were applied, and 0.9% (n = 5) when the Prigerson and Jacobs (2001) criteria were applied. There was little overlap: only 0.3% of participants were diagnosed with CG according to both systems. The likelihood of developing CG after experiencing bereavement was 22.2% when the Horowitz et al. (1997) criteria were applied, and 4.6% when the Prigerson and Jacobs (2001) criteria were applied. These findings imply that the Horowitz et al. (1997) criteria are less strict and more inclusive than the Prigerson and Jacobs (2001) criteria. It is therefore vital that clinicians and researchers indicate which diagnostic system they have used. But it also shows clearly that the two criteria sets do not measure the same syndrome criteria. These findings demonstrate the importance that further research and studies are needed to investigate the validity of CG disorder as a diagnosis, and verification of the validity of the diagnostic criteria is warranted before declaring this phenomenon appropriate for inclusion in standardised psychiatric taxonomies.

Trauma and bereavement

A finer-grained consideration of the distinction versus overlap between trauma and bereavement is also essential when considering potential criteria
for complicated grief. The loss of a significant person is by nature a shock- ing and very often traumatic event. One major concern is how to address the overlap between trauma and bereavement. There is bereavement with and without a traumatic experience and trauma with and without a bereavement experience. Additionally, a bereaved individual can suffer after the loss of a significant person from PTSD and CG, or only from CG or only PTSD.

In DSM-IV, an event can be considered traumatic if it includes the experi- encing, or confrontation with actual or threatened death (DSM-IV, APA, 1994, p. 424). Further, the stressor criterion is defined as “learning about unexpected or violent death … experienced by a family member or close associate”. Therefore, witnessing or learning of the death permits the diag- nosis of PTSD because bereavement could be considered a traumatic event. But there are also arguments that bereavements, which occur under normal non-traumatic circumstances, are not necessarily traumatic events (Stroebe & Schut, 2006). For example, Stroebe and Schut stated that an expected and peaceful death of an elderly person should generally not be included in the definition of a traumatic event, though there might be individual cases in which the same situation could be traumatic, for example, for a grandchild.

The interaction between trauma and bereavement has been described in different ways, representing different research interests, in the scientific com- munity (Stroebe et al., 2001). One position focuses on the phenomenology of the bereavement reaction rather than on the type of stressor, and proposes that trauma and bereavement are distinct (Pynoos, Nader, Frederick, Gonda, & Stuber, 1987; Raphael & Martinek, 1997). Other groups suggest that be- reavement should be considered a traumatic event, and that therefore CG can be subsumed under PTSD (Figley, Bride, & Mazza, 1997). Yet another research group proposes that the diagnostic criteria ‘traumatic grief’ should be based on the nature of the death event (Green, 2000; Rando, 2000). The final position is the focus of recent research on CG, which posits that CG can occur as a consequence of both traumatic and nontraumatic bereavement (Horowitz et al., 1997; Prigerson & Jacobs, 2001).

Two case examples will illustrate the complexity of the problem of over- lapsing diagnoses: A 47-year old married woman lost her 13-year-old only son, who committed suicide by lying down in front of a train. The son’s death was completely unexpected and came as a great shock to her and her husband. The bereaved mother suffered positive and negative intrusions of her son: on the one hand, she had visual images and nightmares of her son lying down in front of the train, but on the other hand, she also had positive intrusions of the last birthday of her son and how happy he had been getting his new computer. She had strong feelings of guilt and yearned and pined for her lost son. The patient had high PTSD and CG scores. In the second case, a 35-year old bereaved mother grieved the death of her 7-year-old daughter,
who had suffered from cancer for three years and who died at home, surrounded by her family. Even though the death of her daughter was expected, the final hours and the actual death of her daughter were experienced by her mother in a traumatic way. When the undertaker came to carry out the body of her daughter, she started to scream and refused to let the men take her daughter’s body out of the house. Four years after the death of her daughter, she still suffered intrusions relating to the moment of dying and the circumstances which surrounded the death. The patient showed high PTSD and CG scores when beginning with psychotherapy. These two examples clearly illustrate the complexity of CG as a distinct disorder and the difficulties in differentiating between the three categories of bereavement: non-traumatic bereavement, traumatic bereavement and trauma. These categories can overlap and can be distinct from each other. The diagnosis of PTSD in traumatic bereavement has been shown in a number of studies. In a study on conjugally bereaved individuals who have lost their spouse in a natural way, 10% met diagnostic criteria for PTSD (Zisook, Chentsova-Dutton, & Shuchter, 1998). By contrast, more than one-third of study participants who lost their spouses of suicide or accidents suffered of PTSD. These studies suggest that loss due to violent death may greatly influence an eventual grieving process.

Nevertheless, in recent years, a number of studies have shown that PTSD and CG are distinct disorders (Momartin, Silove, Manicavasagar, & Steel, 2004; Silverman, Jacobs, Kasl, Shear, Maciejewski, Noaghiul et al., 2000). For example, Silverman and colleagues (2000) found in their study of bereaved spouses (N = 85) that 18% met the criteria of CG and 7% met the criteria of PTSD at 4 months after their loss. Momartin et al. (2004) conducted a study with Bosnian refugees (N = 126) who had experienced particularly tragic losses. Most of the losses occurred either in public, or in concentration camps in the form of murder and torture, witnessed by relatives and friends. More than half of the participants showed PTSD, whereas only widowhood, but not gender or age, was associated with CG. Nevertheless, PTSD was unrelated to CG, a finding that might support evidence that the syndromes are for the most part distinct.

The question arises as to what the differences are between a diagnosis of PTSD or CG. Research conducted in the past few years showed some important features of different symptomatology between the two disorders. Bereavement reactions involve distinct anxiety reactions: traumatised individuals are typically anxious about the threat experienced with the traumatic event, whereas bereaved individuals experience separation anxiety (Stroebe et al., 2001). A sense of safety is often diminished after experiencing a trauma, while this does not typically occur with bereaved people after a nontraumatic bereavement. The core symptoms of yearning, pining, feeling sad and lonely are also not necessarily experienced after trauma without bereave-
ment. Similar symptoms of the two disorders are e.g., intrusive thoughts, even though they appear to be qualitatively different. Intrusions of PTSD involve negative and distressing memories of the traumatic event and related memories (Horowitz et al., 1993), whereas CG intrusions after a non-traumatic bereavement are typically of the deceased person and can be also experienced as positive and comforting. These positive and treasured memories can be permitted to such a degree that they have maladaptive qualities and prevent the bereaved person from re-orientation (Horowitz et al., 1993). Bereaved individuals can also experience the symptom of avoidance in different ways than traumatised individuals. Traumatised individuals typically avoid reminders of the traumatic event, whereas bereaved people might avoid places, people and conversations related to the deceased person, but also specifically seek out reminders (Stroebe et al., 2001). However, if a bereaved individual has experienced the loss in a traumatic way, avoidance and intrusions might similarly be focusing around the traumatic circumstances, and it might be extremely difficult for the bereaved person experiencing positive memories of the deceased. One important distinction is the separation distress component. Yearning and searching for the deceased, intrusive thoughts about and longing for the deceased and the loss of the person are often the source of distress.

Another different feature is the impact intensity of the traumatic event. The extremity of a traumatic event has a strong impact on the PTSD symptoms. The greater the level of traumatic exposure, the greater impact has this on the individual who experiences the trauma (Green, 2000). However, in traumatic bereavements, the enormity of the impact is strongly combined with aspects of the relationship, which has a strong influence on the grief process (Stroebe & Schut, 2006). In traumatic bereavements, the kind of relationship to the deceased and the closeness to the deceased have an additional impact.

Concluding, it appears that – even though there seems to be evidence that PTSD and CG are distinct disorders which can also overlap – one question regarding future diagnostic criteria which remains is whether the two different types of bereavement (non-traumatic and traumatic bereavement) should not be taken into account to a greater extent than is currently the case. Would we not obtain more valid diagnoses if we would suggest CG as one diagnostic criterion with two separate subcategories, namely traumatic bereavement and non-traumatic bereavement? The current diagnostic criteria were developed on the basis of a sample of elderly widows and widowers who experienced losses, which were not specifically traumatic or violent, and therefore they might very well identify normal or non-traumatic bereaved individuals. However, these samples might not necessarily mirror the algorithm of traumatically bereaved individuals. If the consensus criteria would have been based on traumatically bereaved individuals (i.e., suicide survivors), they would very likely find a different CG algorithm that would reflect more as-
pects of (negative) intrusions, relational aspects, feelings of guilt, and/or trauma-related avoidance behaviour. The question therefore remains whether the traumatically bereaved can in fact be satisfactorily identified with the present proposed criteria. The inclusion of the mode of death (non-traumatic or traumatic) into the criteria would provide a better conceptual and empirical background for future research. There are, however, also other important aspects of bereavement which could give us more diagnostic validity about the grade of complication of a grief process. In the following, we will describe the factor of the relation to the deceased as an indication of the level of suffering.

Relationship to the deceased

Another feature relating closely to complicated grief that has frequently been omitted from consideration in defining and categorising complicated grief has to do with the bereaved person's past and present relationship to the deceased. For the surviving person, the death of a significant person often leaves an empty space, which – especially shortly after the death – cannot be easily comprehended. However, after the immediate shock period, the bereaved individual often experiences that the deceased person has not just left an 'empty space', but that the relationship to the deceased is continuing, and in fact the relationship to the deceased person is a central factor for the measurement of the grief process over time (Rubin et al., 2008). The importance of the interpersonal relationship to the deceased has been the focus predominantly of the psychodynamic and the attachment theories (Rubin, Malkinson, & Witztum, 2000). But clinicians, too, experience that the emotional attachment and the re-organising of the relationship to the deceased are important aspects of the grief process. Other features of the relationship, such as the type of the relationship or closeness, also have an influence on grief reactions (Bowlby, 1980; Rubin, 1999).

Rubin (1999) developed the Two-Track Model showing that the bereavement process occurs along two main tracks. The first track refers to the bereaved's functioning or is living his or her life affected by the loss, and the second addresses how the bereaved individual is maintaining the inner relationship with the deceased. Rubin Malkinson, and Witztum (2003) described the death of a significant person as an attack on the relationship and the internal representation of that person needs therefore to be reorganised (Rubin et al., 2003). They describe this process as a shift from a psychological relationship with a living person to a person who is now deceased, a potentially traumatic experience. According to the authors, the coherence and association of the deceased person in the mind of the bereaved plays a prominent role in the bereavement process. The internal representation of the
deceased person can be very complex. The memories of the deceased person can be very emotional, intrusive, and can give discomfort as well as a sense of well-being, and the nature of the relationship to the deceased gives important information of the perception and the relation to the deceased. Therefore, Rubin and colleagues (2008) emphasised the necessity to include assessment of the cognitive-emotional organisation of the relationship with the deceased in the future DSM. They stated that the nature of the post-loss relationship can give an important understanding of the complications of grief. In the proposed criteria the items ‘yearning’ and ‘strong emotion’ mainly represent the post-loss relationship to the deceased. Aspects of how the psychological relationship with the deceased continues should be included in conceptualisation of any classification of bereavement dysfunction (Rubin et al., 2008). Interventions could especially profit from the inclusion of the relational assessment. The continuing bond and how this can be actively involved in the life without the deceased is an important focus of most grief interventions. Therefore, not only should the symptoms and dysfunction criteria be taken into account, but the relational aspects should also be considered.

Conclusions

During the past years, researchers and clinicians have emphasised the need to recognise CG as a separate diagnostic category with the status of a psychiatric disorder in the forthcoming DSM-V. A large number of studies has been conducted, notably by Prigerson and colleagues (e.g., Prigerson & Jacobs, 2001, Prigerson et al., 2009) and Horowitz and colleagues (e.g., Horowitz et al., 1997). Studies provided evidence that a small but important minority of bereaved individuals show a more extreme and enduring grief process. Therefore, the attempt of researchers to identify these individuals with a diagnostic approach is understandable. But do we really need a separate, multifaceted taxonomy of grief reactions for this small minority? Or, is the current approach of the DSM-IV at this stage of research possibly the best solution? This chapter has reviewed the different theoretical frameworks and different perspectives and important features of CG from various researchers with different conceptual backgrounds. However, many important questions remain concerning the conceptualisation, validity of the syndromes and the distinction between traumatic bereavement and trauma, as well as between normal versus pathological forms of grieving.

A main criticism of our review is the absence of a clear conceptualisation of grief processes and the problem of different conceptualisations which exist in the literature. Sometimes concepts of CG overlap, but in general, there is little agreement between the research groups and the symptoms they focus
on when they conduct their empirical studies. Some conceptualisations concentrate on the distinctiveness of CG from other psychiatric disorders, others focus more on relational aspects, or subtypologies of grief. Unfortunately, very little consideration has been given to cultural or relational aspects of normal and complicated grieving (Stroebe et al., 2001). Bonanno and Kaltman (2001) suggest there is a pressing need for cultural comparative grief assessment in a longitudinal design to identify what is human bereavement in general. It is to be assumed that different cultures show different grieving patterns, but so far we know little about normal or pathological grief processes in different cultures. This is even more important since patients often come from different cultural backgrounds, due to migration. The grieving process of a Swedish bereaved individual might be very different from a bereaved person with a Bosnian or Turkish cultural background, even if they are born in the same country.

We also described the historical development and differences of proposed diagnostic criteria (Horowitz et al., 1997, Prigerson et al., 1999; 2009) and our review showed that there are a number of nosological and conceptual concerns for a criteria set for complicated grief. Over the past years, the research group of Prigerson and colleagues undertook the most efforts at finding a diagnostic criterion for CG. Various studies, the development of a consensus criterion, and the recently published psychometric validation of criteria proposed for DSM (Prigerson et al., 2009) have been conducted. While Prigerson and colleagues (2008) claim that there is consensus about the syndrome of CG, we are in line with Stroebe and Schut (2006) that there is still a large diversity and considerable disagreement. One main concern is the approach of traumatic and non-traumatic bereavements in CG in a diagnostic taxonomy. As stated, we have concerns about the algorithm of CG and Prolonged Grief (Prigerson & Jacobs, 2001; Prigerson et al., 2009), which are both based on elderly widows and widowers, a specific subgroup, and only a very small number of whom have experienced traumatic bereavement. There is therefore a need for a systematic comparison of grief severity for specific subgroups of bereavement, such as bereaved parents, elderly widows and widowers, the normally bereaved, the traumatically bereaved, bereaved adolescents, and prenatal or neonatal losses.

As already stated above, the most recent concept of Prolonged Grief Disorder (Prigerson et al., 2009), where the two categories ‘separation distress’ and ‘traumatic distress’ were substituted by the categories ‘Separation Distress’ and ‘Cognitive, Emotional and Behavioural Symptoms’, remains hampered by a lack of robust empirical evidence. It would therefore be sensible to investigate and validate this new group of criteria again especially in relationship to traumatic and non-traumatic bereavement. These investigations are even more urgent since the proposed algorithm for diagnostic criteria of
Prolonged Grief needs more research-based evidence which is also valid for different subgroups (Hogan et al., 2003).

The question remains as to what the advantages or disadvantages of CG with its own separate diagnostic criteria would be. Ideally, a consensus about the diagnostic criteria for CG and its inclusion in the nosology would lead to more research and controlled studies. More research would result in suitable new treatment possibilities for individuals with CG, which would reduce the psychological strain on these people. In addition, more research would help clarify the phenomenology of CG and its risk factors. It would be worthwhile exploring whether convergent evidence from other post-stress conditions (e.g., PTSD, adjustment disorders) could enrich the body of knowledge on CG (Maercker, Einsle, & Kollner, 2007).

However, including CG in the nosology could also result in disadvantages. One concern could be that a CG diagnosis may pathologize or stigmatise a normal grief reaction (Prigerson & Jacobs, 2001; Stroebe et al., 2000; Stroebe et al., 2001; Lichtenthal et al., 2004).

In conclusion, the inclusion of CG in one of the leading guides for researchers and practitioners such as the DSM would have a far-reaching impact (Stroebe et al., 2000) and there are good arguments for a new diagnostic category. However, this review has come to the conclusion that at this point of research the inclusion of CG as an entity may still be too early. Too many important issues concerning the nature of CG remain unanswered, and preliminary acceptance of the proposed criteria might lead to the converse of the original aim. So far research in the field of diagnostic criteria has focused on non-traumatic samples. However, traumatic and non-traumatic bereavement might differ widely regarding intervention, and especially clinicians who work with specific groups of bereaved patients might need to focus on different conceptualisations. For example, practitioners who have mainly traumatically bereaved patients might focus more on the stress-response theory concept. A diagnostic criterion should therefore first identify those who actually suffer from traumatic or non-traumatic bereavement. In a next step the appropriate diagnoses and, at a later date, intervention should be offered.

References


variables in psychological functioning after the death of a first degree relative. 


grief as psychiatric disorder presenting greatest risk for suicidality. *Suicide & Life-Threatening Behaviour*, 34, 350-362.


Received August 21, 2009
Revision received January 29, 2010
Accepted February 19, 2010
ANXIOUS AND DEPRESSIVE AVOIDANCE AND SYMPTOMS OF PROLONGED GRIEF, DEPRESSION, AND POST-TRAUMATIC STRESS DISORDER

Paul A. BOELEN & Jan van den BOUT

Utrecht University, The Netherlands

Following loss, people can develop symptoms of depression, Post-Traumatic Stress Disorder (PTSD), or Complicated Grief (CG) – also termed Prolonged Grief Disorder (PGD). A recent cognitive-behavioural model has proposed that avoiding confrontation with the reality of the loss (called “anxious avoidance” [AA]) and refraining from activities that could foster adjustment (called “depressive avoidance” [DA]) both play a critical role in CG/PGD. The present study examined this assumption, using self-reported data from 161 mourners. Findings showed that items constituting AA and DA represented two distinct factors. Both factors were strongly correlated with other measures of bereavement-related avoidance and both accounted for a unique part of the explained variance in CG/PGD severity, beyond relevant background variables, negative cognitions, and concomitant symptom-levels of depression and PTSD. DA also explained unique variance in depression beyond these variables. Moreover, AA and DA mediated the linkages of neuroticism, attachment anxiety, and attachment avoidance with symptom-levels of CG/PGD.

Introduction

There is increasing evidence that in an estimated 5 to 20% of bereaved people a loss gives rise to serious mental health problems such as depression, Post-Traumatic Stress Disorder (PTSD), or Complicated Grief (CG; Forstmeier & Maercker, 2007; Prigerson & Jacobs, 2001). CG, or Prolonged Grief Disorder (PGD) as it is recently termed, entails chronic, intense grief-reactions including separation distress, difficulties accepting the loss, preoccupation, and recurrent images of the lost person that cause significant impairments in functioning for at least 6 months (Prigerson, Horowitz, Jacobs, Parkes, Aslan, Goodkin et al., 2009; Prigerson, Vanderwerker, & Maciejewski, 2008). Parallel to the development of validated criteria for CG/PGD, there is increasing attention for the treatment of this condition. For instance, Shear,
Frank, Houck, and Reynolds III (2005) found “complicated grief treatment” – a novel treatment containing elements of interpersonal therapy and cognitive-behavioural therapy (CBT) – to be effective in the reduction of CG/PGD symptoms. Boelen, de Keijser, van den Hout, and van den Bout (2007) found evidence for the effectiveness of brief cognitive-behavioural therapy for CG/PGD. Although these findings are encouraging, not all patients included in these studies improved, leaving room to further improve and refine treatments. For the refinement of effective treatments for CG/PGD, it is essential to have more knowledge about intrapersonal processes that are involved in the development and maintenance of this condition.

Recently, we developed a cognitive-behavioural (CB) conceptualisation of CG/PGD that was designed to offer a framework for the generation of hypotheses about processes involved in this condition and to inform efficacious treatment for it (Boelen, van den Hout, & van den Bout, 2006). This model proposes that CG/PGD develops and persists under the influence of three interrelated processes: (a) insufficient elaboration of the reality of the loss resulting in a lack of integration of this reality with pre-existing knowledge about the self and the loved one stored in autobiographical memory; (b) persistent negative thinking, specifically negative assumptions about global themes (self, life, and the future) and catastrophic misinterpretations of one’s own grief-reactions (e.g., “If I express my feelings, I will go mad”), and (c) avoiding stimuli that remind of the loss (called anxious avoidance) and avoiding activities that could facilitate adjustment (called depressive avoidance). The model is strongly influenced by Ehlers and Clark’s (2000) model of Post-Traumatic Stress Disorder (PTSD). In addition, several of its propositions are also part of other theories of grief. For instance, Shear and Shair’s (2005) recently developed “biobehavioural model of bereavement” proposes that symptoms of acute grief usually resolve following revision of the internalised representation of the deceased to incorporate the reality of the death and that failure to accomplish this integration results in CG/PGD. This notion resembles the first of the three processes from our own model. In Stroebe and Schut’s (1999) “dual process model of bereavement” (DPM), confronting the loss and the associated pain (loss-orientated coping) and confronting stressors that came about as a result of the bereavement (restoration orientated coping) are both critical in the process of coming to terms with loss. This is reminiscent of, albeit not totally similar to, our model’s third process proposing that anxiety-driven avoidance of “loss-orientation” (i.e., anxious avoidance) and sombreness and pessimism-driven avoidance of “restoration-orientation” (i.e., depressive avoidance) are important in the development and maintenance of CG/PGD.

Research has confirmed some of the basic hypotheses from our CB model. For instance, a recent study found evidence that a “sense of unrealness”
about the loss, conceptualised as a subjective sense of uncertainty or ambivalence about the irreversibility of the separation resulting from a lack of integration of the loss with pre-existing knowledge, plays a role in CG/PGD (Boelen, 2010). In addition, a prospective study yielded evidence that both global negative beliefs and catastrophic misinterpretations play a role in the development of CG/PGD (Boelen, van den Bout, & van den Hout, 2006). Importantly though, no studies have yet directly tested the role of depressive and anxious avoidance strategies. That is not to say that researchers have not theorised about (e.g., Ramsay, 1977) and investigated the role of avoidance in grief. For instance, in several studies we ourselves found distinct measures of cognitive avoidance (e.g., thought suppression, rumination) and behavioural avoidance (avoidance of places that remind of the loss) to be correlated with CG/PGD severity and related symptoms (e.g., Boelen, 2009; Boelen & van den Hout, 2008; Boelen, van den Bout et al., 2006). Likewise, in studies of Bonanno, Keltner, Holen, and Horowitz (1995) and Shear, Monk, Houck, Melhem, Frank, Reynolds et al. (2007) generic measures of deliberate avoidance of loss-related stimuli have been found to be significantly associated with loss-related distress. However, the distinct role of depressive and anxious avoidance as conceptualised in our CB model has not yet been studied (Boelen, van den Hout et al., 2006).

Both anxious and depressive avoidance are postulated to be detrimental. Among other reasons, anxious avoidance is assumed to maintain CG/PGD symptoms by preventing elaboration and integration of the loss, whereas depressive avoidance is assumed to block the correction of negative views of the self, life, and future that may develop following loss. Important too is that, as one of the model’s three key processes (poor integration, negative thinking, and avoidance), both depressive and anxious avoidance are assumed to mediate the role of personality variables that may exert an influence on CG/PGD symptom severity, such as neuroticism and insecure attachment.

The overarching aim of this study was to advance our understanding of mechanisms involved in the development of CG/PGD by examining the role of anxious and depressive avoidance in emotional complications following loss. To this end, a nine-item Depressive and Anxious Avoidance in Prolonged Grief Questionnaire (DAAPGQ) was constructed, encompassing items that represent manifestations of both depressive avoidance (DA) and anxious avoidance (AA). Next, we tested a number of predictions derived from our CB model of CG/PGD.

With respect to the dimensionality it was predicted that (a) items of DA and AA constituted distinguishable factors rather than a single dimension. Items were subjected to a confirmatory factor analysis (CFA) to test this prediction. With respect to the linkages of DA and AA with general features of the loss, we predicted that (b) both DA and AA would diminish over time.
and would thus be correlated with the time that had passed since the loss occurred. To examine convergent validity of DA and AA, we examined their correlation with other measures of loss-related avoidance (see Method section), expecting (c) that these correlations would be strong and significant. As noted, the CB model proposes that DA and AA contribute to emotional complications following loss. Accordingly, on the condition that DA and AA would emerge as separate factors in the CFA, it was expected that (d) both factors would be strongly correlated with self-reported CG/PGD severity – even when controlling for the influence of background and loss-related variables that affected DA, AA, or these symptoms. The CB model predicts that DA, AA, and negative cognitions represent partially overlapping but distinct determinants of post-loss psychopathology (Boelen, van den Hout et al., 2006). With this in mind, it was also predicted that (e) DA and AA would remain associated with symptom-levels of CG/PGD, even when controlling the shared variance between DA and AA, and the variance explained by indices of catastrophic misinterpretations of grief-reactions and global negative beliefs. The CB model also posits that DA and AA are more central to symptoms of CG/PGD, than to other emotional problems following loss. Accordingly, it was also predicted (f) that DA and AA would be more strongly related to symptom-levels of CG/PGD than symptom-levels of depression and PTSD, when controlling for the shared variance between these symptoms, as well as for the degree to which global negative beliefs and catastrophic misinterpretations were endorsed. Finally, based on the CB model, it was predicted that (g) DA and AA would mediate the linkages of neuroticism and attachment style – personality variables that have been found to be correlated with CG/PGD in previous research (e.g., Wijngaards-de Meij, Stroebe, Schut, Stroebe, van den Bout, van der Heijden et al., 2007) – with symptom-levels of CG/PGD.

Methods

Participants and procedure

Data were available from 161 bereaved people who were recruited in the context of an ongoing research program on cognitive processes in emotional problems following loss that the current study was part of. All were recruited via professional and lay mental health care workers (e.g., grief counsellors, therapists, clergy) who handed out questionnaire packets to mourners they came in contact with through their work-related or voluntary activities. The research program was approved by an institutional review board and written informed consent was obtained from all participants. Characteristics of the
The ICG-r is a 30-item questionnaire that taps symptoms of CG/PGD and other maladaptive grief-reactions. Participants rate the presence of symptoms in the last month on 5-point scales ranging from “never” to “always”. Items (e.g., “I feel myself longing and yearning for [-]”) are summed to form an overall CG/PGD severity score. The English version (Prigerson & Jacobs, 2001) and the 29-item Dutch version (Boelen, van den Bout, de Keijser, & Hoijtink, 2003) have adequate psychometric properties. In the present sample, the $\alpha$ was .96.

**Symptom Measures**

Inventory of complicated grief-revised (ICG-r)

The ICG-r is a 30-item questionnaire that taps symptoms of CG/PGD and other maladaptive grief-reactions. Participants rate the presence of symptoms in the last month on 5-point scales ranging from “never” to “always”. Items (e.g., “I feel myself longing and yearning for [-]”) are summed to form an overall CG/PGD severity score. The English version (Prigerson & Jacobs, 2001) and the 29-item Dutch version (Boelen, van den Bout, de Keijser, & Hoijtink, 2003) have adequate psychometric properties. In the present sample, the $\alpha$ was .96.

**Table 1**

Demographic and loss-related background variables of the sample ($N = 161$)

<table>
<thead>
<tr>
<th>Demographic Characteristics:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender ($N ($%)$)</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>33 (20.5)</td>
</tr>
<tr>
<td>Women</td>
<td>128 (79.5)</td>
</tr>
<tr>
<td>Age (years) ($M (SD)$)</td>
<td>53.5 (14.4)</td>
</tr>
<tr>
<td>Education (years) ($M (SD)$)</td>
<td>15.6 (3.1)</td>
</tr>
<tr>
<td>Loss-related Characteristics:</td>
<td></td>
</tr>
<tr>
<td>Deceased is ($N ($%)$)</td>
<td></td>
</tr>
<tr>
<td>Partner</td>
<td>89 (53.4)</td>
</tr>
<tr>
<td>Child</td>
<td>16 (9.9)</td>
</tr>
<tr>
<td>Parent</td>
<td>39 (24.2)</td>
</tr>
<tr>
<td>Other relative</td>
<td>20 (12.4)</td>
</tr>
<tr>
<td>Cause of death is ($N ($%)$)</td>
<td></td>
</tr>
<tr>
<td>Illness</td>
<td>90 (55.9)</td>
</tr>
<tr>
<td>Violent (accident, suicide, homicide)</td>
<td>19 (11.8)</td>
</tr>
<tr>
<td>Unexpected Medical Cause (e.g., heart attack)</td>
<td>26 (16.1)</td>
</tr>
<tr>
<td>Other cause</td>
<td>19 (11.8)</td>
</tr>
<tr>
<td>Time from loss in months ($M (SD)$)</td>
<td>53.6 (80.7)</td>
</tr>
<tr>
<td>Symptom Scores ($M (SD)$):</td>
<td></td>
</tr>
<tr>
<td>ICG-r</td>
<td>69.4 (23.1)</td>
</tr>
<tr>
<td>BDI</td>
<td>32.5 (8.8)</td>
</tr>
<tr>
<td>PSS-SR</td>
<td>11.9 (8.1)</td>
</tr>
</tbody>
</table>

*Note: BDI = Beck Depression Inventory. ICG-r = Inventory of Complicated Grief-revised version. PSS-SR = PTSD Symptom Scale Self-Report version.*
PTSD symptom scale self-report version (PSS-SR)

The PSS-SR is a 17-item measure of PTSD symptom severity. Respondents rate the frequency of symptoms on 4-point scales ranging from “not at all” to “five or more times per week/almost always”. The index event was defined as “the death of your loved one” (e.g., “How often did you have unpleasant dreams or nightmares about the death of your loved one?”). The English (Foa, Riggs, Dancu, & Rothbaum, 1993) and Dutch versions (Engelhard, Arntz, & van den Hout, 2007) have good psychometric properties. In the present sample, the $\alpha$ was .88.

Beck depression inventory (BDI)

The BDI is a frequently used 21-item measure of depressive symptoms. It contains 21 groups of four statements representing depressive symptoms at increasing levels of severity. Items are summed to form an overall depression severity score. The English (Beck, Steer, & Brown, 1996) and Dutch versions of the BDI (Van der Does, 2002) have adequate psychometric properties. The $\alpha$ in this sample was .92.

Personality measures

Revised experiences in close relationships questionnaire (ECR-r)

The shortened version of the ECR-r (Fraley, Waller, & Brennan, 2000) was used to measure two components of insecure attachment, namely attachment anxiety (i.e., a person’s predisposition toward anxiety and vigilance about rejection and abandonment) and attachment avoidance (i.e., a person’s discomfort with closeness and dependency or a reluctance to be intimate with others). Attachment anxiety was tapped by a 5-item scale and attachment avoidance by a 6-item scale. Respondents rate their agreement with statements on 7-point scales ranging from “strongly disagree” to “strongly agree”. In the present sample, the attachment anxiety and attachment avoidance scales had $\alpha$’s of .80 and .75 respectively.

Neuroticism scale from the Eysenck personality questionnaire (EPQ-N)

The Neuroticism subscale from the EPQ (Eysenck, Eysenck, & Barrett, 1985) was used to assess neuroticism. Respondents indicate their agreement with 12 statements (e.g., “I am a nervous person”) using a dichotomous (yes/no) response format. The $\alpha$ was 0.79.

Measures of negative cognitions and avoidance

Grief cognitions questionnaire (GCQ) subscales self, life, future, and catastrophic misinterpretations
The GCQ is a 38-item measure of negative bereavement-related cognitions (Boelen & Lensvelt-Mulders, 2005). In the current study, four of its nine subscales were used, namely the subscales Self (six items, e.g., “Since [-] is dead, I am of no importance to anybody anymore”), Life (four items, e.g., “My life has no purpose anymore, since [-] died”), Future (five items, e.g., “In the future I will never become really happy anymore”), and Catastrophic Misinterpretations of grief (four items, e.g., “If I would fully realise what the death of [-] means, I would go crazy”). Internal consistencies of the four scales in the current sample were: Self, $\alpha = .86$; Life, $\alpha = .90$; Future, $\alpha = .83$; Catastrophic Misinterpretation of grief, $\alpha = .87$. Scores on the Self, Life, and Future scale were averaged to obtain one “global negative beliefs” index. This was done to limit the number of predictor variables in subsequent regression analyses.

Depressive and anxious avoidance in prolonged grief questionnaire (DAAPGQ)

The DAAPGQ was specifically constructed for the current study to examine the role of depressive and anxious avoidance (DA and AA) as defined in Boelen, van den Hout et al.’s (2006) CB theory of CG/PGD. Nine items were formulated, based on interviews with mourners suffering from emotional complications after their loss and literature on coping with loss. Five items were constructed to tap DA and four items to tap AA. Items are shown in Table 2. Participants rated their agreement with each item on 8-point scales ranging from “not at all true for me” to “completely true for me”. Psychometric properties of the scale are described below.

Measure of avoidance strategies (MAS)

The MAS is a 10-item measure of bereavement-related avoidance strategies that includes 4 brief subscales (Boelen, 2009; Boelen & van den Hout, 2008). It was included in this study to examine convergent validity of the DAAPGQ. We included three of its subscales, namely the subscale Rumulative Avoidance (two items, $\alpha = .57$, e.g., “I ponder about the question why [-] died”), the subscale Suppression (3 items, $\alpha = .76$, e.g., “I try to keep my feelings and thoughts about the loss under control”), and the subscale Continuing Bonds (two items, $\alpha = .62$, e.g., “I cherish particular objects that are closely linked with [-]”). Participants rated how often they usually engaged in these behaviours on 11-point scales ranging from “never” to “all the time”. Subscale total scores were calculated as the summed subscale item scores.
Results

Dimensionality and internal consistency of the DAAPGQ

To address hypothesis (a) CFA was used to compare the fit of a unitary model with the fit of a two-factor model with distinct DA and AA factors. Outcomes showed that the one-factor model did not fit the data (CFI = 0.88, TLI = 0.85, RMSEA = 0.14). The two-factor model with two distinct, but correlated factors fit significantly better than the unitary model ($\chi^2_{\text{difference}} = 41.02, \Delta df = 1, p < .001$) and had reasonably good fit estimates (CFI = 0.94, TLI = 0.92, RMSEA = 0.10). Modification indexes indicated that the fit would improve when error-terms of the first and third AA items (items 6 and 8 in Table 2) were allowed to correlate. Given the similarity in content of both items, we assumed that these correlations reflected non-random measurement error stemming from content overlap. Accordingly, we tested the fit of an adjusted two-factor model in which these error terms were allowed to be correlated. This model was a significant improvement over the second
model ($\chi^2_{\text{difference}} = 13.3, \Delta df = 1, p < .05$) and had good fit estimates (CFI = 0.96, TLI = 0.94, RMSEA = 0.08). Table 2 shows factor loadings of this model. The correlation between the DA and AA factors was 0.77. Internal consistencies of the DA and AA subscales were .90 and .74 respectively and did not improve with the deletion of a single item.

Descriptive statistics

Table 1 shows mean scores on the ICG-r, BDI, and PSS-SR. Scores were all in the subclinical range (cf. Boelen, 2010; Engelhard et al., 2007; Vand der Does, 2002). Normality data indicated that BDI scores, PSS-SR scores, GCQ subscale scores, AA scores (DAAPGQ), and MAS Suppression scores were positively skewed. Therefore, these scores were log-transformed in all analyses described below. Transformations reduced non-normality of the variables.

Variation in DA and AA as a function of time and other demographic and loss-related background variables

To examine hypothesis (b) we examined the degree to which DA and AA varied as a function of demographic and loss-related variables. As expected, DA and AA were inversely related with time from loss ($r = -.29, p < .001$ and $r = -.17, p < .05$, respectively). Moreover, DA and AA were inversely related with years of education ($r = -.17, p < .05$ and $r = -.37, p < .001$, respectively) and positively associated with age ($r = .17, p < .05$ and $r = .19, p < .05$, respectively). In addition, DA and AA varied as a function of kinship ($F(3, 160) = 6.76, p < .001$ and $F(3, 160) = 4.64, p < .01$ respectively). Post-hoc tests showed that those who lost a parent had significantly lower DA scores than those who lost a partner ($p < .001$) or child ($p < .01$) and significantly lower AA scores than those who lost a partner ($p < .01$). AA and DA did not vary as a function of cause of loss or gender ($Fs < 2.8, ps > .05$).

Convergent validity of DA and AA

To test hypothesis (c) correlations between DA, AA, and the MAS scores were calculated. The correlation of DA with MAS Suppression was $r = .71$, with MAS Rumination was $r = .57$, and with MAS Continuing Bonds was $r = .36$. The correlation of AA with MAS Suppression was $r = .57$, with MAS Rumination was $r = .57$, and with MAS Continuing Bonds was $r = .41$ (all $ps < .001$). Findings support the convergent validity of DA and AA.
Association of DA and AA with symptom-levels of CG/PGD, depression, and PTSD

Next, to test hypotheses (d), (e), and (f), we examined associations of DA and AA with the severity of symptoms of CG/PGD, depression, and PTSD. We also examined the degree to which associations remained significant when taking into account relevant demographic and loss-related background variables, negative cognitions, and concomitant symptoms. Relevant background variables were those that were associated with DA and/or AA (see above) and those associated with symptom-levels. CG/PGD severity varied as a function of age ($r = .20$), years of education ($r = -.30$), time from loss ($r = -.28, ps < .01$), and kinship ($F(3, 160) = 17.73, p < .001$). Depression varied as a function of time from loss ($r = -.18, p < .05$), and kinship ($F(3, 160) = 4.28, p < .01$). PTSD severity varied as a function of education ($r = -.21, p < .01$), time from loss ($r = -.24, p < .01$), and kinship ($F(3, 160) = 9.04, p < .001$).

Three regression analyses were run with CG/PGD, depression, and PTSD severity consecutively treated as dependent variables. Predictors were entered sequentially in blocks. First, relevant background variables were entered (block 1), followed by DA and AA scores (block 2). Then, scores on the GCQ subscales were entered (block 3). Finally, we entered concomitant symptoms (e.g., symptom-levels of depression and PTSD when CG/PGD severity was the dependent variable) in order to examine the associations of DA and AA with each symptom measure, when controlling for the shared variance between symptoms. Outcomes of the regressions are summarised in Table 3.

Block 1: background variables

Relevant background variables explained 30.6%, 10.2%, and 20.7% of the variance in symptom-levels of CG/PGD, depression, and PTSD severity. Time, education, child loss, and parent loss explained unique variance in CG/PGD severity. None of the variables explained unique variance in depression and PTSD severity.

Block 2: DA and AA

In block 2, DA and AA added 40.7%, 46.6%, and 38.7% to the explained variance in CG/PGD, depression, and PTSD severity respectively. Child loss, parent loss, DA, and AA explained unique variance in CG/PGD severity. DA explained unique variance in depression severity. DA and AA explained unique variance in PTSD severity.

Block 3: negative cognitions

Negative cognitions added 11.4%, 13.6%, and 6% to the explained variance in CG/PGD, depression, and PTSD severity. Unique correlates of CG/
Table 3
Summary of regression analyses predicting symptom-levels of CG/PGD, depression, and PTSD

<table>
<thead>
<tr>
<th>Block 1: Demographics</th>
<th>Block 2: Depressive and Anxious Avoidance</th>
<th>Block 3: Negative Cognitions</th>
<th>Block 4: Concomitant Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG/PGD</td>
<td>DEP</td>
<td>PTSD</td>
<td>CG/PGD</td>
</tr>
<tr>
<td>β</td>
<td>β</td>
<td>β</td>
<td>β</td>
</tr>
<tr>
<td>Background Variables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.059</td>
<td>-.109</td>
<td>-.139</td>
</tr>
<tr>
<td>Time from loss</td>
<td>-.154*</td>
<td>-.104</td>
<td>-.143</td>
</tr>
<tr>
<td>Education</td>
<td>-.162*</td>
<td>-.092</td>
<td>-.164</td>
</tr>
<tr>
<td>Partner Loss</td>
<td>.168</td>
<td>.160</td>
<td>.095</td>
</tr>
<tr>
<td>Child Loss</td>
<td>.202*</td>
<td>.149</td>
<td>.183</td>
</tr>
<tr>
<td>Parent Loss</td>
<td>-.266*</td>
<td>-.106</td>
<td>-.230</td>
</tr>
<tr>
<td>Depressive and Anxious Avoidance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Avoidance</td>
<td>.493***</td>
<td>.724***</td>
<td>.540***</td>
</tr>
<tr>
<td>Anxious Avoidance</td>
<td>.277***</td>
<td>.032</td>
<td>.199**</td>
</tr>
<tr>
<td>Negative Cognitions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global Negative Beliefs</td>
<td>.255***</td>
<td>.409***</td>
<td>.121</td>
</tr>
<tr>
<td>Catastrophic Misinterpretations</td>
<td>.278***</td>
<td>.144*</td>
<td>.256***</td>
</tr>
<tr>
<td>Concomitant Symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complicated Grief</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>.074</td>
<td>-</td>
<td>.132</td>
</tr>
<tr>
<td>PTSD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R²</td>
<td>.306</td>
<td>.102</td>
<td>.207</td>
</tr>
<tr>
<td>R² change</td>
<td>.306</td>
<td>.102</td>
<td>.207</td>
</tr>
<tr>
<td>F change</td>
<td>10.75***</td>
<td>2.76*</td>
<td>6.34</td>
</tr>
</tbody>
</table>

Note: CG/PGD = complicated grief/prolonged grief disorder. DEP = depression. PTSD = Post-Traumatic Stress Disorder. * p < .05, ** p < .01, *** p < .001.
PGD severity were DA, AA, global negative beliefs, and catastrophic misinterpretations. Unique correlates of depression severity were DA, global negative beliefs, and catastrophic misinterpretations. Unique correlates of PTSD severity were DA and catastrophic misinterpretations.

Block 4: concomitant symptoms

In block 4, depression and PTSD scores added a small but significant amount of 3.2% to the explained variance in CG/PGD symptom severity. Apart from parent loss and concomitant PTSD, DA, AA, global negative beliefs, and catastrophic misinterpretations explained unique variance in CG/PGD severity in this final model. CG/PGD and PTSD severity added 4.4% to the explained variance in depression. Concomitant PTSD, DA and global negative beliefs were unique correlates of depression in this final model. Finally, CG/PGD and depression severity added 8.8% to the explained variance in symptom-levels of PTSD. CG/PGD severity was the single variable explaining unique variance in PTSD severity in this fourth block.

Tests for mediation

To test hypothesis (g), six distinct mediational models were tested in which DA and AA were considered as separate mediators of the linkages of neuroticism, anxious attachment, and avoidant attachment with CG/PGD symptom severity. Mediational models were tested using guidelines of Baron and Kenny (1986). Four criteria had to be met to establish mediation. First, the independent variable (IV) had to be significantly associated with CG/PGD severity (Step 1 - estimation of “path c”). Second, the independent variable had to be significantly associated with the mediator (Step 2 - estimation of “path a”). Third, the mediator had to be significantly associated with CG/PGD severity (Step 3 - estimation of “path b”). Finally, the effect of the IV on CG/PGD severity should attenuate when controlling for the mediator (Step 4 - estimation of “path c’’). The mediator variable could be considered a “partial mediator” when the association of the IV with CG/PGD severity would be reduced but still would be significant, and a “perfect mediator” when it became non-significant. If Steps 1 through 4 were met, Sobel’s test was conducted to examine if the mediational pathway was significant (Preacher & Hayes, 2004; Sobel, 1982). In all regression analyses, we controlled for age, education, time, and kinship as these variables were associated with CG/PGD severity.

Outcomes of the regression are summarised in Table 4. Findings showed that both DA and AA were partial mediators of the linkage between neuroticism and symptom-levels of CG/PGD (see Models 1 and 2). With respect to attachment, DA emerged as a perfect mediator of the linkage between
<table>
<thead>
<tr>
<th>Model</th>
<th>Path a</th>
<th>Path b</th>
<th>Path c</th>
<th>Path c'</th>
<th>Sobel’s test</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.46 (0.26)**</td>
<td>1.23 (0.12)**</td>
<td>3.91 (0.48)**</td>
<td>2.12 (0.41)**</td>
<td>4.92**</td>
</tr>
<tr>
<td>2</td>
<td>0.03 (0.01)**</td>
<td>39.23 (4.90)**</td>
<td>3.91 (0.48)**</td>
<td>2.69 (0.43)**</td>
<td>2.89**</td>
</tr>
<tr>
<td>3</td>
<td>0.49 (0.12)**</td>
<td>1.46 (0.13)**</td>
<td>1.01 (0.26)**</td>
<td>0.30 (0.19) ns</td>
<td>3.84**</td>
</tr>
<tr>
<td>4</td>
<td>0.01 (0.003)**</td>
<td>48.10 (5.33)**</td>
<td>1.01 (0.26)**</td>
<td>0.48 (0.21)**</td>
<td>3.40**</td>
</tr>
<tr>
<td>5</td>
<td>0.26 (0.12)*</td>
<td>1.47 (0.12)**</td>
<td>0.70 (0.24)**</td>
<td>0.32 (0.17) ns</td>
<td>2.13*</td>
</tr>
<tr>
<td>6</td>
<td>0.01 (0.003)*</td>
<td>49.91 (5.12)**</td>
<td>0.70 (0.24)**</td>
<td>0.35 (0.19) ns</td>
<td>2.27*</td>
</tr>
<tr>
<td>7</td>
<td>1.46 (0.26)**</td>
<td>0.006 (0.001) ***</td>
<td>0.022 (0.003) ***</td>
<td>0.013 (0.002)***</td>
<td>4.10***</td>
</tr>
<tr>
<td>8</td>
<td>0.489 (0.124) ***</td>
<td>0.008 (0.001) ***</td>
<td>0.006 (0.001) ***</td>
<td>0.002 (0.001)***</td>
<td>3.54***</td>
</tr>
<tr>
<td>9</td>
<td>0.260 (0.119)*</td>
<td>0.008 (0.001)*</td>
<td>0.004 (0.001)**</td>
<td>0.002 (0.001)*</td>
<td>2.11*</td>
</tr>
</tbody>
</table>

anxious attachment and CG/PGD severity (Model 3), whereas AA partially mediated this association (Model 4). Finally, both DA and AA were perfect mediators of the linkage between attachment avoidance and CG/PGD severity (Models 5 and 6).

The previous section showed that DA made a unique and specific contribution to the explained variance in depression severity, above and beyond concomitant symptom-levels of PTSD and negative beliefs. Hence, it was deemed relevant to explore whether or not DA also mediated possible associations of neuroticism, anxious attachment, and attachment avoidance with depression. Accordingly, three additional mediational models were tested: Neuroticism $\rightarrow$ DA $\rightarrow$ Depression (Model 7), Attachment Anxiety $\rightarrow$ DA $\rightarrow$ Depression (Model 8), and Attachment Avoidance $\rightarrow$ DA $\rightarrow$ Depression (Model 9). Outcomes of the regression analyses and Sobel tests conducted to examine these models are summarised in Table 4. Outcomes showed that DA was a partial mediator of the linkages between these three personality variables and depression symptom severity.

Discussion

Research has shown that different forms of deliberate avoidance behaviours in the aftermath of the death of a close loved one are related to emotional complications following loss (e.g., Boelen & van den Hout, 2008; Bonanno et al., 1995; Shear et al., 2007). In line with these findings, in our recently developed CB model of CG/PGD, avoidance behaviour is regarded as one of the three processes that are critical to the development and maintenance of this condition – the other two processes being a lack of integration of the loss with the autobiographical knowledge base and negative thinking (Boelen, van den Hout et al., 2006). In this model, we tried to come up with a parsimonious distinction between DA and AA in an attempt to specify the forms of avoidance that are particularly maladaptive in coming to terms with loss. DA reflects depressive withdrawal and restriction from activities, that is assumed to be driven by negative expectations about the effects of engaging in potentially helpful behaviours (e.g., “Meeting friends will not make me feel better”) and one’s abilities to do so (e.g., “I am unable to take up new responsibilities”). AA has been defined as occurring when mourners avoid confrontation with the reality of the loss, driven by fear that confrontation with this reality is unbearable and will have disastrous consequences, such as going “mad”.

The current study represents the first attempt to examine the role of DA and AA in emotional problems following loss, using the newly constructed 9-item DAAPGQ. The main findings can be summarised as follows. First,
CFA confirmed that items constituting DA and AA represented two distinct correlated factors, rather than a single dimension. Both factors had high internal consistencies. Importantly, these findings confirm the distinction between both constructs made in the CB model. Second, it was found that both DA and AA scores were significantly lower in those whose bereavement was of longer duration. Yet, correlations were low suggesting that, once present, tendencies to avoid the reality of the loss (AA) and active adjustment (DA) only marginally decline under the influence of time. A third main finding was that both DA and AA were significantly related with other indices of loss-related avoidance, which supports the convergent validity of these constructs. It is noteworthy that both DA and AA were highly associated with items tapping loss-related rumination (e.g., “I ponder about the question why [–] died”). This supports the notion that, as in PTSD (cf. Ehlers & Clark, 2000), in the context of grief, rumination can represent a form of cognitive avoidance (Boelen, van den Bout et al., 2006; Stroebe, Boelen, van den Hout, Stroebe, Salemink, & van den Bout, 2007).

Next, we examined associations of DA and AA with symptom-levels of CG/PGD, depression, and PTSD in a series of regression analyses. A fourth main finding was that, as predicted, both AA and DA were correlated with symptom-levels of CG/PGD, even when we controlled for the influence of relevant background and loss-related variables. Notably, correlations remained significant when we controlled for the influence of loss-related global negative beliefs and catastrophic misinterpretations. In fact, DA, AA, loss-related global beliefs, and catastrophic misinterpretations each were unique correlates of CG/PGD severity. These findings are in line with one of the basic premises of our cognitive-behavioural model (Boelen, van den Hout et al., 2006) which postulates that these variables represent distinguishable processes, each accounting for a unique part of the explained variance in CG/PGD.

Apart from CG/PGD, we also examined associations of DA and AA with symptom-levels of depression and PTSD and tested the specificity of DA and AA to these three symptom-clusters. Findings showed that DA but not AA was significantly associated with depression severity, even when controlling for relevant background variables, negative cognitions, and concomitant symptoms. Yet, neither DA nor AA was associated with PTSD severity when controlling for these variables. The finding that DA was also specifically associated with depression runs counter to our prediction that DA and AA would be specific to CG/PGD. However, the finding of a significant linkage between DA and depression severity is not unexpected as, by definition, depression is associated with a reduction of normal activity levels.

In our final round of analyses, we tested the hypothesis that DA and AA would mediate the linkage of neuroticism, attachment anxiety, and attachment avoidance with CG/PGD severity. Indeed, in keeping with earlier find-
ings (Wijngaards-de Meij et al., 2007) we found that neuroticism and both attachment dimensions were significantly related with the severity of CG/PGD. Importantly though, these associations attenuated when we controlled for DA and AA. Stated differently, in distinct mediational models, it was found that DA and AA were significant mediators of the linkages between neuroticism, attachment anxiety, and attachment avoidance on the one hand, and CG/PGD severity on the other hand. These findings confirm another notion that is central to our CB model, namely, that DA and AA mediate the contribution of personality factors to the development and maintenance of CG/PGD. Given that DA turned out to be a significant correlate of depression, we also examined mediational models in which DA mediated the association of neuroticism and the attachment dimensions with depression severity. Findings showed that DA emerged as a significant mediator in these analyses.

Several limitations should be kept in mind when interpreting outcomes of this study. First, the cross-sectional design precludes any conclusions about causality. The current findings are in accord with the notion that DA and AA contribute to CG/PGD severity following loss. However, prospective and experimental studies are needed to establish the causal role of these variables in post-loss psychopathology. In a related vein, prospective studies are needed to test the notion that personality factors such as neuroticism and insecure attachment style precede the tendency to engage in avoidance of the reality of the loss and making active adjustments which, in turn, precedes the maintenance of CG/PGD and depression. A second caveat is that this study mostly relied on women who were bereaved by the loss of their partner due to an illness. Thus, generalisation of the findings to non-assessed groups should be done with caution. A third limitation is that only few additional measures of loss-related avoidance were used to assess convergent validity of the DA and AA constructs. It would be relevant for future studies to explore the validity of DA and AA, taking into account other measures of deliberate grief-avoidance such as the one constructed by Shear et al. (2007) and more general (not specifically loss-related) measures of avoidance, such as the Cognitive-behavioural Avoidance Scale (Ottenbreit & Dobson, 2004).

Notwithstanding these considerations, the current study is the first to provide evidence for the role of DA and AA in emotional problems following loss, by showing that both forms of avoidance are distinct, that both make a significant unique contribution to the explained variance in symptom-levels of CG/PGD – even when controlling for negative cognitions and concomitant symptoms of depression and PTSD, and that both DA and AA mediate the associations of neuroticism, attachment avoidance, and attachment anxiety with CG/PGD symptom severity. As such, the findings support important assumptions from our CB model (Boelen, van den Hout et al., 2006). Moreover, indirectly, findings support the distinction and distinct importance of loss-
orientation and restoration orientation as conceptualised within the DPM (Stroebe & Schut, 1999). If future studies would confirm that both forms of avoidance are involved in the development and maintenance of CG/PGD, this would suggest that targeting these behaviours is important in the treatment of this condition. Boelen, van den Hout et al. (2006) have described several interventions based on general cognitive-behavioural therapy that can be used to reduce the maladaptive avoidance behaviours. For instance, exposure to stimuli that are reminders of the loss could be used to target AA. In addition, to curb DA, therapists could use pleasant event scheduling (helping the person to schedule activities he/she previously enjoyed and that will likely give a sense of achievement) and systematic activation (helping the person to achieve specific occupational, recreational, and social goals by identifying and planning steps towards these goals). There is quite some evidence for the effectiveness of exposure in the treatment of CG/PGD (Boelen et al., 2007; Ramsay, 1977; Shear et al., 2005). Less clear is the effectiveness of directly targeting DA using the aforementioned and other interventions. Research in the field of depression suggests that behavioural activation and related interventions are very effective (Cuijpers, van Straten, & Warmerdam, 2007; Hopko, Lejuez, Ruggiero, & Eifert, 2003). This may well also be the case in the treatment of CG/PGD. “Restoration of a satisfying life” and “a focus on personal life goals” were part of Shear et al.’s (2005) Complicated Grief Treatment. However, the isolated effectiveness of interventions directly targeting DA and AA remains unclear. Future studies could explore this topic to further enhance our understanding of the role of DA and AA in CG/PGD.

References


Received June 18, 2009
Revision received August 10, 2009
Accepted September 10, 2009
THE EMOTIONAL AND ECONOMIC COSTS OF BEREAVEMENT IN HEALTH CARE SETTINGS

Janice L. GENEVRO & Therese L. MILLER
Agency for Healthcare Research and Quality, USA

Research to date on grief and bereavement in health care providers has focused on those experiences from the perspective of the individual. We propose, however, that the emotional costs of bereavement in the health care setting are also health care systems issues. This paper focuses on the emotional costs of grief and bereavement in health care providers, and on the economic costs of bereavement and bereavement care in health care settings. Evidence regarding the costs and cost-effectiveness of bereavement interventions is limited. We summarise existing relevant research and offer an overview of the types of costs and cost information that would optimally be collected in research on bereavement in health care settings. We also propose an analytic framework that could be used to systematically consider the larger picture of bereavement in health care settings, how available evidence fits into this picture, and what evidence is needed to improve care. This approach is derived from health services research. It is hoped that the proposed framework will prove useful in stimulating new research questions, and in guiding research that not only advances our understanding of the emotional and economic costs of bereavement but also improves bereavement care.

Introduction

Although circumstances vary from country to country, a reality of death in the developed world is that most people die in a hospital or other health care setting (Last Acts, 2002; Wilson, Truman, Thomas, Fainsinger, Kovacs-Burns, Frogatt et al., 2009). This presents individual health care providers and health care systems with the challenge of determining how to offer care that makes...
it possible “… to expect and achieve a good or decent death – one that is free from avoidable distress and suffering for patients, families, and caregivers” (Institute of Medicine, 2003, p. 3). We believe that understanding the emotional and economic costs of bereavement in health care settings is one essential step in working toward compassionate, high-quality end-of-life care.

In this article, we briefly summarise the empirical literature related to the emotional and economic costs of bereavement in health care settings and propose an analytic framework as one possibility for generating future systematic research to improve bereavement-related care.

The existing empirical work in this area is in the earliest stages of development, and as has been true of other fields at this stage, research on bereavement in health care settings comprises a patchwork of individual studies rather than a cohesive body of evidence. In addition, the generalizability of the findings of many of the studies is limited by the samples or methods utilised and by differences in health care organisation and financing across countries. However, we believe that it is important to summarise what has been demonstrated with some consistency, both to encourage the use of this information to improve current care and to set the stage for additional, systematic research to guide care improvements in the future.

Our focus with respect to the emotional costs of bereavement is on findings regarding the emotional responses of health care providers to loss; the mental and physical health consequences of grief and bereavement in family members and others have been well described elsewhere (e.g., Genevro, Marshall, & Miller, 2004; Joanna Briggs Institute, 2006; Stroebe, Schut, & Stroebe, 2007).

In examining economic costs associated with bereavement in health care settings, we expand our focus to include all bereaved persons. Knowledge about the cost of bereavement (in terms of usage of medical care and other types of services, for example) and the cost-effectiveness of bereavement interventions (for whom and under what conditions) is likely to be valuable for health care policy makers and others who wish to improve the quality of end-of-life care and must make decisions about how limited health care resources are allocated. We summarise the relevant empirical literature, which consists of only a few studies, and then describe the types of information that would be needed to produce reliable estimates of the economic costs of bereavement for use by health care decision makers.

In keeping with the recommendations of the National Institutes of Health (NIH) State-of-the Science Conference Statement on Improving End-of-Life Care (NIH, 2005), we then propose a conceptual framework based on a health care systems perspective that could be used to guide future research related to the emotional and economic costs of bereavement in health care settings. The use of a conceptual framework is proposed as one pathway to
the development of a systematic body of evidence that ultimately could result in improvements in the quality and accessibility of appropriate end-of-life care, and in improvements in the work lives of health care providers.

This article is based on a review of literature pertaining to the emotional and economic costs of bereavement in health care providers. The empirical research literature that was considered for review was limited to English-language reports published subsequent to 2000; studies were identified through two targeted search processes, the first covering the years 2000-2005 and the second covering 2005-2008. The searches built on previous work by the authors (Genevro et al., 2004). Searches were conducted using key word and MeSH terms in Medline and other relevant health and social sciences data bases. Searches also were conducted using Google Scholar to identify publications in which the primary articles had been cited. Additional searches were conducted using citations in peer-reviewed reports of empirical research published subsequent to 2000 as a starting point. Other potential sources of background or contextual information (e.g., program reports, white papers, reports in the popular media) were identified primarily through Google searches and from citations in articles.

For the purposes of this article, we have focused on studies of the highest quality available. For quantitative studies, quality has been defined as “…the extent to which a study’s design, conduct, and analysis have minimized bias in selecting subjects and measuring both outcomes and differences in the study groups” (Lohr, 2004, p. 12; West, King, Carey et al., 2002). Three core criteria for judging the quality of evidence are internal validity (does a study generate valid information about the populations and settings in which it was carried out?), external validity (can the findings of a study be generalised to broader populations of interest?), and coherence or consistency (does the body of evidence make sense in the context of a larger conceptual model?) (Lohr, 2004, p. 12).

Based on these considerations, we have not included quantitative studies that relied on extremely small samples of convenience, studies that were designed to test the effects of an educational intervention but did not include a control or comparison group, or studies that had other serious design flaws. We have included well-designed and conducted qualitative studies. We caution that this targeted presentation does not represent a systematic review of the evidence.

The emotional costs of bereavement in health care settings

Research to date on grief and bereavement in health care providers has focused on those experiences from the perspective of the individual. Findings
from the growing body of research on grief in health care providers converge with the content of the personal observations of physicians, nurses, and other health care providers who have written eloquently, and often in profoundly moving ways, about their experiences of grief and bereavement in response to the deaths of patients (e.g., Bereiter, 2008; Chen, 2007; Katz & Johnson, 2006; Shanafelt, Adjei, & Meyskens, 2003). Although we do not address them here, these personal reflections offer another window into emotional reactions to death in the health care setting for the interested reader.

We propose that the emotional costs of bereavement in the health care setting are also health care systems issues. Examining the systems-level factors that may contribute to, exacerbate, or ameliorate the responses of health care providers to loss is, we believe, an important avenue for research in the future that could inform improvements in the quality of end-of-life care and in the work lives of providers of care.

Existing quantitative and qualitative research on the emotional costs of bereavement in health care providers is summarised briefly here, highlighting themes that are consistent across the empirical literature of good quality and the personal observations of providers, starting from the individual perspective. We then move to the level of the health care system. Finally, an organising framework for future research from a systems-level perspective is proposed.

Health care professionals’ emotional responses to loss and death in their work

Papadatou (e.g., 2009) has proposed a model of grief in health care providers that emphasises the role that relationships play in the provision of compassionate health care. This model suggests that health care providers, as other people, are likely to experience grief to the extent that they feel emotionally attached to the patients and families for whom they care. Rather than viewing health care providers as remote technicians and patients as simply bodies needing to be fixed, proponents of relationship-centred and patient-centred care suggest that the human interaction between providers and patients is not only beneficial to the patient, but a source of meaning to the provider. This perspective suggests that health care providers who invest themselves in the care they provide, and in the people for whom they care, are likely to experience grief when those patients die.

Studies of medical students and trainees, physicians, nurses, and long-term care staff indicate that many providers – often half or more – report at least one grief-related symptom in response to the death of a patient (e.g., Redinbaugh, Sullivan, Lock, Gadmer, Lakoma, Mitchell et al., 2003; Rickerson, Somers, Allen, Lewis, Strumpf, & Casarett, 2005). Common symptoms
included sadness, feeling upset when thinking about the patient, and feeling numb. A smaller number of health care staff, up to about 10 per cent, reported that they experienced more intense emotional and physical responses (e.g., Redinbaugh et al., 2003).

These responses are consistent with a model of health professionals’ grieving processes proposed by Papadatou (2000; 2009). This model suggests that health professionals fluctuate between two types of responses to the deaths of patients – experiencing grief reactions (by focusing on the experience of loss) and avoiding grief reactions. Papadatou (2000, p. 64) suggests that this fluctuation is “necessary, adaptive, and healthy”. This model is similar in many ways to the Dual Process Model proposed by Stroebe and Schut (1999).

Factors that have been found to influence providers’ emotional reactions to the death of patients include the provider’s sense of closeness or relationship with the patient. For example, duration of the relationship with the patient and closeness with the patient were two factors associated with the number of grief-related symptoms reported by staff in a long-term care facility (Rickerson et al., 2005). In another study of in-hospital physicians, the length of time the staff person had cared for the patient was associated with the number of symptoms of grief, and with the extent to which the provider found the death disturbing, but also was associated with greater feelings of closeness with the patient and having had a positive experience in caring for them (Redinbaugh et al., 2003).

The possible consequences of providers’ repeated exposures to loss and the deaths of patients also include burnout and occupational distress (e.g., Redinbaugh, Schuerger, Weiss, Brufsky, & Arnold, 2001). For example, a survey of the reactions of obstetricians to stillbirth or neonatal death found that 10 per cent of respondents indicated that the emotional toll of caring for a mother with a stillbirth led them to consider giving up their obstetric practice entirely (Gold, Kuznia, & Hayward, 2008).

Preliminary evidence indicates that the same complex set of emotions that health care providers may experience in response to the deaths of patients may also contribute to the provision of perceived or actual suboptimal care. For example, a study of family practice and internal medicine physicians indicates that clinicians who perceive themselves as stressed, dissatisfied, and burned out also report that they feel less capable of providing optimal care (Williams, Manwell, Konrad, & Linzer, 2007). In addition, depression is associated with self-reported medical errors in medical trainees (Fahrenkopf, Sectish, Barger, Sharek, Lewin, Chiang et al., 2008).

One reaction to the death of a patient can be to question the quality of the care that was provided (e.g., Reynolds, 2006; Ruopp, Good, Lakoma, Gadmer, Arnold, & Block, 2005). Physicians and medical students have reported feeling guilty in response to the death of a patient (Ruopp et al., 2005;
Serwint, Rutherford, & Hutton, 2006). Providers also may experience guilt because of perceived pressure to provide highly technological and aggressive care (Ruopp et al., 2005) that may be at odds with what they believe to be best for the patient, potentially at odds with other care providers, or at odds with the needs and wishes of the patient and family (e.g., Chiu, Hilliard, Azzie, & Fecteau, 2008). This perceived pressure may lead to ethical dilemmas regarding the provision of care and the health care provider’s role in determining and providing the highest-quality, most appropriate end-of-life care. These ethical dilemmas can themselves cause stress, which has been characterised as ‘moral distress’ (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004, p. 1075). Moral distress has been called “… an endemic problem among critical care nurses and a common reason for nurses to leave the field” (Byock, 2006, S419-S420).

**Conclusion**

Limited evidence indicates that some health care providers experience grief and other emotional reactions in response to the death of patients. The studies that are available indicate that factors such as closeness and duration of the relationship with the patient affect the responses of providers to patients’ deaths. However, large, representative (and therefore generalisable) studies have not been conducted. It is therefore not possible to draw firm conclusions about the extent to which health care providers experience grief, or are at risk for complications of grief.

**Health care system influences on providers’ responses to death and loss**

The culture of medicine and the training of health care providers have the potential to promote the provision of compassionate, high-quality care, and promote and sustain the well-being of individual providers. Research and the observations of individual providers would suggest, however, that this is a missed opportunity. Critiques of the prevailing culture of medicine in the United States suggest that an emphasis on technology rather than on the psychosocial aspects of care, in combination with a focus on cure, leads to a perception of death as failure (e.g., Sullivan, Lakoma, & Block, 2003, p. 693).

Data from multiple studies indicate that many physicians and physicians-in-training do not feel that they have been adequately prepared to provide end-of-life care or manage their own emotional reactions to the deaths of patients. Concerns about the training of health care professionals are reflected in evaluations of textbook content as well as content of curricula. Although it is possible that the inclusion of content related to end-of-life care and bereavement care has improved in the past several years, content analysis of
medical textbooks, pharmacy textbooks, and introductory psychology texts early in this decade indicate that substantial gaps exist in content related to grief and bereavement (e.g., Bookwalter, Rabow, & McPhee, 2003; Coppola & Strohmetz, 2002; Doe & Katz, 2006; Rabow, Hardie, Fair, & McPhee, 2000).

Health care providers also report feeling unsupported by their workplace and colleagues in their efforts to deal with their emotional reactions to the deaths of their patients, both in terms of formal support from their workplaces and more informal support from colleagues (Kaplan, 2000; Papadatou, 2000). Stage of career is related to reported levels of desired support from colleagues, with physicians in their first year after medical school (known as interns in the United States) reporting needing more support than more experienced faculty (Redinbaugh et al., 2003). Available evidence indicates that mentoring and support from colleagues may be particularly effective strategies to help providers develop ways of responding to patients’ deaths that are healthy for them personally and help them provide good care (e.g., Rushton, Reder, Hall, Comello, Sellers, & Hutton, 2006; Spickard, Gabbe, & Christensen, 2002).

In addition to feeling that they have not received adequate training and are unsupported in providing optimal psychosocial care at the end-of-life, health care providers have observed that the characteristics of the systems in which they work, including demands of time, make it difficult to allow themselves to experience the complex emotions associated with losing a patient (Shanafelt et al., 2003).

Moss and Moss (2002, p. 206) found that nursing home staff “carefully monitor their own feelings and expressions in an attempt to reach an appropriate balance between the loss and the expectations of the world of work”. Nursing home staff, who may develop very close relationships with those for whom they care over extended periods of interaction, also may experience “disenfranchised grief” (e.g., Doka, 2002) when they feel their relationships with the person who died does not give them the right to feel or express grief, or that their loss is not considered legitimate by the families of their patients, their institutions, or others. Moss and Moss (2002) suggested that disenfranchised grief may have direct costs to caregivers (in terms of staff well-being) and indirect costs to others, including other staff and residents. It may also have benefits, however, in that disenfranchised grief may make it possible for staff to do their jobs through the emotional distance it provides.

Conclusion

To conclude, we believe that as part of their commitment to the provision of high-quality end-of-life care, health systems must attend to the grief and
other emotional responses that may be experienced by health care providers. Doing so has the potential to improve the care of patients and families and reduce occupational distress in health care providers.

Additional research, especially epidemiological and descriptive research with representative samples and psychometrically sound measures, is needed to provide a firm foundation of evidence regarding health care professionals’ emotional responses to loss and death in their work. What is the prevalence of symptoms of grief in the general population of health care providers? In what ways does the experience of grief vary by years in practice, by specialty, by setting? Do the attitudes of clinicians toward death and loss differ from those of the general population, and if so, in what ways? How do most health care providers cope with the loss of patients? Specific areas that merit further investigation include the identification of factors that may predispose health care providers to complicated grief reactions, including organisational or professional attitudes toward the experience or expression of grief, “chronic” bereavement that may be experienced when working in certain specialties or in certain settings, and the loss of meaning in one’s work. As noted here, preliminary evidence has been gathered that addresses some of these questions, but a great deal of additional research is needed.

The economic costs of bereavement in health care settings

Although our examination of the literature related to the emotional costs of bereavement in health care settings was limited to health care providers, in this section on economic costs we expand the focus to include health care-related costs for all bereaved persons. Information about the effects of bereavement on health care utilisation and related costs, and about the cost-effectiveness of bereavement interventions, is likely to be of value to health care policy makers and others who wish to improve the quality of end-of-life care and must make decisions about how limited health care resources are allocated.

Unfortunately, evidence regarding the costs and cost-effectiveness of bereavement interventions is limited (e.g., Onrust, Smit, Willemse, van den Bout, & Cuijpers, 2008). Therefore, we provide an overview of the types of costs and cost information that would optimally be collected in research on bereavement in health care settings, and then summarise relevant research findings.

Analysing costs in health care is difficult for many reasons, including challenges in measuring costs, challenges in acquiring data, and challenges in defining what actual costs consist of (Lipscomb, Barnett, Brown, Lawrence, & Yabroff, 2009). Four types of costs have been identified as important in
analysing the costs of preventive interventions such as bereavement programs (Foster, Porter, Ayers, Kaplan, & Sandler, 2007). These are medical, nonmedical, productivity, and intangible costs. Direct medical costs include, for example, the costs of consultations with physicians, hospitalisation, and home care. Nonmedical costs include costs such as parking and travel, which may be direct costs to the patient or may be covered by some other entity. Categorisation of medical and nonmedical costs may vary from organisation to organisation. For example, depending on how services such as ethics consultations or chaplaincy services are provided and paid for, these services could be considered direct medical costs or nonmedical costs. Productivity costs are indirect, and include costs associated with work time lost due to incapacitation and/or time spent in medical visits. Estimates of productivity costs also may include the loss of capacity to perform tasks at home. Intangible costs are costs that are nonmonetary, such as stigma or loss of professional satisfaction, and are often extremely difficult to measure (e.g., Foster et al., 2007; Onrust et al., 2008).

In our search of the literature, we found four studies and one report from a large research initiative on end-of-life care that included information relevant to the economic costs of bereavement care in health care settings.

In the most directly applicable study, Onrust and colleagues (2008) conducted a cost-utility analysis of a community bereavement intervention comprising a visiting service for widowed individuals. The cost-utility analysis was conducted in conjunction with a randomized clinical trial of the visiting service intervention, which was carried out in 18 municipalities in The Netherlands. The researchers examined costs from a societal perspective, and included direct medical costs (costs of all types of health care services, not just services delivered by physicians), direct non-medical costs to patients (travel expenses, parking), and costs to patients attributable to inability to perform domestic tasks. The intervention consisted of 10-12 home visits by trained volunteers, offered to older individuals who had been widowed during the past year, had moderate or strong feelings of loneliness, no “full-blown mental disorder”, and the capability of participating in a 1-hour interview. Participants in the comparison intervention received a brochure on depressive symptoms that also included information to improve well-being. The primary outcome measure was a widely-used, generic measure of health status, quality-adjusted life years. The results of the study indicate individuals in the intervention group made less use of health care services. In the intervention group, costs separate from the cost of the intervention decreased. In the comparison group, costs increased. However, the cost savings in the intervention group were not large enough to compensate for the actual cost of the intervention (Onrust et al., 2008).

One other estimate of the cost of bereavement counselling is embedded
in an actuarial assessment of the costs of hospice care commissioned by the National Hospice and Palliative Care Organization (NHPCO) in the United States. Using data from 1998-1999, it was estimated that the “per patient per day” (PPPD) cost of bereavement counselling (based on an estimated 1.5 visits per patient) is $5.46 (Cheung, Fitch, & Pyenson, 2001, p. 16). The NHPCO National Hospice Data Set (Connor, Tecca, LundPerson, & Teno, 2004) also includes cost data gathered in 2002 from hospices around the country, but costs for bereavement services were not reported.

Prigerson, Maciejewski, and Rosenheck (2000, p. 350) studied health, health services use, and health costs in widowed and married individuals using data gathered as part of the longitudinal Americans Changing Lives study, which surveyed a representative sample of adults over the age of 25 years who lived in the continental United States. After controlling for demographic characteristics, life satisfaction, a number of variables related to health status, follow-up health insurance coverage, health services utilisation at baseline, and sample selection bias, the authors found that the widowed group at follow-up had a significantly higher average number of physician visits and days spent in a nursing home than the married group. Analyses also revealed that mean total health care costs and adjusted mean outpatient costs were higher for the widowed group than for the group that did not become widowed between 2 assessments (conducted 3 years apart). However, the researchers found that estimated adjusted total health care costs and estimated adjusted outpatient costs were significantly higher for widowed individuals who reported high levels of marital harmony than for widowed individuals who described their marriages as discordant. The authors suggest that “prior work demonstrating the connection between positive marital quality and greater severity of traumatic grief symptoms suggest that the influence of marital harmony on health, health service utilisation, and health care costs may be mediated through symptoms of pathological, or complicated, grief” (Prigerson et al., 2000, p. 356). It was not possible to test this hypothesis directly, however, because the data did not include assessments of traumatic grief symptomatology.

The study examined many of the variables that should be considered in estimating health care costs related to bereavement (e.g., total health care costs, costs of outpatient care), but findings were based on a small sub-sample of 61 adults drawn from the larger study. Because of the limitations of the study (the small sample size and the self-report nature of the health services utilisation data), these findings can contribute only modestly to a larger understanding of the economic costs of bereavement in health care settings.

In another study conducted in the United States, Prigerson and colleagues (Zhang, Wright, Huskamp, Nilsson, Maciejewski, Earle et al., 2009) investigated associations between end-of-life conversations between patients with
advanced cancer and their physicians, and health care costs in the last week of life; bereavement care was not directly addressed in this study. As part of this study, formal (e.g., physicians and nurses) and informal caregivers (e.g., spouses) were asked to rate the “overall quality of the patient’s death/last week of life” on a Likert-type scale that ranged in value from 0 (worst possible) to 10 (best possible). The investigators found that end-of-life conversations between patients and physicians were associated with significantly lower health costs in the patient’s last week of life. The researchers also found that higher health care costs at the end of life “were associated with poorer quality of death/last week of life, as reported by the patient’s formal (e.g., physicians and nurses) and informal (e.g., spouse) caregivers” (Zhang et al., 2009, pp. 480-481).

A final report demonstrates additional challenges in gathering cost data that can be used to develop a general understanding of the economic costs of bereavement in health care settings. Twenty-two demonstration projects for delivering improved palliative care were funded by the Promoting Excellence in End-of-Life Care, a national program of The Robert Wood Johnson Foundation in the United States. These demonstration projects were designed to address “documented deficiencies in the care of patients and families facing the final stage of life” (Byock, Twohig, Merriman, & Collins, 2006, p. 137). Financial outcomes and effects on costs were assessed in some projects, but because of variations in research design and methods across projects, there are no aggregate findings available. For example, in some of the evaluations of individual projects, resource use (measured in visits, hospitalisations, and hospice days) was used as a proxy for cost data. In other projects, financial outcomes were assessed directly; key informant interviews were also used in some projects to gather information on costs to participating health care systems (Byock et al., 2006, p. 139). In addition, “[c]omplexities of health care billing and pricing make it difficult to account for actual costs” (Byock et al., 2006, p. 142). Taking these limitations into consideration, data were reported by several of the projects that indicate that providing palliative care (concurrent with life-prolonging treatment) “was financially neutral or associated with measurable savings” (Byock et al., 2006, p. 142). No cost data were reported related to provision of bereavement services.

Conclusion

The evidence available indicates how difficult it is to collect and analyse reliable cost data at the individual, provider, and systems level, all of which are required to accurately estimate the total economic costs of bereavement in health care settings. Because of the limited research in this area, it is not possible at present to draw conclusions about the costs of bereavement, or
the cost-effectiveness of bereavement services, in health care settings even in one country. In addition, although the types of costs and principles of cost analysis might be the same, differences in health care financing in different countries dictate that conclusions cannot be generalised across financing systems. However, findings from the most directly relevant studies suggest that additional well-designed, larger-scale studies of the economic costs of bereavement and bereavement care in targeted populations (e.g., older widowed adults) would be likely to provide information that could be used in a variety of circumstances to guide the design and provision of effective care.

A framework for studying the emotional and economic costs of bereavement in health care providers and health care systems

Research on the emotional and economic costs of bereavement in health care settings is in the early stages of development and there is much to be learned. A recent systematic review of evidence on improving the quality of palliative care at the end of life did not include bereavement research, but suggests that future reviews address this topic (Lorenz, Lynn, Dy, Shugarman, Wilkinson, Mularski et al., 2008). A tremendous opportunity exists, therefore, to systematically consider what evidence is needed by policy-and decision-makers to improve the quality of bereavement care in health care settings, identify gaps in current knowledge, and formulate research questions that should be asked to advance knowledge. The challenge is to build a systematic body of evidence to guide improvements in the quality of end-of-life care, in access to appropriate end-of-life care, and in the work lives of health care providers.

In Figure 1, we propose a conceptual framework that could be used to guide research on the emotional and economic costs of bereavement in health care settings. It is based on similar frameworks developed by the U.S. Preventive Services Task Force in the systematic review of evidence related to the harms and benefits of clinical preventive services (Harris, Helfand, Woolf, Lohr, Mulrow, Teutsch et al., 2001). The value of this type of framework is that it facilitates the systematic identification of key research questions and the types of evidence that could be used – or should be generated – to answer those questions. The proposed analytic framework identifies the chain of evidence that would be necessary to establish the effectiveness of screening for and treatment of complications of grief or other bereavement-related concerns on outcomes such as health, productivity, and quality of life. The framework could apply to a family member, informal caregiver or health care professional who has experienced a loss.

The analytic framework as depicted also builds on a suggested process
Family member, informal caregiver, and/or health care provider who has experienced a loss

**Screening**
- Early identification of patients or providers with complications of grief or other bereavement-related concerns

**Treatment**
- Reduced complications of grief

**Potential Costs:**
- Costs associated with screening, data collection, the opportunity costs of being screened and the indirect costs of developing reliable and valid screening tools.

**Potential Costs:**
- Costs associated with training, care, time and opportunity costs of providing bereavement care; costs of bereavement services/intervention.

**Hypothesized Association**
- Healthy functioning
  - Productivity
  - Quality of Life

**Potential Costs:**
- Costs associated with individuals who are suffering from unidentified complications of grief. These may include: cost of physical and mental health care, medical errors or suboptimal care; decreased quality of life; decreased productivity; staff turnover.

---

**Figure 1**

*Understanding the effects of bereavement on costs: a proposed analytic framework from a health systems perspective*
Table 1
Examples of key research questions related to a proposed framework for the investigation of the emotional and economic costs of bereavement in health care settings, presented in Figure 1

<table>
<thead>
<tr>
<th>Steps in the Proposed Analytic Framework</th>
<th>Examples of Key Research Questions Related to Emotional Costs of Bereavement in Health Care Settings</th>
<th>Examples of Key Research Questions related to Potential Economic Costs of Bereavement in Health Care Settings</th>
<th>Purpose of the Analysis</th>
<th>Target Audience for the Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Describe the population.</td>
<td>Example:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>General population: Bereaved individuals (this could include family members, informal caregivers, and health care providers who have experienced a loss).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subpopulation of interest: Health care providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What is the incidence and prevalence of grief-related symptoms in representative samples of health care providers?</td>
<td>What are the direct costs to health care systems and individuals for physical and mental health care for bereaved health care providers?</td>
<td>Describe the epidemiology of grief in health care providers; describe associated direct and indirect health care costs.</td>
<td>Researchers; health care policy- and decision-makers</td>
</tr>
<tr>
<td></td>
<td>Do symptoms vary by professional role, health care setting, demographic characteristics, and other factors, such as the provision of patient-centred or relationship-centred care?</td>
<td>What are the indirect health care costs associated with bereavement in health care providers? These may include: opportunity costs to individuals for medical visits for physical or mental health problems; costs associated with medical errors and suboptimal care resulting from staff bereavement (or related depression); costs of staff turnover related to chronic bereavement (e.g., recruitment and training costs), decreased productivity, and diminished quality of life.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steps in the Proposed Analytic Framework</td>
<td>Examples of Key Research Questions Related to Emotional Costs of Bereavement in Health Care Settings</td>
<td>Examples of Key Research Questions related to Potential Economic Costs of Bereavement in Health Care Settings</td>
<td>Purpose of the Analysis</td>
<td>Target Audience for the Analysis</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>---------------------------------</td>
</tr>
</tbody>
</table>
| 2. Identify the population(s) and sub-population(s) to which interventions could (should) be targeted.  
Example:  
General population: Bereaved individuals who are experiencing complications of grief or other bereavement-related problems.  
Subpopulation of interest: Health care providers who are experiencing complications of grief or other bereavement-related problems.  
What is the most effective method of screening health care providers for complications of grief (what benefits, if any, does screening offer; who should do it; where should it be done; what are the potential harms, if any, associated with screening)?  
Are there reliable and valid screening tools that can be used to identify bereaved health care providers who are likely to benefit from bereavement care?  
Are there reliable and valid screening tools that accurately identify health care providers who are experiencing complications of grief? | What are the direct costs to health care systems for screening and data collection?  
What are the indirect costs of screening? These might include the development and testing of reliable and valid screening tools. | Determine whether screening for complications of grief in health care providers is needed, feasible, reliable, and effective. | Researchers; health care policy- and decision-makers; health care providers |
<table>
<thead>
<tr>
<th>Steps in the Proposed Analytic Framework</th>
<th>Examples of Key Research Questions Related to Emotional Costs of Bereavement in Health Care Settings</th>
<th>Examples of Key Research Questions Related to Potential Economic Costs of Bereavement in Health Care Settings</th>
<th>Purpose of the Analysis</th>
<th>Target Audience for the Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Provide bereavement care.</td>
<td></td>
<td></td>
<td>Evaluate the effects of a bereavement intervention on physical and mental health outcomes in a specific sub-population of health care providers; determine the costs and cost-effectiveness of the intervention</td>
<td>Health care policy- and decision-makers; program planners; health care providers; researchers</td>
</tr>
<tr>
<td>Example:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Design, implement, and evaluate an on-site bereavement intervention for health care providers in nursing home settings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What types of bereavement care (if any) lead to improved outcomes in health, quality of life, and productivity for health care providers in specific settings?</td>
<td>What are the <strong>direct</strong> costs associated with the intervention? These may include: staff salaries related to the provision of the intervention and associated administrative services; costs to the participants.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there potential harms associated with bereavement care?</td>
<td>What are the <strong>indirect</strong> costs associated with the intervention? These may include: the costs of training staff and/or volunteers to provide appropriate, high-quality bereavement care; overhead related to the provision of bereavement-related services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What are the <strong>indirect</strong> costs that apply in the absence of the intervention? These may include employee assistance services; costs associated with medical errors and suboptimal care resulting from staff bereavement (or related depression); and costs of staff burnout/turnover (e.g., recruitment).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What is the effect of the intervention on total direct and non-direct costs?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
for health cost analysis. Lipscomb and colleagues (2009, p. S120) recently identified “the elements of a research agenda for improving the scientific soundness and relevance of health cost analyses for decision making”. These elements comprise a series of steps in health cost analysis that the authors recommend be adapted to the specific area or intervention of interest. The two steps in the series that are most relevant here are: 1) to define the purpose of the analysis, the types of costs included, and the target audience for the analysis; and 2) to identify the resources used and their economic costs (Lipscomb et al., 2009, p. S120).

In Table 1, we combine the proposed analytic framework (Fig. 1) with the first two steps in health cost analysis proposed by Lipscomb and colleagues (2009). We link key research questions with steps in the analytic framework, define the purposes of and target audiences for the suggested analyses, and identify possible types of costs that could be included. The examples in Table 1 offer an idea of the types of studies that could be conducted to provide policy- and decision-makers with evidence about the emotional and economic costs of bereavement in health care settings, and that could be used to guide improvements in the quality of bereavement care.

We understand that it is unlikely that any single study could address the entire analytic framework. However, it does offer a way to think systematically about a program of research that could be developed to provide evidence that answers questions at each step, with the goal of developing a chain of evidence across the entire framework.

Conclusions

Researchers have taken beginning steps to understand the grief reactions of health care providers and the economic costs of bereavement and bereavement care, but a great deal of work remains to be done to generate a comprehensive understanding of the emotional and economic costs of bereavement in health care settings. We propose that one way to maximise the intellectual contribution of research in this area would be to use an analytic framework to consider the larger picture of bereavement in health care settings, how available evidence fits into the larger picture, and what evidence is needed. This approach, which is derived from health services research, may be unfamiliar to social sciences researchers. We hope, however, that it will be useful in stimulating thinking about how best to investigate questions related to the emotional and economic costs of bereavement in health settings, and in guiding the design and implementation of multi-method, interdisciplinary research that both advances our understanding and improves bereavement care.
References


Joanna Briggs Institute. (2006). *Literature review on bereavement and bereavement*
care. Joanna Briggs Collaborating Centre for Evidence-based Multi-professional Practice, Faculty of Health and Social Care, The Robert Gordon University, Aberdeen, Scotland.


Received August 25, 2009
Revision received February 19, 2010
Accepted February 25, 2010
EFFECTS OF SUPPORT, COUNSELLING AND THERAPY BEFORE AND AFTER THE LOSS: CAN WE REALLY HELP BEREAVED PEOPLE?

Henk SCHUT & Margaret STROEBE
Utrecht University, The Netherlands

Can other persons, personally or professionally, help bereaved individuals deal with the loss of a loved one? An increasing number of empirical studies, as well as qualitative and quantitative reviews, have addressed this question. Here, the main findings are summarised and implications for researchers and practitioners considered. First, provision of help from the informal social network and volunteers/professionals in the post-loss period is examined. Second, and uniquely in this research area, examination is extended to the efficacy of intervention for family members prior to their bereavement (i.e., in the context of palliative/end-of-life care). To what extent do the pre-loss patterns mirror those for post-bereavement intervention efficacy? A main conclusion is that intervention is not effective for bereaved persons in general, either when this is provided before or after the actual loss. It is important to identify and target high-risk persons. Further scientific and clinical implications of the patterns of results are discussed.

Introduction

The death of a loved one can occur in a peaceful, timely manner with ample opportunity to say goodbye, or it can follow a violent, untimely death that comes without any forewarning or possibility for preparation. Whatever the circumstances, the loss of a loved one is associated with intense suffering and can lead to serious mental and physical health problems (Stroebe, Schut, & Stroebe, 2007). While some emotional reactions can hardly be avoided following the loss of a loved one (e.g., most people feel intense sadness and distress), a key question is how others can protect the bereaved from unduly long-lasting and/or extreme consequences. Is there scientific evidence that intervention is really beneficial to the bereaved?

When death occurs expectedly, as described above, support from the informal network and volunteers or professional counsellors/therapists can potentially be provided for family members facing the incumbent loss of their loved one; when it is unexpected, this is naturally not possible, intervention

Henk Schut and Margaret Stroebe are affiliated with the Department of Clinical and Health Psychology, Utrecht University.
Correspondence concerning this article should be addressed to Henk Schut, Utrecht University, Dept. Clinical and Health Psychology, P.O.Box 80140, 3508 TC Utrecht, The Netherlands. Email: h.schut@uu.nl
can in such cases only take place in the post-loss period. In the available scientific literature, considerable attention has been paid to the efficacy of post-loss intervention: empirical studies and reviews in the bereavement research literature have focused on this period. Yet, a growing number of researchers have also examined the efficacy of providing support earlier in time, namely, to family members in palliative or end-of-life-care settings. To our knowledge, and somewhat surprisingly, the link specifically between post- and pre-bereavement intervention efficacy has not yet been made in the research literature. In our view, there is much to be gained by examining the results of these two growing bodies of evidence alongside each other, not least because it should ultimately provide a more complete picture of the benefits of care from others to persons suffering the (impending) loss of a loved one. For example, it is possible that effective pre-loss intervention may lower the need for post-loss intervention. Thus, a major interest here is to examine whether the patterns found for the efficacy of post-loss intervention are paralleled by those for the pre-loss provision of help.

To summarise, a number of questions are central. We revisit the questions that have been the focus of bereavement research in this area: Does support from family and friends ameliorate the impact of loss? Does voluntary or professional help reduce the impact of bereavement? Following the arguments presented above, we add a third question that has typically been omitted in reviews of the efficacy of bereavement intervention: Is intervention effective for family members within the context of palliative and end-of-life care? These three questions form the underlying theme of this article, in which we present key empirical findings and raise some challenging issues for researchers and clinicians alike.

Before addressing these questions, we need to be clear about precisely what types of help we cover in discussing benefits for bereaved persons during the post- and pre-loss periods. We look at psychological support from both informal as well as organised or institutional sources, that is, at help from others that aims to ameliorate grief. When considering volunteer/professional sources of intervention, we cover psychological aid, counselling and therapy. We exclude those sources that have not yet been subject to sufficient empirical testing, such as pastoral care and support being offered by funeral directors and general practitioners.

Furthermore, it is important to note that we are not providing a comprehensive review, that is beyond the scope of this article. Rather, we have selected what we consider to be well-designed, more-conclusive studies as illustrations for the patterns of results reported in the scientific literature. In particular, such studies typically included pre- and post measurement (preferably with follow-up data collection). Studies had an experimental as well as a non-intervention control condition, with careful assignment to groups.
In the next section we concentrate on the efficacy of post-loss intervention. First, we address the question whether social support is helpful to the bereaved. Following that, we examine the role and impact of counselling and therapy in bereavement. We then go on to consider pre-loss efficacy research, examining the benefits of intervention in the terminal phase of the loved one’s life. Finally, we discuss broader implications of these findings.

Efficacy of support: post-loss studies

Does social support help?

There are two ways in which help from friends and family can facilitate adjustment during bereavement. First, it can protect individuals against the impact of a major stressor. This so-called *buffering effect* (Cohen & Wills, 1985) states that the availability of social support protects individuals to some extent from the deleterious effects of stressful life events. Considering that bereavement is a stressful situation, this implies that social support is more helpful to bereaved persons than to people who have not suffered a loss. Second, social support can facilitate life in general, regardless of whether or not one is confronted with stressful situations. The latter is also known as the *main effect* of social support on health. If this is correct, social support is as helpful to the bereaved as it is to the non-bereaved, in other words, it makes life easier in general.

The above two possibilities were first put to the test in a study by Stroebe, Stroebe, Abakoumkin, and Schut in 1996, in which the impact of social support on depression was examined in a sample of widowed men and women compared with married counterparts. Results showed that there was no evidence of a buffering effect: social support helped widowed as much as it did married persons. Those with more support from persons around them reported less depression than those with lower levels of support, regardless of marital status. This seems to suggest that, although social support in general is helpful, the loss of a loved one leads to deficits in support that cannot be compensated by others, providing no evidence for a buffering effect. Rather, these findings may be more consistent with theories that state that such compensation is not possible. Most notably, they seem to be in line with attachment theory claims. Bowlby (1973) argued that an attachment figure is uniquely able to foster general feelings of security and that others cannot simply take over this function. More specifically, Weiss (1973) differentiated social from emotional loneliness. Social loneliness refers to the feeling that there is nobody to count on for support, there is absence of an engaging social
network and lack of social embeddedness. Emotional loneliness denotes a sense of utter aloneness and isolation, whether or not others are accessible. Weiss reasoned that the loss of an attachment figure results in emotional loneliness and that social support from friends cannot reduce this type of loneliness.

Further analyses of the Stroebe et al. (1996) data confirmed this. Levels of social loneliness were similar for married and for widowed, but were higher for those low on social support in both marital categories. By contrast, the pattern for emotional loneliness showed that widowed persons had significantly higher levels of this type of loneliness, regardless of whether they were receiving high or low social support. In other words, the widowed were extremely emotionally lonely, compared with the married, and it did not seem that social support from others had an impact on this. Further support for this comes from a study by Guiaux (in progress), which included a large number of participants, had data collected both before and after the loss, and used sophisticated techniques of data analysis. Results showed that help from friends and family positively affected social loneliness, but did not affect emotional loneliness. Together, these studies suggest that emotional loneliness is a core element of grief, and that it is precisely this that cannot be reduced by friends and family. As much as one may want to help, this illustrates the limitations inherent in our efforts to try to help the bereaved.

These results seem disappointing with respect to receiving support. But is it possible that giving support to others is successful in predicting stress-related outcomes among the bereaved? In this context, Brown, Brown, House, and Smith (2008) suggested that bereaved people who provided support to others would show evidence of stress buffering. They examined the role of self-reported helping behaviour on the bereaved helpers’ depression rates in a longitudinal investigation, controlling for many potentially-confounding variables (e.g., health and robustness). Giving help to other bereaved people was associated with faster decline in depression for the helper over time. Along similar lines, in another sophisticated, longitudinal study, Li (2007) investigated how volunteer participation among widowed persons has an impact on coping with the death of a spouse. Importantly, participation among widowed persons was compared with that of continually married counterparts, enabling examination of bereavement-specific versus general effects of volunteering. Compared with their continually married counterparts, people who experienced spousal loss reported greater likelihood of pursuing volunteer roles a few years after the death of their spouse. Importantly, volunteering was found to protect against depressive symptoms, suggesting that this type of helping offsets the negative effect of widowhood on well-being.

In conclusion, although it seems evident that help is needed and appreciated, there are limits to the support that others can offer in helping the
bereaved. One cannot, it seems, take away the pain of losing the deceased person or in any way “replace” him or her. Ironically, taken together, the studies outlined above also seem to suggest that social support is helpful, but even more to the one who is providing than the one who is receiving it.

*Do grief counselling and grief therapy help?*

Next we turn from informal to more organised or professional help. Before assessing the state of knowledge about the efficacy of these types of intervention, it is necessary to draw a fundamental distinction, namely, between *satisfaction with* versus *effectiveness of* intervention. In both research and clinical settings, these two very different phenomena are often treated as the same thing, causing much confusion about the efficacy of intervention.

Satisfaction with versus effects of intervention

The question whether grief interventions are helpful is likely to be answered differently according to the interests of or type of person to whom one addresses this question. If one asks clients, studies show that the vast majority is satisfied. Gallagher, Tracey, and Millar (2005), for instance, undertook an evaluation of bereavement counselling by clients subsequent to their participation in a service provided by Cruse, a national organisation for bereavement care in the UK and Northern Ireland. Six weeks after the end of counselling, clients in the study reported (strongly or very strongly) that they now felt the loss less intensely (89%); experienced fewer physical symptoms (88%); felt less anxious (81%), found it easier to cope (85%); felt more confident (72%), were more able to relate to others (86%) and were more able to look to the future (80%). Therapists and counsellors may indeed be inclined to endorse this picture of the bulk of clients being satisfied with the help offered. Certainly, these results are impressive in that they indicate high satisfaction with the provision of help.

However, as noted above, it is of crucial importance to differentiate *satisfaction* with intervention from *effects* of intervention. Change in distress that takes place during intervention is often attributed to the intervention itself, whereas over time change can take place naturally, and precisely this is the case with a process like grieving, in contrast to more stable conditions such as phobias. For example, finding it easier to cope could be a result simply of the passing of time and may have nothing to do with the intervention. If researchers were asked about the efficacy of intervention, they would be more likely to take this natural change into account. A good design of an efficacy study would include the possibility of differentiating natural change from change attributable to the intervention. To establish whether an intervention is helpful, it would require a comparison between an intervention and a non-
intervention control group. The design of such a study would necessitate a pre and post intervention assessment¹. Although the two kinds of approaches complement each other, it needs to be kept in mind that clients can be satisfied with help that is not effective and vice versa.

Effects of intervention post-loss

During the last decade, several extensive qualitative reviews and meta-analyses have been published, reporting patterns in the efficacy studies of grief therapy and grief counselling (Allumbaugh & Hoyt, 1999; Currier, Holland, & Neimeyer, 2007; Currier, Holland, & Neimeyer, 2010; Currier, Neimeyer, & Berman, 2008; Kato & Mann, 1999; Larson & Hoyt, 2007; Schut & Stroebe, 2005; Schut et al., 2001). Although these evaluations do not all come to exactly the same conclusions, and the scientific debate about the efficacy of bereavement intervention still continues, the evidence points in the direction that most bereaved people do not need and will not gain from grief therapy or counselling. It seems that the majority of bereaved people is resilient enough to adapt to the loss without the involvement of counsellors and therapists (Bonanno, Wortman, & Nesse, 2004). Outreaching interventions aimed at all bereaved people, regardless of their background or situation, cannot be regarded as beneficial in terms of diminishing grief-related symptoms (Schut et al., 2001). This appears to be true for interventions for adults as well as for children (Currier et al., 2007). The first one to draw this conclusion was actually Parkes (1996), more than a decade ago, when he concluded that there was no evidence that all bereaved people benefit from counselling and that research had shown no benefit to arise from the routine referral of people to counselling for no other reason than that they have suffered a bereavement. Some years have passed since Parkes wrote these words, and there are signs that processes and procedures have changed in bereavement care. Nevertheless, unsolicited and routine help is still being offered to the bereaved.

Intervention programs that are in principle open to all bereaved persons, with the criterion for participation being simply that one has experienced a loss through death, are known as primary preventive interventions². For primary preventive intervention to be helpful it seems at least necessary for clients to initiate help themselves, instead of help being offered to them (Currier et al., 2008; Schut & Stroebe, 2005; Schut et al., 2001). Interventions targeted at bereaved persons at risk of developing complications, so-called secondary

---

¹ These are just basic requirements for evidence-based treatments (see Kazdin, 2008 for a detailed discussion).
² Different labels were subsequently used by Currier et al. (2008), but refer to the same categories.
preventive interventions, appear sometimes to be modestly effective, but often this improvement is only temporary. When important longer-term effects are analysed, positive effects of the intervention often seem to vaporise. Clear and positive results are established when interventions exclusively target grievers displaying complicated grief in trying to adapt to the loss, known as tertiary preventive interventions. In the latter category, outcomes may even compare favourably with psychotherapies for other disorders (Currier et al., 2008).

How can such rather disappointing results be explained, specifically the results in the first category of interventions for all bereaved people? First of all, as was suggested before, it seems likely that, specifically when help is being offered to the bereaved instead of being asked for, a substantial proportion of bereaved people was not in need of help and was resilient enough to deal with the loss without interference from care givers (cf. Bonanno et al., 2004; Raphael, Minkov, & Dobson, 2001, Schut et al., 2001). The fact that they nevertheless accepted help being offered to them does not contradict this. That people may be resilient does, after all, not mean that they are not affected by the loss, and help offered in times of emotional turmoil is likely to be accepted, despite the fact that the person may have been able to deal with their loss by using their natural resources.

Research does indeed suggest that primary preventive intervention that is initiated by the bereaved themselves shows better results (cf. Larson & Hoyt, 2007; 2009; Schut & Stroebe, 2005), which can be understood as substantiating the above argument. A second explanation may be that help offered may interfere with the natural grieving process. Tudiver, Hilditch, Permaul, and McKendree (1992, p. 180), for instance, suggested that, for their mutual help groups, “focusing widowers’ attention on their own and others’ grief may have hindered an early (and measurable) recovery from their grief”. A study in the Netherlands by de Keijser (1997) also showed that the natural support system of the bereaved tends to be perceived by the bereaved themselves as withdrawing when professional help is accepted. A third possible explanation may be that the intervention offered to the bereaved could be based on questionable assumptions. The majority of interventions for bereaved persons is based on the assumption that confronting the loss, working through grief, is indeed beneficial, although research has shown this not always to be the case (cf. Bonanno, Keltner, Holen, & Horowitz, 1995; Stroebe, 1992, Stroebe, Schut, & Stroebe, 2005, Wortman & Cohen-Silver, 2001).

In conclusion, taken together, the patterns of findings available so far, as summarised above, suggest that intervention is not effective for all bereaved persons. Health care professionals need to identify and provide support for “at risk” persons and those experiencing complications in their grieving process. Nevertheless, we want to emphasise that more research is needed, as illustrated next.
The relevance of risk factors in intervention: an example

Since prevention of pathology is desirable on the one hand, and since, on the other hand, it is equally desirable to target interventions as much as possible toward those who gain from them, preventive interventions for risk groups need more attention (this point will be elaborated on when we come to pre-bereavement intervention). The fact that effects for that category of bereavement care are generally speaking modest and temporary should be regarded as a challenge, both scientifically and clinically. It seems likely that results within this category of grief interventions could be improved if we had better understanding of risk and protection factors. Such factors have been categorised according to the situation and circumstances of death, intrapersonal risk or protective factors, interpersonal or non-personal resources and protective factors, as well as coping styles, strategies and processes (Stroebe et al., 2007). In recent decades many studies have focused on tracing risk factors within these categories, but thus far this has not resulted in a clear picture of moderators and mediators in the grief process (Stroebe et al., 2007). This is likely to be due to the complexity and interaction of these factors in how they influence the level and course of grief manifestations (e.g., between personality and circumstances of death) (Stroebe, Folkman, Hansson, & Schut, 2006). This makes it very difficult to develop valid and reliable screening instruments for use by practitioners.

Yet, not all risk factors are complicated to start with. Let us take a closer look at gender for instance. Research has sufficiently proven that men react more strongly to the loss of their spouse than do women (Stroebe, Stroebe, & Schut, 2001) and there is also ample evidence that women show stronger grief reactions after the loss of a child than men (cf. Murphy, 2008). This suggests a rather strong interaction between gender and relationship to the deceased on grief manifestations. Furthermore, several intervention studies have suggested gender specific effects of grief intervention for persons experiencing difficulty in dealing with their loss. Schut, Stroebe, van den Bout, and de Keijser (1997) found that an emotion focused intervention was more efficacious in the long term for widowers, while a problem focussed approach turned out to be more helpful for widows. This study needs replication, but it may also explain why some results of grief intervention are disappointing. For instance, Walter (1999, p. 182), on the basis of these results, concluded that “In general, in such situations, women like talking about their feelings and men like to stay away from counselling, but overall, the system may be ineffective, because it gives clients what they want rather than what they need. […] Bereavement organisations have been offering the wrong things to the wrong people”.

Murphy (2008; Murphy, Johnson, Cain, Das Gupta, Dimond, Lohan et al. 1998) also studied gender differences in effects of grief intervention, but
focussed their study on parents having lost a child through suicide, homicide or accident. Furthermore, Murphy developed an intervention that combined emotion and problem focussed aspects. Strikingly, Murphy and colleagues found no effects at all of the intervention for fathers. Among mothers, they found a positive outcome for those with relatively high levels of distress before the interventions, while negative results were discovered for mothers with relatively low levels of distress at baseline.

To conclude: even with respect to a risk factor such as gender that should be relatively easy to investigate, we have to conclude that too little attention has thus far been paid to the impact of grief intervention. Yet, the studies mentioned above do suggest that risk factors such as gender are very important to take into consideration in developing bereavement care in the community. However, the studies also seem to suggest that even a simple moderator like gender soon becomes rather complicated, in that apparent levels of distress at baseline and relationship to the deceased seem to play an important interacting role in terms of effects of interventions. Nevertheless, it seems of crucial importance to take these aspects into consideration, because otherwise bereavement organisations could indeed be offering the wrong things to the wrong people as Walter (1999) seems to be warning us.

Effects of intervention before the loss

As noted at the outset, reviewers of the efficacy of bereavement intervention, including ourselves, have excluded examination of the effects of professional support on bereaved family members in the period before the loved one died. Perhaps this is not surprising since, historically, end-of-life care and bereavement care were typically the focus of separate scientific investigation. Also, clearly, such provision would not be possible for the subgroup of persons whose loved one dies suddenly or unexpectedly. In our view, though, it is a natural extension to examine whether pre-bereavement intervention is effective for family members, and whether the patterns identified above are actually replicated in the end-of-life phase.

One important distinctive feature of this pre-loss as opposed to post-loss care – that could actually influence the impact of this type of intervention – is the fact that there is often continuity in the care provided before and after the loss. Such continuity often implies a certain stability in pre-bereavement and post-bereavement support (e.g., Field, Payne, Relf, & Reid, 2007), possibilities for early risk assessment (e.g., Parkes, 1996; Payne & Relf, 2001) and rather naturally-occurring possibilities for follow-up assessment (Walsh, Foreman, Curry, O’Driscoll, & McCormack, 2008). For such reasons, we cannot assume that the conclusions drawn so far with regard to the effects of post-bereavement intervention are applicable to the provision of support before the loss has occurred. For example, pre-loss intervention may indeed be
more generally beneficial to family members, not just for those at high risk of difficulties in adjusting to impending loss. It becomes very important, then, to extend the scope of investigation to examining the efficacy of end-of-life care for family members.

Major reviews of the literature on the efficacy of end-of-life care on the bereaved have been provided by Lorenz, Lynn, Morton, Dy, Mularski, Shugarman et al. (2004), and by Higginson, Finlay, Goodwin, Hood, Edwards, Cook et al. (2003), who conducted a meta-analysis of 26 studies of palliative and hospice care. These reviewers came to similar conclusions. Family members were more satisfied with the quality of care than those who had not received terminal care (there were also substantial positive effects on patients). However, it was concluded that there were no effects with respect to post-loss bereavement outcomes on caregivers and family members. Lorenz et al. (2004) further concluded that results were highly discrepant across studies. The reviewers also had critical remarks to make about the quality of the studies in general (Harding & Higginson, 2003). In one of the best studies reviewed (Ringdal, Jordhoy, Ringdal, & Kaasa, 2001), family members were randomly assigned to receive comprehensive palliative care or conventional oncological care. Follow-up was conducted one year after loss. No differences in bereavement outcome were found between the family members in the comprehensive intervention and the control group.

Similar to the conclusions we drew from the post-bereavement intervention efficacy studies, the pattern here seems to be in line with those we drew concerning primary intervention. Again there is no sound evidence that offering help to family members in the context of end-of-life care in general is effective. Therefore, we have to look at risk groups again. One well-designed randomized controlled trial that examined the impact of family focused grief therapy in palliative care was conducted by Kissane, McKenzie, Bloch, Moskowitz, McKenzie, & O’Neill (2006; Kissane & Lichtenthal, 2008). While the overall impact of family focused grief therapy was modest, significant improvement in distress and depression was found among individuals with high baseline levels of distress. The above results indeed suggest that a focus on risk groups in the provision of pre-loss intervention may be the best strategy to follow, as was the case for post-loss intervention. However, as Harding and Higginson (2003) stated, more high quality research is needed before firm conclusions can be drawn.
Conclusions

The identification of patterns, and finding similarities in these across the pre- and post-loss investigations of the efficacy of intervention, is hopefully useful to both researchers and clinicians in planning their work. Nevertheless, it is evident that helping the bereaved deal with the consequences of bereavement is not simple. That is not only true in the case of friends and family, but also for volunteers and professionals in the bereavement sector. We all need to be modest in what we think we can accomplish. This does not mean that we cannot help, but we need to be aware that what may be the core element of grief, emotional loneliness, is something a bereaved person needs to slowly and at his or her own pace adjust to, and that help from others is incapable of healing that pain. That does not mean that friends and family cannot help, they can indeed. But it does not seem to help bereaved persons any more than it does non-bereaved.

As for volunteers and professionals providing help to the bereaved, according to the research available at present, they need to be modest too. No evidence has been found that care for the bereaved in general, provided on an institutional level, is effective. This is specifically the case when help is provided routinely and is initiated by care providing agencies instead of the bereaved themselves. Grief interventions for specific target groups show better results, but there is much that needs to be done before this, in itself a promising category of intervention, proves its true value. The primary challenge, and maybe even the key responsibility for further development of the theoretical and empirical basis for this type of intervention, lies with the scientific community, although close collaboration with practitioners will be necessary. Tertiary preventive interventions, advanced therapeutic programs for complicated grief, have convincingly been developed and tested in recent years (cf. Boelen, de Keijser, van den Hout, & van den Bout, 2007; Shear, Frank, Houck, & Reynolds, 2005). The primary focus, therefore, should now be on the development and testing of interventions targeted toward risk groups, thus preventing complications from occurring. This direction urgently needs more than crude examination of differences in change over time in grief manifestations between intervention groups and non-interventions groups. Moderators and mediators need to be taken into account too. Clinicians are typically aware of this, but researchers such as ourselves can do well to remember: It seems clear that one size does not fit all.
References


Ringdal, G.I., Jordhoy, M.S., Ringdal, K., & Kaasa, S. (2001). The first year of grief and bereavement in close family members to individuals who have died of cancer. *Palliative Medicine, 15*, 91-105.


IMPROVING THE EFFICACY OF INTERVENTION FOR BEREAVED INDIVIDUALS: TOWARD A PROCESS-FOCUSED PSYCHOTHERAPEUTIC PERSPECTIVE

Emmanuelle ZECH(1), Anne-Sophie RYCKEBOSCH-DAYEZ(1, 2), & Emily DELESPAUX(1)

(1) Université catholique de Louvain & (2) Fonds de la Recherche Scientifique – FNRS

Professional psychotherapeutic intervention programs for bereaved individuals are not highly effective. We explore the range of possible reasons for this, based on arguments made in the literature and on further key considerations that have so far been neglected. Limited efficacy may be due to inclusion of bereaved individuals who do not need help; inappropriate types of intervention; inadequate quantity (too much or too little); or incorrect timing of the intervention (too soon or too late). Accordingly, we propose that effective intervention will require (1) motivated bereaved persons, (2) identifying and working on processes that cause or maintain the difficulties presented by the bereaved person, and (3) flexibility on the part of the therapist. We describe a number of processes underlying the difficulties encountered by bereaved people, which need consideration in therapy. In addition to these process-focused interventions, working on the therapeutic relationship will be a fundamental factor in helping bereaved individuals cope with their difficult grief.

Several qualitative reviews have been published on the efficacy of grief interventions (e.g., Jacobs & Prigerson, 2000; Jordan & Neimeyer, 2003; Raphael, Minkov, & Dobson, 2001; Schut & Stroebe, 2005; Schut, Stroebe, van den Bout, & Terheggen, 2001). In addition, three recent meta-analyses have been conducted (Currier, Neimeyer, & Berman, 2008; Kato & Mann, 1999; Litterer-Allumbaugh & Hoyt, 1999). Consistently, the reviews have concluded that primary care interventions for bereaved individuals, that is,
interventions open to all persons who become bereaved, in order to prevent the occurrence of mental health or grieving problems, are not efficacious (e.g., Schut et al., 2001). These results indicated that most bereaved individuals do not need or will not benefit from a psychological intervention beyond the natural coping processes that are already taking place. With regard to secondary care interventions – interventions directed toward bereaved individuals at risk of developing complicated grief reactions or mental health problems –, the reviews have indicated that studies have produced mixed results, mainly modest in size and rather temporary. The results have also indicated that the selection of specific participants increased the probability to find significant results. In particular, the results have revealed that, when the type of intervention was appropriate, taking into account the bereaved individual’s characteristics (e.g., such as their gender), the interventions tended to be more efficacious. Finally, and most relevant to the current article, with regard to psychotherapeutic interventions for the bereaved, which are interventions for individuals selected on the basis of their mental health or grieving difficulties, the reviews have indicated that the interventions, although yielding generally positive results, and more positive than for the primary or secondary types, seemed less efficacious than could be expected. Indeed, effect sizes on grief or depressive symptoms varied from $d = .052$ (Kato & Mann, 1999, on 11 controlled studies) or $d = .13$ (Currier et al., 2008, on 23 studies) to $d = .39$ (Currier et al., 2008), if participants were selected for their risk of presenting pathological grief reactions, and $d = .43$ for short-term effects in 35 pre-post test studies (Litterer-Allumbaugh & Hoyt, 1999). These effect sizes are pretty consistent and indicate that psychotherapeutic interventions for bereaved individuals are moderate at best.

Explaining the moderate efficacy of tertiary intervention programs for bereaved individuals who suffer complications in their grief processes

How can these results be explained? Why are interventions directed to bereaved individuals with grief complications not more efficacious? Next, we examine four hypotheses that could explain this. Moderate efficacy may be due to (1) the inclusion of bereaved individuals who do not need help; (2) the use of inappropriate types of intervention; (3) an inadequate quantity (too much or too little) of intervention, or (4) an incorrect timing of intervention (too soon or too late). These hypotheses, which will be explored in more

---

1In doing so, we leave out reflections related to the help provided by volunteers or self-help groups and focus specifically on psychotherapeutic interventions provided by trained professionals.
detail in the following section, are related to a main point we would like to make in this article: bereaved people need to get individualised intervention for their own specific problems, to the right extent, and at the right time.

We propose that the standardisation implied by current gold standards for testing the efficacy of therapeutic interventions makes it less likely to find significant therapeutic effects for bereaved individuals in the context of scientific evaluations of efficacy. Indeed, basic to scientific standards is the requirement of replicability of results. As a consequence, gold standards involve the use of a randomized blind design, manualized therapies with a precise and structured protocol of intervention, a fixed number of sessions, and trials in which patients typically meet the criteria for a single diagnosis (Reed, McLaughlin, & Newman, 2002; Seligman, 1995). For example, the use of protocols implies that therapists will strictly apply and behave in such a way that both validity and reliability are warranted. As a consequence, the space for flexibility and adaptation to a specific client’s characteristics is left beyond consideration. We propose that this is precisely why interventions for bereaved individuals who suffer complications in their grief processes might not prove to be very efficacious. The main reason is that bereaved individuals, even when they are presenting difficulties and are looking for professional help, do not present the same symptoms, and even when they do so, the processes that underlie the symptoms (e.g., repetitive thoughts) may actually be different. These will be examined in further detail in the second section of this manuscript and specific intervention directed toward these processes will be outlined.

**Inclusion of bereaved individuals who do not need or want help**

A first hypothesis as to why intervention for bereaved individuals is only moderately effective is that many bereaved individuals do not need professional interventions in addition to the help or resources that they already naturally developed after bereavement (e.g., Schut & Stroebe, 2005; Schut et al., 2001). There are two things to consider in relationship to this claim. First, only a small proportion of individuals will develop chronic problems and difficulties in the range of pathological reactions that might not resolve without professional help (Forstmeier & Maercker, 2006; Prigerson, Ahmed, Silverman, Saxena, Maciejewski, Jacobs et al., 2002). The prevalence of persons who would be categorised as developing pathological or complicated grief reactions is still not well-established. Estimations have, however, yielded prevalence rates of complicated, traumatic, or prolonged grief ranging from 4.6% (Forstmeier & Maercker, 2006) to 34% (Prigerson et al., 2002). It has been suggested that about 10 to 15% of people suffer pathological grief reactions after 6 months of bereavement (Prigerson, Frank, Kasl, Reynolds, Anderson, Zubenko et al., 1995). Thus, if interventions are given to bereaved
people, simply on the basis that they have suffered a loss, this would not be likely to lead to a reduction in difficulties, since it would address 85 to 90% of people who do not suffer to an extent that could be considered pathological. In addition, it is important to remember that suffering is part of normal grieving, which cannot be impacted on by intervention. The effect size would then be considerably diminished. Consequently, interventions need to be targeted toward bereaved individuals who are in need of intervention.

The second point relates to the motivation to search for help. Some bereaved individuals might not ask for professional help when they need it, while others might ask for help although they do not reach diagnostic criteria (e.g., severe functional impairment). In fact, several studies have shown that most bereaved individuals not only do not need professional help, as indicated above, but that they also do not ask for it (e.g., Lund, 2007). In sum, these results suggest that intervention studies might have included bereaved individuals who actually did not need or want help. In intervention and in efficacy studies, it is thus important to select bereaved participants who will receive and want to receive therapeutic intervention because of their grieving difficulties.

Inappropriate intervention

A second hypothesis relates to the type of intervention that pathological or complicated grievers are receiving: they might not get what they need. Until the late '90s, most psychotherapeutic programmes were based on theories that were in line with the “grief work” hypothesis (e.g., Stroebe, 1992; Stroebe & Stroebe, 1991). This hypothesis postulates that bereaved individuals have to do their grief work in order to cope with bereavement. Stroebe (1992, p. 19-20) defined grief work as “a cognitive process of confronting the reality of loss, of going over events that occurred before and at the time of the death, and of focusing on memories and working towards a detachment from the deceased”. Following this, traditional interventions largely or even exclusively focused on promoting confrontation strategies and the relocation or relinquishing of the bond to the deceased (e.g., Ramsey’s (1977, 1979) “flooding technique”, Gauthier & Pye’s (1979) “systematic desensitisation” or Lieberman’s (1978) “forced mourning”). More recently, following inconsistencies in research findings concerning the efficacy of grief work, Stroebe and Schut (1999) developed a theoretical model, the Dual-Process Model of Coping with Bereavement (DPM), which not only included confrontation with loss (so-called “loss-orientation”) but also avoidant coping strategies as necessary mediators of health and well-being. Most importantly, the authors hypothesised a fundamental oscillation process between these various coping strategies. In fact, the diversity of tasks and problems that individuals encounter (“restoration-orientation”) in addition to grief over the loss of their loved one would require the use of multiple cop-
ing strategies. Research on the efficacy of coping strategies after stressful or major life events confirms that the use of multiple and flexible coping strategies is most efficacious (e.g., Folkman, Lazarus, Gruen, & Delongis, 1986; Suls & Fletcher, 1985). Recent studies that investigated the efficacy of oscillation strategies during bereavement have begun to provide some evidence of the importance of the DPM parameters for positive outcomes (Caserta & Lund, 2007; Richardson & Balaswamy, 2001; Wijngaards, Stroebe, Stroebe, Schut, van den Bout, van der Heijden et al., 2008).

Following the DPM, intervention that promotes grief work alone would not be efficacious for those who suffer complications in their grieving. The DPM postulates that exclusive use of either loss-, or restoration-oriented strategies would lead to pathological grief reactions such as chronic grief in the first case and absent or inhibited grief in the second.2 Flexibility (oscillation) is of utmost importance to cope with bereavement: bereaved individuals receiving psychotherapeutic interventions based on the grief work hypothesis alone might actually not get what they need. If the DPM predictions are correct, chronic grievers are already focusing on confrontation strategies related to grief work and they thus focus on thoughts, images of, and bonds to the deceased while they should also focus on avoidant and/or restoration-oriented aspects. Thus, psychotherapeutic interventions should incorporate oscillation, and pathologically-bereaved individuals should accordingly be encouraged to use other strategies than the ones they are ineffectively using. A recent intervention programme developed by Shear, Frank, Houck, and Reynolds (2005) for bereaved individuals presenting complicated – i.e., chronic – grief reactions (Prigerson et al., 1995) was created to address processes postulated by the DPM, including restoration-oriented tasks. In support of the DPM, results revealed that this treatment was more effective than a control treatment (i.e., interpersonal psychotherapy) which focused essentially on loss-focused tasks (i.e., on grief, the relationship between symptoms, grief and interpersonal problems, and a more realistic assessment of the relationship to the deceased). To conclude, in line with other authors (Stroebe & Schut, 1999), we propose that bereaved individuals should not get the same intervention but an intervention that addresses the specific process that is at hand and explains their difficulty.

Inadequate quantity of intervention

A third reason why therapeutic interventions for bereaved individuals might not be that efficacious is that, with the use of structured intervention programmes, bereaved individuals typically not only get a fairly identical

2Absent grief may not always reflect pathological processes, it might actually indicate either that the bereaved person does not grieve, or is doing well and thus presenting no symptoms.
programme, but also, in principle, the same number of therapy sessions. However, as suggested above, bereaved persons are likely to have specific, individual needs. A complete intervention programme may take between 10 (de Keijser & Schut, 1991) to 16 sessions (Shear et al., 2005). It is possible that the time spent with one specific technique (e.g., for 4 sessions) is not enough to resolve a particular dysfunction, and that the “dose” or quantity offered is thus insufficient. On the other hand, it is possible that other bereaved individuals would need less than or none of what is proposed, in which case the “dose” might be too much. This might lead to either boring or overwhelming the client.

An example of this is provided by the Shear et al. (2005) study reported earlier. Half of the clients who left the DPM programme (called “complicated grief therapy” by the authors) did so because they “considered the treatment too difficult and/or did not believe that telling the highly painful story of the death could help them” (Shear et al., 2005, p. 2606). In addition, about the same number of patients refused part of the proposed programme which involved an imaginal exposure exercise in which they had to talk to the deceased person “because they considered it too difficult” (Shear et al., 2005, p. 2606). In the other condition, more than half of those who discontinued treatment did so “because of perceived lack of effectiveness” (Shear et al., 2005, p. 2606). These findings suggest that a significant minority of participants in such programmes (15 to 22% in that study) refuse (at times) to comply either because the programme or task was too difficult for them, or because they viewed it as ineffective. Thus, the use of protocols, if they are not sufficiently tailored to the specific needs and difficulties of the bereaved individuals (e.g., also addressing their ambivalence over change), might prove to be less efficacious.

Incorrect timing of intervention

Finally, a fourth explanation of the insufficient efficacy of psychotherapeutic interventions is that the timing of the intervention might not be optimal. It is indeed possible that the intervention is provided at a wrong moment in the grieving process, and with respect to the rhythm with which the bereaved person is addressing his or her own particular concerns. It is still not clear as to whether the timing of the intervention in relationship to the duration of bereavement (i.e., the time elapsed since bereavement) is important for efficacy. First, it is possible that greater efficacy could be found once problems or difficulties have developed and are maintained over time, and thus not early after bereavement, since it is later on that these bereaved individuals will need the intervention most. In a way, this would be consistent with the results found for primary and secondary care interventions for bereaved persons, which have
been shown to be less effective than psychotherapeutic interventions that are provided to bereaved individuals who suffer complicated grief reactions and which are typically given later in the grieving process than preventive interventions. Alternative reasoning would suggest that an early psychotherapeutic intervention would actually be more effective since the pathogenic processes might not yet be strongly entrenched in the bereaved person’s functioning. With regard to the empirical literature, it seems that no study to date has directly tested whether the timing of the psychotherapeutic intervention made a difference in efficacy. Neimeyer and Currier’s (2009) meta-analysis addressed this question by examining whether the timing of the intervention after bereavement moderated the efficacy on outcome. Their results indicated that this was not the case. This should further be confirmed by empirical investigation. For now, there is no consensus with regard to when or whether an intervention should be provided at a specific time after the death.

The literature on the efficacy of psychotherapy in general may actually provide an answer to this “when the intervention should be given” question: findings have indicated that it will be most efficacious when people are ready to engage in therapeutic sessions and motivated for change (see Lambert & Bergin, 1994; Miller & Rollnick, 2002). This suggests that the most important point might not be when after bereavement professional help is given but when the bereaved person is ready to get help. This implies that the person needs to realise that he or she is in need for help and is prepared to accept it. The person might then, in a second step, ask for help. Taking into account motivation and motives for help-seeking will include not only whether the person asks for help, whether the request comes from the person him- or herself versus any other person in the surroundings (or even if help is offered or advertised as in many intervention programmes), but also the reason why the bereaved person asks for help.

Conclusions

A short conclusion of this section could be “one suit does not fit all the bereaved”. We have indeed suggested that, to be efficacious, therapeutic interventions for complications in grieving processes need to be individualised in “what is given, to whom, to what extent, and when”. This implies taking into account whether a bereaved person really needs professional psychotherapeutic help, as well as his/her motivation and reasons for help seeking. Second, the therapist should provide the psychotherapeutic intervention at the right moment and with the right dose, according to what is best for the client at that moment in his or her grieving process. Third, a psychotherapeutic intervention needs to be flexible, not only with respect to timing, but also the content of the treatment programme. And finally, psychotherapeutic
intervention should address the specific difficulties or dysfunctions that are presented by the bereaved individual (we expand on this below). The propositions that are made next go further toward identifying what precisely is needed to address the specificities in the complications that appear in the grieving person.

Reactions and what lies beneath: processes underlying complications in bereaved individuals’ grief reactions

Next, we examine difficulties or complications in grief processes that are frequently presented by bereaved individuals. Examples of reactions that occur during bereavement (e.g., Rubin, 1999; Ryckeboer-Deuze & Zech, 2010; Stroebe & Stroebe, 1987) are provided and we examine when these reactions might become problematic. More importantly for the message of the present article, we then propose several processes that might be underlying these grieving complications. In doing so, we do not join the debate relating to whether reactions presented by the bereaved individual are (or not) pathological in the psychiatric sense, that is, whether they reach the diagnostic criteria of a disorder (for a discussion about this debate, see Wagner & Maercker, this issue). In line with a person-centred approach (Elliott, Greenberg, & Lietaer, 2004; Rogers, 1957/2007), the psychotherapeutic point of view taken is rather to examine whether the reaction or symptom is problematic from the bereaved person’s perspective, whether it is maintained over time, and whether the bereaved person is unable to deal with or get rid of it by him- or herself. This then becomes the definition of a complication or difficulty in the grieving process that will need psychotherapeutic intervention. This way to deal with “complications” in grieving implies that we do not use a category or a norm as a reference and we do not consider that some specific reactions are per se pathological. As a consequence, we propose that psychotherapeutic intervention should not focus on symptoms or reactions that are presented, but rather on the underlying process that maintains the reaction or symptom. This is the reason why we call such strategies “process-focused psychotherapeutic intervention.”

The problems and difficulties that bereaved people report and the potential underlying processes that cause or maintain them are presented separately for ease and clarity of presentation. They are, however, linked to one another. The first most obvious reactions after the death of a loved one are emotional reactions (see Emotional reactions). Emotional reactions arise from the evaluation and significance of the eliciting event, in this case the death of a person (e.g., Frijda, 1986). The evaluation is based on the person’s frame of reference which includes his or her goals, values, beliefs, self- and other-perceptions. The occurrence and evaluation of the event may also lead to shattering of this
frame of reference (shattered beliefs and existential dilemmas) because the information included in the event comes into cognitive conflict with the person’s frame of reference. This discrepancy also leads to recurring thoughts that intrude in the person’s mind (see Ruminations versus intrusive thoughts). Finally, the attachment Working Models of Self and Other (e.g., Bartholomew & Horowitz, 1991) may also be challenged, since bereavement can imply the loss of an attachment figure (see Attachment: bonds to the deceased person). In the present article, we address only intrapersonal or intrapsychic processes that are initiated by bereavement and will not consider problems that are related either to physical health, or to interpersonal relationships.

**Emotional reactions**

Why are emotional reactions sometimes a problem? In general, emotions should not *per se* be considered as problematic. Indeed, emotions signal desires and needs, are initially adaptive (e.g., Greenberg, 2002; Greenberg & Paivio, 1997), and are usually self-regulated (Frijda, 1986). The problem in coping with emotional reactions may come from different sources. First, several emotions may be experienced at the same time and this makes the regulation of emotions complex, since the person may be overwhelmed or confused by various emotions (feelings of shock, depressive affect and grief, helplessness and hopelessness, anxiety, guilt and regrets, anger, anhedonia, loneliness, relief, see e.g., Glick, Weiss, & Parkes, 1974; Shuchter & Zisook, 1993). The complexity in emotional regulation may also come from the fact that these emotions may be contradictory or mixed (e.g., feeling sadness and joy at the same time), complex or subtle (e.g., envy, jealousy, nostalgia), or a first emotion may induce a secondary emotion (e.g., feeling guilty because one experienced joy or relief that the person died or feeling angry at oneself because of being unable to stop feeling sad, see Greenberg, 2002). A second problem is that people may be or become unaware of their emotional reactions. This can occur because these emotions are too painful and the person may repress, suppress, deny, over-control, or avoid them to such an extent that they become unconscious. Finally, although emotions can be fully experienced, people may be encouraged by those around them to avoid these states and this may induce conflict (e.g., bereaved persons may continue to dwell on their suffering while others admonish them to react differently). In these instances, bereaved persons can also get confused, not knowing who to listen to, themselves or others.

How can complex, repressed, or conflicting emotional reactions be regulated? Regulating emotions implies accessing the emotions and concerns underlying one’s emotions, acknowledging, distinguishing, and experiencing the various emotions so as to heighten their awareness and their value, on the
one hand, but also to accept them, on the other hand. Empathic reflections on
the experiences of the bereaved person enable access to these feelings so that
they become more conscious and distinct (Greenberg, 2002; Norcross, 2002;
Watson, 2007). Acknowledgment of the bereaved person’s experiences in a
non-judgmental way allows emotions to be accepted or changed by the client
(Greenberg, 2002; Norcross, 2002; Watson, 2007).

In addition to these general person-centred principles, we propose that dif-
ferent emotions should not be dealt with through the same strategies. In par-
ticular, it is important to distinguish emotions relating to fear or anxiety from
other negative emotions, such as sadness, anger, or guilt. There are a number
of reasons for this. First, fear is known to habituate with mere exposure while
this does not seem to be the case with emotions like sadness or anger, which
tend to perpetuate or even increase with repeated exposure. For example, it
has been shown that the expression of anger, as when beating a cushion “to
let one’s anger out”, does not decrease the anger but rather increases it, since
it may actually lower the threshold at which people would act their anger out
(Littrell, 1998). Dalgleish (2004, p. 251) also noted an essential distinction
between fear and anxiety, on the one hand, and other negative emotions, on
the other hand, describing this as follows:

“Fear is prospective. That is, it is about something negative that might
happen in the future. Repeated exposure to a traumatic memory involv-
ing fear will quickly reveal an absence of future threat, thus allowing the
fear to dissipate. In contrast, emotions such as anger, shame, and guilt are
retrospective. That is, they are about something negative that has already
happened. Repeated exposure to a traumatic memory involving these
emotions is merely likely to accentuate what was guilt-, shame- or anger-
inducing about the original experience”.

This suggests that fear-related emotions should be dealt with through ex-
posure or confrontation strategies, while other-than-fear-related emotions
should be dealt with through recognition, understanding, and acceptance
strategies (see above).

Shattered beliefs and existential dilemmas

Another consequence of experiencing bereavement is related to a second-
ary, more subtle impact of the event, which involves the disconfirmation of
expectations and models of the world and the self, the loss of meaning (Rimé,
2009), and the uncovering of existential dilemmas (Yalom, 1980/2008). In-
deed, the death of a dear person involves information to be processed that will
come in cognitive conflict with the bereaved person’s pre-existing framework,
assumptions, values, or beliefs (Neimeyer, 2001; Parkes, 1972). Bereavement
may shatter beliefs about justice (e.g., people get what they deserve and de-
serve what they get), the predictability of events (e.g., bad things won’t happen to me or my beloved ones), their controllability (e.g., bad things can be dealt with or avoided), their own vulnerability (e.g., life will not end suddenly, one can suffer), their self-worth or -esteem (e.g., I am a good or valuable person), self-confidence (e.g., being powerful), and the benevolence of other people (e.g., people are good, they won’t hurt me) (Janoff-Bulman, 1992). When experiencing a significant event, fissures arise in this symbolic universe (Rimé, 2009) and people do not understand why this all happened. People facing adversity are often questioning why it happened to them: they search for the meaning of it and try to make sense of the events (Neimeyer, 2001).

In addition, the death of a significant person may induce intense existential questioning related to four existential challenges that humans face (Yalom, 1980/2008). First, facing the death of someone may bring back the reality, uncontrollability, and inevitability of our own death and limited existence. Second, the loss of a significant other usually brings feelings of loneliness, utter isolation from others, and one’s fundamental existential isolation. Third, bereavement may lead one to realise one’s existential freedom. This implies psychological freedom to choose the directions in one’s life and brings with it responsibility concerning who we were, are, and will become (i.e., responsibility in our values and actions). This means, for example, that the deceased person cannot be regarded anymore as responsible for the directions of the bereaved person’s life. Finally, as already indicated above, the loss of a dear person may highlight the existential dilemma that life is per se meaningless. Humans can search and find meaning in their lives, but meaning is not intrinsically given.

As such, these fractures in the bereaved person’s pre-existing framework may be non-existent for some, small for others, but intense and prolonged for even other bereaved individuals (Neimeyer, 2001). In this latter case, which represents complications in the grieving process, bereaved people may report that life has become meaningless and not worth living, bringing feelings of bitterness or fundamental injustice in life, absolute loneliness, and uncontrollability. How can this type of experience be dealt with? It should be noted that existential challenges have no ultimate answer and thus no given solution (Yalom, 1980/2008). This may cause anxiety or terror. This is why people develop various behavioural or symbolic strategies to suppress or rationalise these thoughts (Rimé, 2009). Basic beliefs are part of the symbolic strategies that people develop to fight against existential anxiety and terror (see also Terror Management Theory, Pyszczynski, Greenberg, & Solomon, 1999). Fissures in these representational constructions can be dealt with by finding new behavioural or symbolic strategies that could make sense for the bereaved individual and that could restore their beliefs and values. It is important to recognise that, although people function and behave accord-
ing to their own beliefs and values, they are usually not aware of them, or of their associated dilemmas. Being guided toward awareness of them and accepting responsibility renders the person powerful and able to control and make choices in his/her life (Yalom, 1980/2008). The manner whereby this is reached is important: the therapist needs to respect and recognise the value and usefulness of the client’s defences – the client would otherwise protect him- or herself even more (see Miller & Rollnick, 2002). Similarly, Acceptance and Commitment Therapy (ACT, Hayes, Strosahl, & Wilson, 1999) proposes to work on and access the values that people struggle for in their lives (e.g., being a good person). This will enable people to find realistic and alternative ways to direct their life, in line with their values. Thus, psychotherapeutic intervention should first access the bereaved person’s values and make them more conscious, in order to be able, in a second step, to work on meaningful ways to reach these values.

**Ruminations versus intrusive thoughts**

“Negative emotions initiate a state of cognitive dissonance and are thus at the beginning of important cognitive efforts toward dissonance reduction” (Rimé, 2009, p. 64). One of the most frequent cognitive reactions after bereavement has to do with thoughts related to the lost person and the deceased, including the circumstances that led to the death (e.g., Lehman, Wortman, & Williams, 1987; Schoenberg, Carr, Peretz, Kutscher, & Cherico, 1975). To our knowledge, there is no consensus with regard to the definition or proposed processes that define when a repetitive thought might be considered as involving dysfunctional processes. Several propositions of dysfunctional mechanisms have been made in the literature (e.g., Watkins, 2008) but it is beyond the scope of this article to discuss these. We propose that recurring thoughts can take different forms that are underlined by different processes and lead to different emotional experiences. It is thus important to differentiate between them, since the effective intervention will accordingly be different.

A first type of thought is mental rumination (for a review, see Nolen-Hoeksema, 2001). People ruminating are constantly focusing in a passive and repetitive way on their own negative emotions or symptoms of distress and on the possible causes and consequences of these emotions and symptoms. Rumination, even extreme rumination early on after loss, is a normal part of grieving. However, in some more complicated cases, mental rumination can actually be maintained over time in a vicious circle. This type of thought has then consistently been found to be related to periods of depression and anxiety (Nolen-Hoeksema, 2001). Investigations have shown that the vicious circle maintaining rumination can be described as follows. On the one hand, the more people ruminate, the more their distress will be amplified. On the other
hand, the more people are distressed and depressed, the more likely they will be to ruminate about themselves and their lives. This self-perpetuating process can be explained in terms of the following processes. First, people who ruminate often say that they do so to try to understand their emotions and solve their problems. They are thus tempted to ruminate more and more. However, mental ruminations have been found to interfere with good problem-solving (Lyubomirsky & Nolen-Hoeksema, 1993). This is so because people ruminating are thinking more negatively about themselves (e.g., they blame themselves more for their problems, are less self-confident) and about their lives (their past and the future) (e.g., Lyubomirsky & Nolen-Hoeksema, 1995; Nolen-Hoeksema, 1991). They thus become less able to find innovative solutions to their problems. Second, mental ruminations have been associated with impaired instrumental behaviours. People who ruminate are less motivated to engage and are actually engaging less in everyday activities, including social interactions, that could increase their sense of control and lift their mood (Lyubomirsky & Nolen-Hoeksema, 1993; Nolen-Hoeksema, 2001). Thus, people who ruminate are less likely to distract themselves or get social support (e.g., Nolen-Hoeksema & Davis, 1999).

For bereaved people who ruminate, one of the ways to stop these vicious circles is to engage in distraction from these ruminative thoughts, either by doing something else (e.g., going out) or thinking about something else than their grief and problems (e.g., Nolen-Hoeksema & Morrow, 1993). In this case, implementing distraction from the ruminative thoughts so as to be replaced either by neutral thoughts (giving relief from negative moods), or by positive ones – even temporarily – may bring relief, which could in turn have long-term positive consequences on the person’s well-being and behaviours (Nolen-Hoeksema, 2001).

In contrast to the ruminations which are related to a prolonged and rather voluntary confrontation with bereavement-related thoughts, intrusive thoughts are thoughts that intrude in the person’s mind without his or her will. They are typically involuntary and underlined by an involuntary process of access to the thoughts in working memory. They are said “to pop up” into the person’s mind and bring up anxiety, horror, or helplessness feelings. Intrusive thoughts are related to anxiety and, in the most extreme cases, to anxious disorders such as post-traumatic stress disorder (Diagnostic and Statistical Manual of Mental Disorders, 4th ed.; DSM-IV; American Psychiatric Association, 1994). The frequency and intrusive characteristics of these thoughts have been explained by a different mechanism than the one proposed above for mental ruminations. In this case, the thoughts provoke anxiety feelings that are so overwhelming that the person tries to avoid them. Because the person avoids thinking about the event, the event cannot be integrated and thoughts reappear (e.g., Ehlers & Clark, 2000; Horowitz, Bonanno, & Holen,
Intrusive thoughts will thus come back until the cognitive dissonance is resolved (see above). The efficacious strategy to stop the vicious circle responsible for repetitive intrusive thoughts will be confronting them, since it is their prolonged avoidance that leads to their maintenance. To counter experiential avoidance, the therapeutic principle is thus to allow and to accept the experience of (negative) feelings and thoughts (e.g., Hayes et al., 1999).

To conclude, we propose that bereaved people may encounter two types of repetitive thoughts that are underlined by different processes and that should be dealt with by different intervention strategies. On the one hand, if bereaved people show extreme and prolonged mental rumination about their loss and negative emotions, they should be guided toward switching away from an ineffective confrontation strategy (ruminating) to an avoidant strategy (distract from or suppress their thoughts). On the contrary, if they present anxiety-related intrusive thoughts, the effective strategy would be to switch from an ineffective avoidant strategy to a confrontation strategy. In fact, although the underlying processes are different for mental ruminations and intrusive thoughts, the intervention would be in both cases to reinstate the oscillation between different sorts of coping strategies. Bringing back flexibility in one’s coping would be the effective process.

*Attachment: bonds to the deceased person*

The loss of a significant other is an event likely to activate the attachment behavioural system (Bowlby, 1980; Hazan & Shaver, 1987), a motivational system that regulates the proximity to attachment figures, that is, persons who provide protection, support, and care. In bereavement, this system is activated precisely because of the loss of an attachment figure, a person who would normally function as a security base against distress. When does the bond to the deceased person become a problem for the bereaved individual? In theory, there are essentially two cases that are related to insecure attachment dimensions (e.g., Bartholomew & Horowitz, 1991) and that will represent problematic bonding after the death: people scoring extremely high on attachment-related anxiety could develop chronic grief reactions, while people scoring extremely high on attachment-related avoidance would rather present absent or inhibited grief reactions (Stroebe, Schut, & Stroebe, 2005). In the first case, the bond would be too strong and the bereaved would be too dependent on and cling too much to the tie to be able to recover from grief: he/she would be unable to loosen or relinquish it. In the second case, the bond would be too loose or denied and the bereaved would avoid suffering and behave as if nothing had happened. In line with the DPM, Stroebe et al. (2005) proposed that these two types of extremely non-securely attached persons should be guided to oscillate between loss- and restoration-oriented strate-
gies. Indeed, people scoring extremely high on attachment-related anxiety could benefit from loosening their ties to the deceased, while people scoring extremely high on attachment-related avoidance could benefit from doing more loss-oriented tasks such as going over memories about the deceased.

In practice, absent grievers or extremely avoidantly-attached persons are less likely to show up in consultation (Lopez, Melendez, Sauer, Berger, & Wyssmann, 1998; Mallinckrodt, Gantt, & Coble, 1995) because their strategy is precisely to avoid or suppress the idea or fact that there might be a problem and because they have a negative view of others, which may make them disinclined to seek help from another person (Bartholomew & Horowitz, 1991). On the contrary, chronic grievers or extremely anxiously-attached persons might consult because of their intense suffering and need to express their emotions and grief (Stroebe et al., 2005). The question then becomes whether, to what extent, and how extremely anxiously-attached persons have to relinquish or loosen the bond related to the deceased person in order to adapt to the loss. An alternative way of looking at this question is to determine the conditions under which the bond could be maintained in a healthy way. Rando (1993) has proposed two conditions for the healthy continuation of bonds: first, the bereaved needs to fully acknowledge that the person is dead as well as the implications of the loss and second, the continued bonds must not interfere with moving forward into a new life. Building on this proposition, Field (2008) suggested that internalisation makes it possible to establish proximity to the deceased at the mental representational level, while at the same time, it is fully accepted that the person will never return in reality.

But how does this take place in concrete terms? We propose that the therapist needs to work on the *significance* of the bonds or behaviours for bereaved clients rather than on the behaviours themselves (e.g., not being able to touch or to give away a deceased’s belongings). This therapeutic strategy was suggested following the results of a study conducted on the relationship between, on the one hand, the attitudes of 113 bereaved adult children toward the inheritance of the belongings of their deceased parent, in particular, the linking objects – objects that are related to the deceased – and, on the other hand, the intensity of their grief reactions (Coulange, 2005). The results indicated that expressing the need to possess the deceased’s belongings was related to more intense grief reactions, while having the belongings or not was unrelated to the intensity of grief reactions. This thus suggested that the actual attachment behaviours were less important for the bereaved person’s well-being than the significance they had put on having or not having these linking objects.

In therapy, it is also important to note that most bereaved individuals will report ambivalence over the relinquishment or continuation of their bond to the deceased. Whether the person will actually change his or her behaviours is likely to be determined by three aspects described in Motivational Inter-
viewing (Miller & Rollnick, 2002): whether he or she feels (1) it is important to change and thus wants to change, (2) it is possible to change (being able to change which is related to self-efficacy and self-esteem), and (3) ready to change, which is a question of priority (e.g., the good timing). It has been well established that forcing a change will heighten the person’s defences and be counterproductive, even leading to a deterioration of the mental health of the client (Goldfried, 2007). In sum, this means that the therapeutic strategy with extremely anxiously-attached persons will be to work on the meanings related to keeping the bonds to the deceased as well as those related to loosening them.

Beyond the focus on specific processes: on the development of a therapeutic relationship

We assume, following the general literature, that features to do with the therapeutic relationship will affect the outcome of bereavement intervention too. In fact, we even speculate that the quality of the therapeutic relationship should be even more important for efficacy in the case of grief therapy because the bereaved person has to deal with the loss of an affective relationship. In the general psychotherapy literature, it is now well established that empathy and warmth, that is, one aspect of positive unconditional regard, are substantially and consistently associated with positive therapeutic outcomes (for a review, see Norcross, 2002). As a consequence, the Task Force on empirically validated relationships of Division 29 in Psychotherapy of the American Psychological Association recommended, on the one hand, empathy and warmth as essential for therapeutic efficacy and, on the other hand, congruence and acceptance as being probably effective (Watson, 2007). It has indeed been demonstrated that an empathic, accepting, and congruent response facilitates the regulation of affects through several means: it (1) stimulates the consciousness of emotional responses; (2) helps clients to put their inner experiences into words and to symbolise them; (3) allows the client to modulate his or her emotional responses by using words; and (4) cultivates the client’s reflexive ability by emphasising that the client’s perspectives are subjective and that other ways of representing the world exist (Watson, 2007; Zech, 2008). The empathetic attitude could also lead to positive outcomes because (1) it increases therapeutic satisfaction and, as a consequence, compliance with the intervention; (2) it creates a corrective emotional experience and makes the client feel valued, respected, and understood; (3) it encourages exploration of feelings and can facilitate emotional processing and (4) it can mobilise the client’s efforts toward change (Farber, 2007; Norcross, 2002). A positive unconditional attitude also (1) allows clients to become more responsible for their choices (they decide, they gain psychological freedom, they are in control, they gain self-confidence
and esteem), (2) increases the possibility that the client’s defences against distress and negative states will not be reinforced, and (3) the client’s potential is trusted and growth can occur. By trying to maintain positive unconditional regard, the therapist stays flexible and adapts to his or her client’s characteristics and state-of-mind moment for moment. This is made possible if the therapist makes the intervention his/her own, which means that the therapist should be as authentic as possible, that is, able to be self-aware of his or her own attitudes, emotions, and values, and to communicate them when it is relevant (Rogers, 1957/2007). In sum, the psychotherapeutic intervention should be provided by an authentic, empathic, and warm therapist.

Conclusions

In the first part of this article, we proposed that intervention programmes developed for bereaved individuals might be less effective than they could be, partly because each person gets the same standardised intervention even if their grieving difficulties, reactions, impairments are different and occur at different time points. It was proposed that psychotherapeutic grief interventions need to be flexible and adapted to each bereaved individual according to “what is given, to whom, to what extent, and when”.

In the second part of this article, we further argued that interventions for bereaved individuals who suffer from complications in their grieving processes will be most effective if the therapeutic strategy used specifically addresses the processes that underlie the development and maintenance of the problematic reactions or symptoms. The general principle of the intervention should be to make “stuck”, static, or vicious circles of reactions become more flexible. Specific propositions were made with regard to pathogenic processes and intervention strategies for handling emotional reactions, shattered beliefs and existential dilemmas, mental ruminations and intrusive thoughts, and insecure attachments to the deceased person.

Finally, in the third part of this article, in line with an experiential and person-centred perspective, we have proposed that the therapist should try to endorse the therapeutic attitudes of congruence, empathy, and positive unconditional regard (Rogers, 1957/2007). These attitudes are known to improve the quality of the therapeutic relationship, which is an essential explanatory factor with respect to therapeutic efficacy (e.g., Norcross, 2002). In sum, in the process-focused psychotherapeutic perspective described above, we have integrated recent cognitive-behavioural, humanistic, client-centred, and existential views in suggesting guidelines for psychotherapeutic interventions with bereaved individuals who suffer from complications in their grieving processes.
Many of these propositions still need empirical investigation and support. Putting this process model to test will require not only examining whether psychotherapeutic interventions that are adapted to the bereaved individual’s pathogenic processes are more efficacious than standardised or manualized interventions for “complicated grievers”, but also conducting laboratory studies examining subtle cognitive processes, such as how memories related to the death intrude in the bereaved person’s mind and how these thoughts are controlled or avoided by complicated grievers in comparison to normal grievers.

References


POSITIVE OUTCOMES FOLLOWING BEREAVEMENT:
PATHS TO POSTTRAUMATIC GROWTH

Lawrence G. CALHOUN, Richard G. TEDESCHI, Arnie CANN, & Emily A. HANKS
University of North Carolina, Charlotte, USA

Recent theory and research have drawn attention to the need to better understand the positive changes, termed posttraumatic growth, that often occur in bereaved individuals; even as negative emotions related to grief persist. We describe five dimensions of posttraumatic growth and present a model for understanding how the loss of a close other can eventually lead to a recognition of important positive personal changes. Loss, especially unexpected loss, disrupts an individual’s beliefs about the world and initiates a process of rebuilding an understanding. During this process, many people come to realise their own strengths, appreciate the impact of their relationships, and have new spiritual insights. A strategy for facilitating growth during clinical work also is described.

Introduction

In the last 25 years there have been major advances in the empirical findings and theoretical conceptualisations about grief (Bonanno, Wortman, & Nesse, 2004; Stroebe, Hansson, Schut, & Stroebe, 2008a). Some prevalent assumptions about the typical responses of grieving persons (Freud, 1917/1957; Lindemann, 1944) were empirically examined and found not to be entirely supported (Stroebe, Hansson, Stroebe, & Schut, 2001a, 2001b; Wortman & Silver, 1989, 2001). During the same time period, systematic investigation of the possibility that psychological growth could emerge from the struggle with major life crises and losses was also occurring (Aldwin, 1994; Park, Cohen, & Murch, 1996; Tedeschi & Calhoun, 1995).

The idea that significant positive changes can occur in persons who are confronted with significant challenge, suffering, and loss is ancient (Tedeschi & Calhoun, 1995), and previous pioneering scholars of the 20th century also suggested this possibility (Caplan, 1964; Dohrenwend, 1978; Frankl, 1963). However, systematic investigations of this phenomenon are more recent and they suggest that many persons dealing with a wide range of major life stressors (Andrykowski, Brady, & Hunt, 1993; Elder & Clipp, 1989; Joseph, Wil-
liams, & Yule, 1993), including bereavement (Calhoun & Tedeschi, 1989-90; Hogan, Greenfield, & Schmidt, 2001; Kessler, 1987), report significant positive changes from their struggle with their challenges and losses.

Several significant factors combined to encourage clinicians and researchers to begin to focus on growth *per se*. For example, Schaefer and Moos (1992) wrote a chapter on crisis and personal growth, O’Leary and Ickovics (1995) published a paper on “resilience and thriving in response to challenge”, and we published the first book (Tedeschi & Calhoun, 1995) looking specifically at the phenomenon of positive change arising from the encounter with major life crises, such as bereavement. Quantitative ways of assessing growth also became available. For example, Joseph et al. (1993) described the development of the *Changes in Outlook Questionnaire*, Park et al. (1996) published their findings and introduced the *Stress-Related Growth Scale*, and we reported on the development of our own scale, the *Posttraumatic Growth Inventory* (Tedeschi & Calhoun, 1996). By mid-2009, a search using the *PsychInfo* system of the American Psychological Association listed 333 sources on “posttraumatic growth” and 71 on “stress-related growth.”

Although a variety of terms have been offered for this phenomenon, we will use the term *posttraumatic growth* (Tedeschi & Calhoun, 1995, 1996) to refer to positive changes experienced as the result of the struggle with major life crises. In this paper we will provide an overview of the general characteristics of posttraumatic growth, describe a model for how growth may unfold in the grief experience, with a particular focus on challenges to the individual’s assumptive world (Parkes, 1971), and we will conclude with some suggestions for clinical work with bereaved persons.

Grief and posttraumatic growth

Available findings on the course of grief suggest that it does not unfold in neat stages, but it rather tends to be characterised by the oscillation between different psychological states and processes (Stroebe & Schut, 1999). For many people the distress triggered by loss does not dissipate within a few short months, but it can last for many years (Carnelley, Wortman, Bolger, & Burke, 2006; Rogers, Floyd, Seltzer, Greenberg, & Hong, 2008). Conversely, however, the assumption that the loss of a loved one inevitably produces high levels of enduring psychological distress also has been found to be incorrect, at least for a significant proportion of bereaved persons (Bonanno et al., 2004). There is also evidence that for some people, perhaps many, coping with bereavement can provide the context for significant positive changes, i.e., posttraumatic growth (Cadell, Regehr, & Hemsworth, 2003; Engelkemeyer & Marwit, 2008; Matthews & Servaty-Seib, 2007; Wagner, Kanevelsrud, & Maercker, 2007).
Although the observation that the grief experience can include the possibility of personal growth is also not new (Nadeau, 2008), many investigations of the grief process have failed to attend to this phenomenon (Stroebe, Hansson, Schut, & Stroebe, 2008b). The available research suggests that posttraumatic growth is not uncommon in people facing major difficulties, including bereavement.

In this paper, we will focus the discussion on growth in the context of grief; changes that persons regard as significantly positive and that emerge from their struggle with loss. Before proceeding further, however, it is important to keep several things in mind. Posttraumatic growth clearly occurs in a context of significant life challenges, with concomitant states of psychological distress and sometimes great suffering. It would be a gross misinterpretation of what we are saying to assume that the focus on growth minimises the importance of attending to the negative responses that for many can accompany the experience of loss. Further, we tend to regard the assumption that the experience of growth will, or should, produce a commensurate reduction in psychological distress as erroneous. The data are somewhat inconsistent on the relationships between various measures of growth and general measures of psychological distress (Helgeson, Reynolds, & Tomich, 2006), but the available evidence does suggest that the experience of growth is best viewed as statistically independent from the experience of posttraumatic losses (Baker, Kelly, Calhoun, Cann, & Tedeschi, 2008; Cann, Calhoun, Tedeschi, & Solomon, in press). It is also important to remember that not all persons confronted with major stressors, including bereavement, experience growth. Another reminder is that we are not suggesting that the encounter with loss and trauma is the only context in which individuals can grow and develop; the focus here is on the process of growth that does occur in circumstances that have historically been viewed, especially among behavioural scientists of the 20th century, as tending to produce only negative psychological consequences. With these caveats in mind, we turn now to the general domains of posttraumatic growth.

Posttraumatic growth tends to be reflected in changes experienced in five different areas (Morris, Shakespeare-Finch, Rieck, & Newberry, 2005; Taku, Cann, Calhoun, & Tedeschi, 2008), and one of these is self-perception. The change in self-concept that reflects growth can be summarised with the somewhat paradoxical phrase more vulnerable, yet stronger. The loss of a loved one, particularly when the death is violent or sudden, tells the survivors that they are indeed vulnerable to losses that are unpredictable, unexpected, and perhaps tragic. The experience of loss, however, can also lead many persons to experience themselves as stronger and more self-confident (Calhoun & Tedeschi, 1989-90; Carnelley et al., 2006). As one bereaved parent told us: “I’ve been through the absolute worst that I know. And no matter what
happens, I’ll be able to deal with it.” This brief statement reflects the view that the person has indeed been, or may still be, experiencing significant psychological distress and major challenges to adjustment and adaptation. But, along with the difficult and negative aspects, there is the assumption that simply surviving “the worst that I know” offers the person evidence of their personal strength in the context of adversity (Linley & Joseph, 2004).

Another domain of posttraumatic growth is an experience of changed relationships with other persons. Certainly, as with any domain of growth, crises and losses can produce negative changes in relationships; but many bereaved persons also describe positive changes in their relationships with others. One of the items of the Posttraumatic Growth Inventory reflects this dimension – the experience of an increased sense of closeness with others. This closeness is often expressed about significant personal others, such as members of one’s family and close friends. However, there is also the indication that this sense of connectedness to others is experienced as a feeling of greater compassion toward others in general, or to others who share similar difficult losses. As one bereaved person said: “I’ve become very empathic towards anybody in pain and anybody in any kind of grief.”

When people die, the bereaved may need to take over responsibilities and relationship connections that were formerly ascribed to the deceased. This seems to be especially the case in spousal bereavement (Calhoun & Tedeschi, 1989-90). Although initially these new roles can be burdensome, they can often open the bereaved to a third domain of growth, new possibilities they had little or no experience with before. Loss also can open up the possibility of new relationships. Of course the person who has died cannot be directly replaced, and bereaved persons seldom wish to think this way, but the vacancy produced in the bereaved person’s life allows for new people to enter.

When a death occurs, people can report that there is a realisation that the end of life may be sooner than they think, or that they must make the most of what time they have. This appreciation of life, living it more vividly, may be difficult for some people to sustain, but it is sometimes consolidated into new habits of living more deliberately rather than routinely. This is a fourth domain of posttraumatic growth.

The fifth general area of posttraumatic growth includes existential elements, and for many persons, depending on particular geographic and cultural contexts, it can also reflect spiritual and religious elements. The metaphor of the “thin places” of Celtic mythology (locations where the borders between this world and ‘the other’ are more permeable), or the more existential idea of mortality salience (Martin, Campbell, & Henry, 2004), offers a way of thinking about this dimension of posttraumatic growth. Bereaved persons, because of their experience with the death of a close other, may experience changes in the way they understand themselves, their existence as mortal...
This dimension of growth has been reported in several studies of the bereaved (Balk, 1999; Rosenblatt, 2000). Grieving persons may experience posttraumatic growth as a result of existential questioning, irrespective of specific spiritual or religious beliefs. For many, however, particularly in the United States, such existential growth includes spiritual or religious elements (but this may not be the case in places where organized religion is less important, such as Europe and Australia).

Religion/spirituality may serve as both a framework promoting growth through increased sense of meaning and purpose (Rogers et al., 2008), as well as a form of growth through deepening faith and conviction. Finding meaning in one’s life following a loved one’s death can represent a spiritual change that may result from bereavement (Balk, 1999). The often difficult experience of losing a loved one can challenge the belief that events in one’s life have meaning and this disruption may initiate a process of reexamination of important components of the assumptive world (Batten & Oltjenbruns, 1999). In a group of bereaved parents, for example, spiritual coping was among the top three predictors of posttraumatic growth (Znoj, 2006), suggesting a possible avenue towards growth. Spirituality has also been found to be an important source of growth for bereaved caregivers of persons with HIV (Cadell, 2007). Continued connections to the deceased can, for some persons, encourage increased spirituality or a desire to maintain spiritual beliefs (Cait, 2004; Sormanti & August, 1997); with the deepening of spirituality representing spiritual growth. A caveat, however, is that the continued connection with the deceased may or may not be generally adaptive (Neimeyer, Baldwin, & Gillies, 2006; Parker, 2005; Stroebe & Schut, 2005).

These five domains clearly do not include every single possible way in which grieving persons may experience growth. Particular circumstances may lead individuals to describe stressor specific changes (e.g., my father died of a heart attack and as a result I try to eat a much healthier diet) or idiosyncratic changes (e.g., the loss led me to want to go into nursing). However, the five broad domains reflected in the items of the Posttraumatic Growth Inventory do seem to capture a wide range of changes common to many circumstances, including bereavement.

A model of growth in the context of grief

Our earlier theoretical model of posttraumatic growth (Tedeschi & Calhoun, 1995) has been refined over time, based on empirical tests of components of the model. A current version of the model, outlining the processes through which highly stressful circumstances, such as the death of someone
very close, can lead to the experience of posttraumatic growth is presented in Figure 1. In what follows, we will provide a brief overview of the elements of the model that are most relevant to bereavement. We will also consider evidence in support of the assumed processes. More extensive descriptions of our complete model of growth, including elements that we do not describe here, can be found elsewhere (Calhoun & Tedeschi, 2004, 2006; Tedeschi & Calhoun, 2004a).
Before they experience the death of a close other, individuals will differ in a variety of personality traits and in the many and varying components of their assumptive worlds. Assumptive world beliefs have been considered a key factor in determining the potential for posttraumatic growth by several theorists (Beder, 2004-2005; Gillies & Neimeyer, 2006; Janoff-Bulman, 1992, 2006; Tedeschi & Calhoun, 1995). Under typical circumstances, this broad set of beliefs helps individuals maintain a sense of how events in the world should unfold, and how they can influence events. They allow individuals to plan and experience the world as predictable, understandable, and meaningful (Parkes, 1971). Differences in assumptive world beliefs can exist based on cultural differences that encourage varying world views (Calhoun, Cann, & Tedeschi, in press; Nisbett, 2003) or based on previous life experiences that have shaped particular assumptions.

The death of a close other usually brings with it the experience of emotional distress. Regardless of the circumstances of the death, some sense of loss and distress is likely. The longer term impact of the death may depend on other, related factors. For example, Bonanno (2004) suggests that differences in resilience are related to the long term adjustment issues that often covary with bereavement. Resilient individuals experience the initial distress, but recover with little need for grief work, while those who are less resilient may continue to experience distress and benefit from working through their grief.

Differences in resilience may represent factors separate from variations in assumptive world beliefs, but the noted differences in responses to a death also should be related to differences in individuals’ assumptive world beliefs. Models of posttraumatic growth focus on the critical importance of the degree to which the death, or any significant traumatic experience, challenges or shatters world assumptions (Calhoun & Tedeschi, 2006; Janoff-Bulman, 1992, 2006; Tedeschi & Calhoun, 1995). When an event challenges the existing world beliefs, the individual must deal not only with the distress resulting from the death, but the guiding principles about how the world is assumed to work also may need to be reassessed. Although the challenge to world beliefs sets the stage for possible growth, as individuals more closely examine the world and their place within it in light of the traumatic event, the disruption also can initially add to the distress experienced.

Evidence in support of the importance of considering the individual’s world views can be drawn from the finding that some deaths present much greater psychological challenges than others. A “natural death”, at the end of a long life, tends to be much easier to accept (Lehman, Wortman, & Williams, 1987), and allows for a clearer sense of meaning to be found (Gillies & Neimeyer, 2006). On the other hand, unexpected deaths that are less consistent with most assumptive world views, such as the death of a young child, are less “natural”, and often lead to greater distress and more growth (Tedeschi
& Calhoun, 2006). In the model in Figure 1, distress is expected regardless of the challenge to the assumptive beliefs, but for those for whom the death is consistent with their assumptive worlds, there is little other cognitive work required. They deal with their loss, survive the distress, and return to a stage of well-being much like the individuals Bonanno (2004) labels resilient. Alternatively, those whose beliefs have been seriously challenged cannot as easily move on. The death may have shattered assumptions, and this disruption requires attention to the rebuilding effort at the same time the distress of the death is being experienced.

Despite the essential importance of the challenge to the assumptive world beliefs in models of posttraumatic growth, until recently no effort had been made to assess directly differences in the disruption of assumptive beliefs. Janoff-Bulman (1989) developed a measure of global assumptive world beliefs, the World Assumptions Scale, and showed differences in these beliefs exist between people who had and who had not experienced traumatic events. However, no research had tried to directly assess the degree to which a specific event had led participants to engage in an examination of their core beliefs about the world. The Core Beliefs Inventory (CBI: Cann, Calhoun, Tedeschi, Kilmer, Gil-Rivas, Vishnevsky et al., 2010) was developed for this purpose.

On the CBI, participants rate the degree to which a recent highly stressful event led them to reexamine a number of core assumptions about themselves and their world. Scores on the CBI have consistently been shown to be predictive of levels of posttraumatic growth, both in analyses of cross-sectional and of longitudinal data, involving a variety of stressful events; greater disruption is associated with greater growth (Cann et al., 2010). CBI scores also were positively related to the level of distress experienced at the time of the event and to symptoms of posttraumatic stress. However, a global measure of distress was not predictive of later posttraumatic growth when CBI scores were included in the prediction models (Cann et al., 2010).

Thus, to the extent that a death disrupts core elements of the assumptive world, individuals experience more distress, show higher symptoms of posttraumatic stress disorder, and also have the potential for greater posttraumatic growth – it is the level of disruption of core beliefs which best predicts growth. Deaths which do not lead to significant reexamination of core beliefs should result in less reported growth. Future researchers might want to be cognisant of the potential importance of determining the degree to which individuals experience a death as an understandable and comprehensible event, consistent with their assumptive world beliefs, or see the death as “unnatural”, and therefore as a challenge to their assumptive worlds.

The cognitive work associated with attempts to rebuild challenged or shattered assumptions begins as the person is also coping with the emotional distress of the unexpected or unnatural death of a close other (Calhoun &
Tedeschi, 2006; Tedeschi & Calhoun, 2004a, 2004b). The model assumes that rumination plays an important part in the attempts to repair or reconstruct a workable belief system in the aftermath of the death. Earlier views of rumination associated such cognitive activities with increased distress and depression (Nolen-Hoeksema, McBride, & Larson, 1997; Segerstrom, Tsao, Alden, & Craske, 2000). However, more recent considerations recognise the multiple forms and impacts of rumination (Segerstrom, Stanton, Alden, & Shortridge, 2003; Treynor, Gonzalez, & Nolen-Hoeksema, 2003; Watkins, 2008). Rumination can be constructive or unconstructive, depending on whether the rumination supports continued negative thoughts and emotions or helps move the person toward problem solving or finding meaning. In our work, and in the model in Figure 1, we have distinguished between intrusive ruminations, the types of thoughts that are less controlled by the individual and are almost always unwanted and are associated with PTSD symptoms, from those ruminations that are more deliberate, focused on understanding a challenge and rebuilding a functional world view.

We assume that, due to the impact of the distress caused by the death and the challenged assumptions, the individual will commonly experience unwanted, negative, intrusive thoughts in the immediate aftermath of the death. As the distress is managed and the person is able to engage in more goal-directed ruminations, deliberate, constructive thoughts will tend to predominate. Although the model suggests a movement from one style of rumination to the next, it is more likely that both styles coexist, or may oscillate (Stroebe & Schut, 1999), as the intrusive thoughts serve as a stimulus to work even harder to engage the deliberate thoughts. Ideally, the frequency and disruptive impact of the intrusive thoughts will decrease as the deliberate rumination provides a reconstructed world view and allows the individual to find meaning in the death experience. However, a failure to successfully rebuild functional assumptive world beliefs could be associated with continued high levels of intrusive rumination, and, potentially, continued distress.

During this stage of cognitive reconstruction, the individual’s efforts can be aided by socio-cultural influences which can guide the thoughts in a more constructive direction, facilitating growth, or, potentially, in a less constructive direction. For example, it has been shown that having a model, knowing someone who has had a similar experience and who has experienced growth, facilitates growth (Cobb, Tedeschi, Calhoun, & Cann, 2006; Weiss, 2004). Evidence also exists for broader influences through cultural rituals that can provide a context for understanding and dealing with events like death (Bonanno, Papa, Lalande, Zhang, & Noll, 2005). Of course, not all culturally-based beliefs or rituals are helpful to the process of grieving. For example, when people who commit suicide are not accorded the same degree of respect as people who have died from other causes, the bereaved family might
experience a version of disenfranchised grief (Doka, 1999; 2008).

A number of recent studies, in which different styles of rumination have been assessed, support the assumed processes in which deliberate rumination will be more strongly predictive of eventual posttraumatic growth, while intrusive rumination early, soon after the death, but not recently, will be associated with posttraumatic growth. Taku, Calhoun, Cann, and Tedeschi (2008), in a sample of bereaved Japanese university students, found that recent intrusive rumination was associated with greater distress, while deliberate rumination soon after the event predicted greater growth. Similarly, in a comparison of samples from the United States and Japan, it was found that across both samples, intrusive rumination soon after the stressful event was positively associated with growth, as was recent deliberate rumination (Taku, Cann, Tedeschi, & Calhoun, 2009).

Finally, in a study that assessed both positive changes, posttraumatic growth, and negative changes in the same domains as growth, posttraumatic depreciation, recent deliberate rumination was positively associated with growth, while recent intrusive rumination was negatively associated with growth. In predicting posttraumatic depreciation, however, recent intrusive rumination was a positive predictor, indicating a negative role for persistent intrusive rumination (Cann et al., in press). Taken together, these studies indicate that deliberate rumination is consistently associated with eventual posttraumatic growth; however, intrusive ruminations are associated with growth when they occur early, soon after the event, and do not persist unabated. Recent intrusive ruminations, perhaps indicative of a failed attempt to restore the assumptive world beliefs, are associated with less posttraumatic growth and greater posttraumatic depreciation.

Note that in the model, eventual success in rebuilding the beliefs and assumptions that comprise the assumptive world is believed to be associated with growth, and, perhaps, with a more complex appreciation of the world and other human beings. Simplistic notions of fairness and control over unpleasant experiences, for example, may be replaced with a more realistic recognition that bad things can happen even when people are good. This new world view may not always be associated with higher levels of well-being. People may have come to recognise their own strengths, to feel closer to others, and to have a new appreciation for life or life direction, but they may also now accept that the world is not always a fair or controllable place, and that bad outcomes cannot always be prevented.

In looking at the data we have collected over a number of years, across multiple studies, we note how bereavement, as a specific experience, differs from other highly stressful events in terms of eventual posttraumatic growth. In an accumulated sample of over 800 participants from the United States, who have completed both the Posttraumatic Growth Inventory (PTGI) and the Core Be-
233 participants reported on the death of a close other. Within this bereaved subgroup, scores on the CBI were positively correlated with all five subscales of posttraumatic growth (all $r's \geq .43$, all $p's < .001$), indicating that for those bereaved persons, disruption of core assumptive world beliefs is associated with eventual posttraumatic growth. A comparison of those reporting on a death ($n = 233$) with those dealing with other events ($n = 571$), indicates that the two groups do not differ on total posttraumatic growth scores or CBI scores ($t's < 1$), but differences are evident on the subscales of the PTGI. Those reporting on a death showed reliably more growth in the areas of Relationships with Others, Appreciation of Life, and Spiritual Change. However, bereaved persons reported less growth in the areas of Personal Strengths and New Possibilities. Although these data represent reactions of individuals dealing with a wide variety of deaths, some probably more “natural” than others, they do provide some hints about the growth experiences of individuals facing bereavement and grief, at least in a North American context.

Posttraumatic growth and clinical practice with grieving persons

There has been a good deal of controversy about the usefulness of clinical interventions with grieving persons. Some data have tended to show that grief therapy is quite unnecessary for most bereaved persons, but for those who do seek professional help, there are some outcomes that are robust and comparable to other forms of psychotherapy (Bonanno & Lilienfeld, 2008; Hoyt & Larson, 2008). Therefore, it is important to consider the persons for whom grief therapy is designed.

In our general model of posttraumatic growth we have emphasised that trauma is, to a great extent, defined by the degree of challenge to the assumptive world, and that posttraumatic growth develops, to a significant but not exclusive degree, out of an attempt to come to new understandings of a world that no longer fits people’s ideas about themselves, how others behave, what their future will be, and the like. Some bereavement circumstances are more likely to challenge these assumptions than others, and some assumptive worlds may be more vulnerable to these challenges than others. Bonanno (2004) has shown that a significant proportion of people are not prone to these difficulties, i.e., they are resilient in the face of bereavement. On the other hand, people who demonstrate posttraumatic growth are likely to be those whose grief process includes challenges to their assumptive worlds, including their sense of meaning and purpose, or their understanding of themselves (Davis, 2008).

Just as with other difficult experiences, where challenges to core beliefs, high levels of distress, and rumination are associated with posttraumatic growth, the same appears to be the case with bereavement. When threat
to self and a need for self-understanding is part of the grief process, post-traumatic growth is a result (Balk, 1999; Davis, Wohl, & Verberg, 2007). Grief therapies have been described that fit with this understanding of what is needed most by persons who are truly in need of intervention: a reconstruction of their beliefs, sense of meaning, and life narrative (Leighton, 2008; Malkinson, 2007; Neimeyer & Wogrin, 2008).

We have described our own framework for intervention, based on our work with posttraumatic growth (Calhoun & Tedeschi, 1999), as an approach that has relevance to work with persons who have experienced a variety of life crises that make necessary a reconstruction of beliefs, meanings, and the life narrative. This model of expert companionship is certainly appropriate for work with bereaved persons, and grows out of significant clinical experience with them (Tedeschi & Calhoun, 2004b; 2006). In working with bereaved parents in particular, we have found a number of concerns that set people on a course that can include posttraumatic growth. There is a high level of distress, a shattering of the expectation that one will outlive one's children, disappointments and surprises about who is, and who is not, understanding and supportive, and questions about the afterlife, all of which are challenges to core beliefs.

This approach that attends to the possibility of posttraumatic growth is not a new form of therapy, but a particular perspective, and it fits well with cognitive, humanistic-existential, and narrative-constructionist approaches. There are several aspects to the posttraumatic growth therapy we call expert companionship that are especially relevant for bereaved persons. In the following we provide very brief descriptions of some elements of this particular clinical stance.

*Humility & respect, not platitudes*

A basic respect for the beliefs and experiences of bereaved persons, often rooted in their culturally-based understandings of death and grief, is essential to setting the stage for posttraumatic growth. Instead of seeking to merely provide comfort and reassurance with platitudes, that are often given by well-meaning friends and family, the clinician working as an expert companion is willing to explore these beliefs, and the doubts about them, that may be raised by the experiences of the bereaved.

*Constancy*

The expert companion is willing to tolerate the fact that bereavement can be a longer-term process than what is expected by friends and family, or the bereaved persons themselves. The clinician is a constant in spite of oscillations (Stroebe & Schut, 1999) in the grief experience of the individual.
Tolerance of the strange, non-rational, and ambiguous

Experiences of death and bereavement can be strange and mysterious for some. People in these circumstances can be reluctant to talk about such things as belief in paranormal phenomena, continuing bonds (Klass & Walter, 2001), or unpredictable bouts of distress. The expert companion is constant as a non-judgmental listener to all these experiences.

Courage to hear

The expert companion may also need to listen to unpleasant stories of death, when illness, accident, or personal violence has produced gruesome and traumatic images of death that the bereaved persons may carry with them.

Appreciation of paradox

In order to facilitate posttraumatic growth, the expert companion must be able to appreciate the two sides, or more, of the stories told by the bereaved. For example: in the vulnerability of grief emerges strength; from doubtful questioning, new insights can emerge; and in the need for support, greater independence can be achieved.

Clinicians working with grieving persons must remember that the process by which posttraumatic growth may unfold occurs in the process of grief itself. A fundamental concern is the timing of discussions of growth, and the attributions made for the cause of posttraumatic growth. The expert companion is sensitive to the readiness of people to consider emerging indications of growth, and how these have come about. Some bereaved persons may decide at the outset that they are going to “make something good come of this”, but the vast majority are simply trying to get through their distress in the early phase of their loss. When clinically appropriate (Zeldow, 2009), the expert companion can bring to the attention of the bereaved person indications of change in the five domains of posttraumatic growth as they seem ready to engage them more deliberately. The clinician should take care to attribute these changes to the struggle with the grief and loss, not to the loss itself. Bereaved persons are, of course, reluctant to think that the loss, e.g., the death of a husband, has produced something good per se. They are more willing to see that their struggle has produced something positive. It is not the loss itself, but the cognitive and emotional work, and the reconstructed assumptive world, including the life narrative, that produces change. This matter also highlights the crucial difference between what has been termed “perceived benefits” and posttraumatic growth (Davis, 2008). Benefits such
as inheritances can certainly come in the aftermath of loss, but they are different in quality from personal growth, and are more likely to be accepted with ambivalence.

A possible framework

In order to attend to, and when appropriate encourage, the process of posttraumatic growth, clinicians may find our model of posttraumatic growth a useful framework when working with grieving patients. The model suggests where in the process the bereaved person may be, and what kind of therapeutic work might be most appropriate. In the early stages, emotional distress will need to be addressed, but not smothered entirely. Some degree of distress may be useful for producing posttraumatic growth. Rumination that is intrusive and unconstructive can be encouraged to become more deliberate, and focused on questions that are indicative of the development of posttraumatic growth, e.g., changes in role and identity, new ways of relating, existential or spiritual beliefs, and the purpose and meaning of life after the experience of loss.

Although posttraumatic growth may be very much an internal experience, with changes in views of self and the world that are not always apparent to the observer, there are ways in which posttraumatic growth can be enacted in life choices, relationships, and priorities. The expert companion can encourage, when appropriate, the enactment of posttraumatic growth so that the changes are not lost over time, but become a valued memorial to the person who has died. Through these changes, the adaptive bond with the deceased can be continued, and in this way, the suffering of bereavement is made meaningful. This does not mean that distress is eliminated, but that it is mitigated by the recognition that the loss has set in motion a reconsideration of life that has wrought valuable changes.

References


Received June 10, 2009
Revision received September 22, 2009
Accepted October 8, 2009