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# GRIEF COUNSELING and GRIEF THERAPY

FIFTH EDITION

## A Handbook for the Mental Health Practitioner

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# PREFACE

The idea for this book came out of a series of workshops that I presented at the University of Chicago for mental health professionals who spent 2 days of continuing education time exploring their own loss history as well as learning a model—the task model—for understanding grief, bereavement, and the process of mourning. These workshops began in 1976; they were offered twice a year for groups of 100 and were oversubscribed each year. Over time we offered such workshops in other parts of the United States. The first edition of the book was published in 1982 and contained much of the material presented at these grief workshops,

The title of the book came out of a lecture that I presented at the University of Florida, Gainesville. I was invited to present the annual Arthur G. Peterson lecture for a large group of mental health professionals. I titled my lecture "Grief Counseling & Grief Therapy." This was the first time that I had made such a distinction, but it made sense to me and its usefulness has persisted over the years. Grief counseling refers to the interventions counselors make with people recent to a death loss to help facilitate them with the various tasks of mourning. These are people with no apparent bereavement complications. Grief therapy, on the other hand, refers to those techniques and interventions that a professional makes with persons experiencing one of the complications to the mourning process that keeps grief from progressing to an adequate adaptation for the mourner. Often there are conflicts of separation with the deceased that need to be addressed. This requires more skill, understanding, and training than doing grief counseling, which can often be facilitated by a skilled friend or family member.

Do we really need grief counselors? I had asked this question in the first edition of this book 35 years ago and said that I don't believe

that we need to establish a new profession of grief counselors. I still believe this. D. M. Reilly (1978), a social worker, says, "We do not necessarily need a whole new profession of . . . bereavement counselors. We do need more thought, sensitivity, and activity concerning this issue on the part of the existing professional groups, that is, clergy, funeral directors, family therapists, nurses, social workers, and physicians" (p. 49). To this, Lloyd (1992) adds, "Skills in working with grief and loss remain core essential tools for professionals who are not necessarily specialist counselors" (p. 151). I agree with this. What I want to do in this book is address those of you in these traditional professions who are already in a position to extend care to the bereaved and have the knowledge and skills required to do effective intervention and, in some cases, preventive mental health work.

In this fifth edition of *Grief Counseling and Grief Therapy*, new information is presented throughout the book. Previous information is updated when possible. The world has changed since 1982 when the first edition of this book was published. There are more traumatic events, drills for school shootings, and faraway events that may cause a child's current trauma. There is also the emergence of social media and online resources, all easily accessible by smartphones at any time. Bereavement research and services have tried to keep up with these changes. In the following pages I have tried to present what is current for your consideration so that you, as a mental health professional, can be most effective in your interventions with bereaved children, adults, and families.

Special acknowledgments are due to the many people who have assisted me with this project. Three of my close friends and colleagues who are familiar with earlier editions of this book made specific suggestions that they felt would strengthen a fifth edition and bring it up-to-date. These colleagues who have encouraged me and given me specific suggestions are (a) Bill Hoy, clinical professor of medical humanities at Baylor University; (b) Mark de St. Aubin, from the College of Social Work at the University of Utah; and (c) Michele Post, a therapist from One Legacy in Los Angeles. I have incorporated most of their suggestions in the book.

Keeping up with current literature on this subject is an enormous task. I have over 5,000 annotated references in my database that was started at Harvard back in the 1970s. Those most current research assistants helping me were Alexes Flates and Haleigh Barnes, both of whom have now completed their doctoral training in clinical psychology and are working in the field. Making this assistance possible was help from

Dr. Clark Campbell, Dean of the Rosemead School of Psychology, and I also wish to thank him.

The professionals in the Worden group that meet every month for support and supervision have helped me and clarified my thinking. These include Ron Attrell, Dennis Bull, Paula Bunn, Galen Goben, Ann Goldman, Linda Grant, Annette Iversen, Laurie Lucas, Mike Meador, Gayle Plessner, and Michele Post.

A special thanks to Sheri W. Sussman, Executive Editor of Behavioral Sciences at Springer Publishing Company. She has added her wisdom and encouragement for each of the five editions of this book and has been a friend for 35 years. And, as always, my family and friends have provided important emotional support.

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**As an aid for using the fifth edition of *Grief Counseling and Grief Therapy* in class, qualified instructors can access the book's ancillary materials (Instructor's Manual, test bank, and PowerPoints) by emailing *textbook@springerpub.com*.**

# INTRODUCTION

Over the 35 years since the first edition of this book was written, there have been a number of new concepts introduced into the field of grief, loss, and bereavement. Before we get into the content of this current edition, I would like to highlight some that I believe are worth noting. Many of these appeared during the past 20 years, and some of these I discuss in more detail in the book. Although tempted to put these into the top 10 in order of importance, I will merely list them. They are all important.

## SOCIAL MEDIA AND ONLINE RESOURCES

One emerging trend is the use of social media and other online resources to help people who are grieving. These *cyber mourning* resources can be used (a) as ways to remember the deceased, (b) as ways to conduct intervention for the bereaved, and (c) as a way to do further research on bereavement and the mourning process (Stroebe, van der Houwen, & Schut, 2008). Let me outline several ways that social media and online resources are currently being used.

1. *Online memorials*. Families, friends, and others can go online and post thoughts about the deceased and send condolences to the family and friends of the deceased. These memorial pages are often set up by the funeral director who served the family or by non–funeral-related groups such as Open to Hope (www.opentohope.com) or nonprofit organizations such as Heal

Grief (www.healgrief.org) where individuals can light online memorial candles or post eulogies, memorial art, or photo projects. There are also Facebook Memorial pages that can be used to announce the death or funeral service, post memories, and celebrate the life of the deceased. For some reason, these pages may attract *strangers* who did not know the deceased but will follow the entries and sometimes post messages (De Groot, 2014).

2. *Internet-based intervention*. Websites have been set up to offer online treatment for people suffering from various types of losses and diagnoses. Such interventions are conducted by a therapist. These include such conditions as posttraumatic stress disorder (PTSD), depression, and prolonged grief disorder. They can also assist people who are experiencing disenfranchised grief from losses that are difficult to talk about, such as a loss during pregnancy or LGBT partner loss. Anonymity that can promote self-disclosure seems to be one of the key attractions for this type of therapy, but this can be fraught with danger. If the patient becomes suicidal or homicidal, it is important that the therapist be able to contact the patient directly and provide direct resources. This type of treatment is not suitable for all patients, and a careful online or telephone-based diagnosis must be made before treatment begins.
3. *Internet bereavement support groups.* These can be found online, and are set up to address special types of losses such as suicide deaths (Feigelman,Gorman, Beal, & Jordan, 2008), while others are established to help those with a general variety of bereavement losses (M. Post, "Grief in the Digital Age" seminar, November 2, 2016). These groups are led, or at least monitored, by professionals who are able to admit or reject people from participation (Paulus & Varga, 2015). Outcome measures can be used pre- and postgroup to measure change due to participation in the group (van der Houwen, Schut, van den Bout, Stroebe, & Stroebe, 2010).
4. *Peer-support web pages*. Such self-help pages are set up after natural disasters (floods, hurricanes, earthquakes), mass shootings, and other catastrophes, allowing those interacting with the site to express feelings and questions, and to generally feel a part of a community grappling with these events (Miller, 2015). These sites offer no personalized professional feedback. However, they can be particularly effective for helping the person who cannot find help elsewhere (Aho, Paavilainen, & Kaunonen, 2012).

5. *Psychoeducational purposes.* Persons who need information about grief and loss and to *normalize* what they are experiencing can use such pages to obtain information about the grief process (Dominick et al., 2009). These are generally not interactional pages but are pages set up to give information on a topic. There are, however, some sites that allow the reader to ask a question about a particular topic that may or may not be answered by another person reading that particular page.
6. *Communicating with the deceased*. Some sites and some Facebook pages are set up in the name of the deceased. Mourners may use these pages to regularly write to the deceased, often in a letter format, expressing their thoughts, feelings, and questions. Those who have studied this phenomenon find that such communications with the deceased are primarily used for the purpose of *meaning making* and second for providing a *continuing bond* with the deceased (Bell, Bailey, & Kennedy, 2015; De Groot, 2012; Irwin, 2015).

For more information on Internet resources for cyber mourning, I would refer you to the book *Dying, Death, and Grief in an Online Universe,* edited by Sofka, Cupit, and Gilbert, and published by Springer Publishing in 2012.

## WHAT IS THE NATURE OF COMPLICATED BEREAVEMENT?

For years, most of those working with complicated mourning and grief therapy have used terms like *chronic grief*, *delayed grief*, and *absent grief* to delineate the diagnosis of those with complicated bereavement or complicated mourning. In fact, some of these concepts were defined by consensus when Beverly Raphael and Warwick Middleton (Middleton, Moylan, Raphael, Burnett, & Martinek, 1993) conducted a survey to determine which terms were the most frequently used by leading therapists in the field. Although there was a surprising degree of consensus, the problem is that complicated grief is a Z code in the *Diagnostic and Statistical Manual of Mental Disorders,* and Z code diagnoses do not qualify for third-party payment through insurance carriers. Another problem has been the lack of precise definitions of these terms, which makes rigorous research of them difficult. The easiest solution has been to conduct research using well-defined pathological entities like depression, anxiety, and somatization, for which there are good standardized measures. Although these clinical entities may be part of the mourner's experience, they clearly are not measures of grief. There were a few

measures of grief like the Texas Revised Grief Inventory (Faschingbauer, Devaul, & Zisook, 2001) and the Hogan Grief Reaction Checklist (2001), but most were normed on a clinical population.

Beginning with the work of Holly Prigerson, Kathryn Shear, and Mardi Horowitz in the 1990s, there has been a 20-year-plus attempt to come up with a diagnosis of complicated grief that would be acceptable to go into the *DSM-5*, which was released in 2013. Such a diagnosis would make insurance money available for the treatment of patients with this diagnosis and would make research funds available for further investigation on this clinical entity. Details on this diagnosis, its development, and its current status can be found in Chapter 5.

## DISENFRANCHISED GRIEF

This term, coined by Ken Doka and further developed by Attig (2004), has been an important addition to the field. Although Doka's first volume came out in 1989, he updated the concept in a second volume that came out in 2002 (Doka, 1989, 2002). Disenfranchised grief refers to losses in the mourner's life of relationships that are not socially sanctioned. A classic example would be the death of someone with whom the mourner is having an affair. If this affair is not widely known, the mourner will not be invited to participate in the funeral rituals and may not receive the social support that many people find helpful after a death. Alternate lifestyles may not be socially sanctioned, and the friend or lover may be ostracized by the family of the deceased. There are numerous other examples of disenfranchised grief, and there are suggestions in this book for re-enfranchising some of these losses to aid the mourner in adapting to the loss.

Aaron Lazare (1979, 1989), an early colleague at Massachusetts General Hospital, talked about two kinds of loss that are directly related to this concept of disenfranchised grief. *Socially negated losses* are those losses that society treats as nonlosses. An example of this would be pregnancy loss, either spontaneous or induced. The second kind of loss related to disenfranchised grief would be *socially unspeakable losses.* These are specific losses about which the mourner has a difficult time talking. Common examples would be death by suicide and death by AIDS. Both of these losses carry some stigma in the broader society. One intervention that can be helpful to those experiencing these types of losses is assisting them in talking about them and exploring their thoughts and feelings about the death. Re-enfranchising suggestions for these types of losses can be found in Chapter 7 of this volume.

## CONTINUING BONDS

Attachments to the deceased that are maintained rather than relinquished have been called continuing bonds. This is not an entirely new concept. Shuchter and Zisook (1988) noted that widows in their seminal conjugal bereavement studies in San Diego maintained a sense of their loved ones' presence for several years after the death. In the Harvard Child Bereavement Study, Silverman, Nickman, and Worden (1992) observed ongoing connections with the deceased parent among a large number of these bereaved school-age children. For most it was a positive experience; for some it was not. The book by Klass, Silverman, and Nickman titled *Continuing Bonds: New Understandings of Grief* (1996) pulled together information from our study and several others to promote the notion that some people stay connected with the deceased rather than emotionally withdrawing, as was the notion previously promoted by Freud (1917/1957).

This new concept was not embraced by all and questions soon arose as to whether continuing bonds can be adaptive for some and maladaptive for others. Are continuing bonds actually associated with a healthy ongoing life? A lot of this controversy is based on the lack of good research evidence for the efficacy of continuing bonds. As more research is done, some of these questions will be resolved. Essentially, the questions center around four main issues: (a) *What types of bonds are the most helpful* in the adaptation to loss? These would include objects from the deceased (linking and transitional objects, keepsakes), a sense of the deceased's presence, talking to the deceased, introjecting the deceased's beliefs and values, taking on characteristics of the deceased, and the like (Field & Filanosky, 2010). (b) *For whom are continuing bonds helpful*, and for whom are they not? This necessitates the identification of subgroups of mourners; the concept should not be applied to everyone. One promising approach to this is to look at the mourner's attachment style in relationship to the deceased (Field, Gao, & Paderna, 2005). In the case of anxious attachments that can lead to chronic grief, holding onto the deceased may not be adaptive. Some mourners need to relinquish and move on (Stroebe & Schut, 2005). (c) *In what time frame are continuing bonds the most adaptive* and when are they less adaptive—closer to the loss, farther from the loss? (Field, Gao, & Paderna, 2005). (d) *What is the impact of religious and cultural differences on maintaining healthy bonds?* This would include beliefs and rituals that promote a connection and memorialization of the deceased cross-culturally in various societies (Suhail, Jamil, Ovebode, & Ajmal, 2011; Yu et al., 2016). More on bonds can be found in Chapter 2.

## MEANING MAKING

Meaning reconstruction and meaning making, concepts introduced and promoted by psychologist Robert Neimeyer, have been an important emphasis in the field over the past 20 years. He sees meaning reconstruction as the central process faced by bereaved individuals. This reconstruction is primarily accomplished through the use of narratives or life stories. When unanticipated or incongruous events such as the death of a loved one occur, a person needs to redefine the self and relearn ways to engage with the world without the deceased. The person cannot return to a pre-loss level of functioning but learns how to develop a meaningful life without the deceased loved one (Neimeyer, 2001). This is central to my third task of mourning, in which the mourner must learn to adjust to a world without the deceased. Death can challenge one's assumptions about the world (spiritual adjustments) and one's personal identity (internal adjustments). Bereaved individuals have serious questions such as: "What will my life look like now?" "What did the deceased's life mean?" "How can I feel safe in a world such as this?" and "Who am I now that this death has occurred?" (Neimeyer, Prigerson, & Davies, 2002).

I think it is important to note, however, that some deaths do *not* challenge personal meaning making in any fundamental way. Davis, Wortman, Lehman, and Silver (2000) conducted research on two different bereaved populations and found that 20% to 30% of the bereaved individuals appeared to function well without engaging in the process of meaning making. Of those who searched for meaning, fewer than half of the individuals found it even over a year after the death. Those who did find meaning, however, were better adjusted than those who searched and didn't find it. But, interestingly, for some, the quest to understand continued even after meaning was found.

Neimeyer (2000), commenting on the Davis research, makes note that the majority in the studies were struggling with meaning making and these should be helped with this process. But, he cautions the counselor about initiating this process if it does not occur spontaneously. He concludes his comments with an important distinction: meaning making is a process, not an outcome or achievement. The meanings associated with death loss are constantly revised. We see this clearly in our work with bereaved children, who, as they age and pass through new developmental stages, ask: "What would my parent be like now?" and "What would our relationship be like now that I am graduating college, getting married, etc.?" (Worden, 1996a). More on meaning making as a task of mourning can be found in Chapter 2.

## RESILIENCE

When Phyllis Silverman and I studied 125 parentally bereaved children over a 2-year period after the death, we noted that children fell into one of three groups. The first was the group of children (approximately 20%) who were not doing well during the 2 years after the death. Since our research grant came from the National Institute of Mental Health for a study intended to identify bereaved children at-risk and prevent problem outcomes, this group became a major focus of our study. Could we identify at-risk children early after the loss so that early intervention might be offered to prevent later negative sequelae from the death? However, we also noticed a second smaller group of children who seemed to be doing very well, and we identified them as *resilient children*. Their academic performance, social life, communication about the deceased, self-worth, sense of control, and healthy identification with the deceased parent were all on the high side. The third and largest group was the group *making do* during the first 2 years of bereavement (Silverman, 2000; Worden, 1996a).

Thanks to the work of George Bonanno (2004, 2009), we have begun to look at resilient bereaved individuals. These are people who adapt well to the loss and are not in need of either counseling or therapy. I think this focus is overdue.

In Arizona, Irwin Sandler, Sharlene Wolchik, and Tim Ayers (2008) have added to our thinking on resilience. Like me, they prefer the term *adaptation* to *recovery*. Those mourners who make a good or effective adaptation to the loss have made a *resilient adaptation*. Sandler's group has identified both risk and protective factors in their study of parentally bereaved children and their families that lead to a good (resilient) or a less good adaptation to the loss. By focusing on positive as well as negative outcomes, a resilient approach goes beyond the narrower focus of pathological outcomes. It is interesting that the risk and protective factors found in Arizona families are similar to those Silverman and I found in the Boston study. Multiple factors at both the individual and social environmental levels are at work here, so Sandler's group calls their theory a *contextual framework on adaptation.* Individuals are seen as nested within families, which are in turn nesting within communities and cultures. This fairly new research and thinking on resilience in bereavement holds promise for our understanding of grief and loss. More on this can be found in Chapter 3.

## TRAUMA AND GRIEF

Like depression and grief, trauma and grief share many of the same behavioral features. A number of articles discuss how they are similar and how they are different. There are some, like Rando, Horowitz, and Figley, who would subsume all grief under trauma, but I find this a stretch. I prefer the model offered by Stroebe, Schut, and Finkenauer (2001), which makes the following three distinctions. The first is *trauma without bereavement*. Here the person experiences a traumatic event that gives rise to trauma symptoms leading to a diagnosis of PTSD or acute stress disorder, mostly depending on the time frame. Other symptoms of depression and anxiety may lead to a comorbid diagnosis. In this first distinction, the traumatic event has not led to any deaths and the person is dealing with one or more of the classic trauma symptoms (intrusion, avoidance, hyperarousal) without bereavement. *Bereavement without trauma* is the second distinction. Here the person has experienced the death of a loved one without experiencing trauma symptoms associated with the event. If there are complications after the loss, one of the complicated mourning categories would apply to this complication. The third category could be called *traumatic bereavement*. Here the person experiences a death and there is something about the death itself (often violent deaths) or something about the person's experience of the death (often related to an insecure attachment or conflicted relationship with the deceased) that gives rise to symptoms associated with trauma.

Two questions emerge in any discussion of traumatic bereavement. First, which is the most important in defining traumatic bereavement—the circumstances of the death or the reaction of the mourner? Second, in the treatment of traumatic bereavement, which symptoms should be addressed first—the trauma symptoms or the grief symptoms? Traumatic stress interferes with grief over loss; grief interferes with trauma mastery (Rando, 2003). Many believe that the trauma symptoms must be dealt with first before the grief can be addressed.

There have always been people who have been exposed to violent deaths, but the number of violent events seems to have increased during the past 15 years. The recent rash of mass shootings and multiple terrorist activities around the world, including September 11, 2001, illustrate the pervasiveness of violence in our society. Such violent events will continue to expose more people to both trauma and bereavement. We need more research on grief and trauma, including research on which interventions are most effective (Rynearson, Schut, & Stroebe, 2013). We also need to educate the media that interventions done in the days following a school shooting are *not grief counseling* but rather *crisis*

*intervention*, and there are major differences between the two in goals and techniques. More on this can be found in Chapter 3.

## SOME CONCLUDING THOUGHTS

Let me conclude this introduction with something that causes me concern: the failure of both clinicians and researchers to recognize *the uniqueness of the grief experience*. Even though the mourning tasks apply to all death losses, how a person approaches and adapts to these tasks can be quite varied. A one-size-fits-all approach to grief counseling or grief therapy is very limiting (Caserta, Lund, Ulz, & Tabler, 2016).

When I was a graduate student at Harvard, Professor Gordon Allport had a strong impact on my thinking. Allport (September 1957, lecture notes) would tell students, "Each man is like *all other men*; each man is like *some other men*; and each man is like *no other man*." Allport was affirming his longtime professional interest in individual differences—an interest that led to his collaboration with Robert White on the longitudinal case studies of men called *Lives in Progress* (1952). These studies affirm both the similarity and uniqueness of each person.

If we were to translate Allport's dictum into the field of bereavement, we would say, "Each person's grief is like *all* other people's grief; each person's grief is like *some* other person's grief; and each person's grief is like *no* other person's grief." Over the last 35 years, we have tended to lose sight of the uniqueness of the grief experience in our clinical and research undertakings. I always liked Alan Wolfelt's (2005) idea of *companioning* the bereaved individual. In this approach, the counselor comes alongside the mourner and they share their personal experiences in a way that can be helpful for both. I worry that in our rush to formulate a *DSM* diagnosis for complicated (traumatic, prolonged) grief, we may focus too much on "Each person's grief is like *some other person's grief*" and lose sight of the uniqueness of grief, the fact that each person's grief is like *no other person's grief*. I have affirmed in each edition of this book that every person's experience of grief is unique to him or her, and people's experiences shouldn't be saddled with the term *abnormal grief*. I much prefer the term *complicated mourning*, which affirms some kind of difficulty in the mourning process that brings the person to the attention of the mental health worker.

Affirmation of the uniqueness of grief is not a new emphasis in the field of bereavement. Colin Parkes (2002) said, "From the start, Bowlby and I recognized 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" (p. 380).

An interesting affirmation of the uniqueness and subjective quality of grief comes from an fMRI study of grief by Gundel, O'Connor, Littrell, Fort, and Lane (2003). After investigating the grief experience in the brains of eight women, they concluded that grief is mediated by a distributed neural network that subserves a number of neural processes affecting various parts of the brain and its functions, including affect processing, mentalizing, memory retrieval, visual imagery, and autonomic regulation. This neural network may account for the unique, subjective quality of grief, and this finding provides new leads in our quest to understand the health consequences of grief and the neurobiology of attachment.

I believe that the mediators of mourning outlined in detail in Chapter 3 hold the key to understanding individual differences in the mourning experience—the adaptation to loss from death.

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# 1 ATTACHMENT, LOSS, AND THE EXPERIENCE OF GRIEF

## ATTACHMENT THEORY

Before one can fully comprehend the impact of a loss and the human behavior associated with it, one must have some understanding of the meaning of attachment. There is considerable writing in the psychological and psychiatric literature as to the nature of attachments—what they are and how they develop. One of the key figures and primary thinkers in this area is the late British psychiatrist John Bowlby. He devoted much of his professional career to the area of attachment and loss and wrote several substantial volumes as well as a number of articles on the subject.

Bowlby's attachment theory provides a way for us to conceptualize the tendency in human beings to create strong affectional bonds with others and a way to understand the strong emotional reaction that occurs when those bonds are threatened or broken. To develop his theories, Bowlby casts his net wide and includes data from ethology, control theory, cognitive psychology, neurophysiology, and developmental biology. He takes exception to those who believe that attachment bonds between individuals develop only in order to have certain biological drives met, such as the drive for food or the drive for sex. Citing Lorenz's work with animals and Harlow's work with young monkeys, Bowlby (1977a) points to the fact that attachment occurs in the absence of the reinforcement of these biogenic needs.

Bowlby's thesis is that these attachments come from a need for security and safety; they develop early in life, are usually directed toward a few specific individuals, and tend to endure throughout a large part of the life cycle. Forming attachments with significant others

is considered normal behavior not only for the child but for the adult as well. Bowlby argues that attachment behavior has survival value, citing the occurrence of this behavior in the young of almost all species of mammals. But he sees attachment behavior as distinct from feeding and sexual behavior.

Attachment behavior is best illustrated by the young animal and the young child, who, as they grow, leave the primary attachment figure for increasingly long periods of time to search an ever-widening radius of their environment. But they always return to the attachment figure for support and safety. When the attachment figure disappears or is threatened, the response is one of intense anxiety and strong emotional protest. Bowlby suggests that the child's parents provide the secure base of operation from which to explore. This relationship determines the child's capacity to make affectional bonds later in life. This is similar to Erikson's (1950) concept of *basic trust;* through good parenting, the individual sees himself as both able to help himself and worthy of being helped should difficulties arise. Obvious pathological aberrations can develop in this pattern. Inadequate parenting can lead people either to form anxious attachments or to form very tenuous attachments, if any at all (Winnicott, 1953, 1965). Various attachment styles can be found in Chapter 3.

If the goal of attachment behavior is to maintain an affectional bond, situations that endanger this bond give rise to certain very specific reactions. The greater the potential for loss, the more intense and the more varied these reactions are. "In such circumstances, all the most powerful forms of attachment behavior become activated—clinging, crying, and perhaps angry coercion.… When these actions are successful, the bond is restored; the activities cease and the states of stress and distress are alleviated" (Bowlby, 1977b, p. 429). If the danger is not removed, withdrawal, apathy, and despair then ensue.

Animals demonstrate this behavior as well as humans. In *The Expression of Emotions in Man and Animals,* written during the latter part of the 19th century, Darwin (1872) described the ways in which sorrow is expressed by animals as well as by children and adult human beings. Ethologist Lorenz (1963) has described this grief-like behavior in the separation of a greylag goose from its mate:

> The first response to the disappearance of the partner consists in the anxious attempt to find him again. The goose moves about restlessly by day and night, flying great distances and visiting places where the partner might be found, uttering all the time the penetrating trisyllable long-distance call.… The searching expeditions are extended farther and farther and quite often the searcher itself

> gets lost, or succumbs to an accident…. All the objective observable characteristics of the goose's behavior on losing its mate are roughly identical with human grief. (Lorenz, 1963, quoted in Parkes, 2001, p. 44)

There are many other examples of grieving in the animal world. Several years ago, there was an interesting account about dolphins in the Montreal zoo. After one of the dolphins died, its mate refused to eat, and the zookeepers had the difficult, if not impossible, task of keeping the surviving dolphin alive. By not eating, the dolphin was exhibiting manifestations of grief and depression akin to human loss behavior.

Psychiatrist George Engel, speaking at the psychiatric grand rounds at the Massachusetts General Hospital, described a case of bereavement in great detail. This case sounded typical of the kinds of reactions that you would find in a person who has lost a mate. Later in his lecture, after reading a lengthy newspaper account of this loss, Engel revealed that he was describing the behavior of an ostrich that had lost her mate!

Because of the many examples in the animal world, Bowlby concludes that there are good biological reasons for every separation to be responded to in an automatic, instinctive way with aggressive behavior. He also suggests that irretrievable loss is not taken into account, and that in the course of evolution, instinctual equipment developed around the fact that losses are retrievable and the behavioral responses that make up part of the grieving process are geared toward reestablishing a relationship with the lost object (Bowlby, 1980). This biological theory of grief has been influential in the thinking of many, including that of British psychiatrist Colin Murray Parkes (Parkes, 1972; Parkes & Stevenson-Hinde, 1982; Parkes & Weiss, 1983). Other prominent attachment theorists include Mary Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978) and Mary Main (Main & Hesse, 1990). The mourning responses of animals show what primitive biological processes are at work in humans. However, there are features of grieving specific only to human beings, and these normal grief reactions are described in this chapter (see Kosminsky & Jordan, 2016).

There is evidence that all humans grieve a loss to one degree or another. Anthropologists who have studied other societies, their cultures, and their reactions to the loss of loved ones report that whatever the society studied, in whatever part of the world, there is an almost universal attempt to regain the lost loved object and/or there is the belief in an afterlife where one can rejoin the loved one. In preliterate societies, however, bereavement pathology seems to be less common than it is in more civilized societies (Parkes, Laungani, & Young, 2015; Rosenblatt, 2008; Rosenblatt, Walsh, & Jackson, 1976).

## IS GRIEF A DISEASE?

George Engel (1961) raised this interesting question in a thought-provoking essay published in *Psychosomatic Medicine*. Engel's thesis is that the loss of a loved one is psychologically traumatic to the same extent that being severely wounded or burned is physiologically traumatic. He argues that grief represents a departure from the state of health and well-being, and just as healing is necessary in the physiological realm in order to bring the body back into homeostatic balance, a period of time is likewise needed to return the mourner to a similar state of psychological equilibrium. Therefore, Engel sees the process of mourning as similar to the process of healing. As with healing, full function, or nearly full function, can be restored, but there are also incidents of impaired function and inadequate healing. Just as the terms *healthy* and *pathological* apply to the various courses in the physiological healing process, Engel argues that these same terms may be applied to the courses taken by the mourning process. He sees mourning as a course that takes time until restoration of function can take place. How much functional impairment occurs is a matter of degree (Engel, 1961). Rather than using terms like *restoration* and *recovery*, I prefer to use the term *adaptation*: some people make a better adaptation to the loss while others make a less good adaptation. In Chapter 5, we look at complicated mourning, where individuals are making a less than adequate adaptation to the loss.

Before we look at the characteristics of normal grief, it would be useful to look at three terms that are often used interchangeably: *grief, mourning, and bereavement*. For purposes of common understanding, in this book I am using the term *grief* to indicate the *experience* of one who has lost a loved one to death. It is comprised of thoughts, feelings, behaviors, and physiological changes that vary in pattern and intensity over time. The term *grief* can be applied to other losses, but in this book, it primarily addresses losses due to *death*. *Mourning* is the term applied to the *process* that one goes through in *adapting* to the death of the person. The finality and consequences of the loss are understood and assimilated into the life of the mourner. *Bereavement* defines the loss to which the person is trying to adapt and the experience of having lost someone close.

## NORMAL GRIEF

Normal grief, also referred to as uncomplicated grief, encompasses a broad range of feelings, cognitions, physical sensations, and behavioral

changes that are common after a loss.[1] One of the earliest attempts to look at normal grief reactions in any systematic way was done by Erich Lindemann (1944) when he was chief of psychiatry at the Massachusetts General Hospital.

In the Boston area, there are two Catholic colleges well known for their football rivalry. Back in the fall of 1942, they met for one of their traditional Saturday encounters. Holy Cross beat Boston College, and after the game many people went to Cocoanut Grove, a local nightclub, to celebrate. During the revelries, a busboy lit a match while trying to change a lightbulb and accidentally set a decorative palm tree on fire. Almost immediately, the whole nightclub, which was packed beyond its legal capacity, was engulfed in flames. Nearly 500 people lost their lives in that tragedy.

Afterward, Lindemann and his colleagues worked with the family members who had lost loved ones in that tragedy, and from these data and others he wrote his classic paper "Symptomatology and Management of Acute Grief" (1944). From his observations of 101 recently bereaved patients he discovered similar patterns, which he described as the pathognomonic characteristics of normal or acute grief:

1. Somatic or bodily distress of some type
2. Preoccupation with the image of the deceased
3. Guilt relating to the deceased or circumstances of the death
4. Hostile reactions
5. The inability to function as one had before the loss

In addition to these five, he described a sixth characteristic exhibited by many patients: they appeared to develop traits of the deceased in their own behavior.

There are many limitations to Lindemann's study. Some of these have been outlined by Parkes (2001), who points out that Lindemann does not present figures to show the relative frequency of the syndromes described. Lindemann also neglects to mention how many interviews he had with the patients, and how much time had passed between the interviews and the date of the loss. Nevertheless, this remains an important and much cited study.

[1] I am using the word *normal* in both a clinical and a statistical sense. *Clinical* defines what the clinician calls normal mourning behavior, while *statistical* refers to the frequency with which such behavior is found among a randomized bereaved population. The more frequent the behavior, the more it is defined as normal.

What is of particular interest to me is that the bereaved we see today at the Massachusetts General Hospital exhibit behaviors very similar to those described by Lindemann more than 70 years ago. In a large number of people undergoing an acute grief reaction, we find some or most of the following phenomena. Because the list of normal grief behaviors is so extensive and varied, I have placed them under four general categories: feelings, physical sensations, cognitions, and behaviors. Anyone counseling the bereaved needs to be familiar with the broad range of behaviors that falls under the description of normal grief.

## Feelings

### Sadness

Sadness is the most common feeling found in the bereaved and really needs little comment. This feeling is not necessarily manifested by crying behavior, but often it is. Parkes and Weiss (1983) conjecture that crying is a signal that evokes a sympathetic and protective reaction from others and establishes a social situation in which the normal laws of competitive behavior are suspended. Some mourners have a fear of sadness, especially the fear of its intensity (Taylor & Rachman, 1991). It is not uncommon to hear a person say, "I lost it at the funeral." Still others try to block sadness through excessive activity only to discover that the sadness comes out at night. Not allowing the sadness to be experienced, with or without tears, can frequently lead to complicated mourning (see Chapter 5).

### Anger

Anger is frequently experienced after a loss. It can be one of the most confusing feelings for the survivor and as such is at the root of many problems in the grieving process (Cerney & Buskirk, 1991). A woman whose husband died of cancer said to me, "How can I be angry? He didn't want to die." The truth is that she was angry at him for dying and leaving her. If the anger is not adequately acknowledged, it can lead to complicated mourning.

This anger comes from two sources: from a sense of *frustration* that there was nothing one could do to prevent the death, and from a kind of *regressive experience* that occurs after the loss of someone close. You may have had this type of regressive experience when you were a very young child on a shopping trip with your mother. You were in a department store and suddenly you looked up to find that she had disappeared. You

felt panic and anxiety until your mother returned, whereupon, rather than express a loving reaction, you hauled off and hit her. This behavior, which Bowlby sees as part of our genetic heritage, symbolizes the message "Don't leave me again!"

In the loss of any important person there is a tendency to regress, to feel helpless, to feel unable to exist without the person, and then to experience the anger that goes along with these feelings of *anxiety*. The anger that the bereaved person experiences needs to be identified and appropriately targeted toward the deceased in order to make a healthy adaptation.

One of the riskiest maladaptations of anger is the posture of turning the anger inward against the self. In a severe case of retroflected anger, the person may be down on him- or herself and could develop severe depression or suicidal behavior. A more psychodynamic interpretation of this retroflected anger response was given by Melanie Klein (1940), who suggests that the *triumph* over the dead causes the bereaved person to turn his or her anger against him- or herself or direct it outward toward others nearby.

### Blame

Anger is often handled in other less effective ways, one of which is displacement, or directing it toward some other person and often *blaming* him or her for the death (Drenovsky, 1994). The line of reasoning is that if someone can be blamed, then that person is responsible and, hence, the loss could have been prevented. People may blame the physician, the funeral director, family members, an insensitive friend, and frequently God. "I feel cheated but am confused not knowing who cheated me. God showed me something so precious and takes it away. Is this fair?" queried one widow (Exline, Park, Smyth, & Carey, 2011).

Field and Bonanno (2001) observed two types of blame in their research. One involved blaming the deceased, the second blaming themselves. Those who *blamed the deceased* experienced more anger and other symptoms in the early months after the death and had fewer continuing bonds. Those who *blamed themselves* experienced more grief symptoms of all kinds and had difficulty accepting the reality of the loss. They tended to keep the deceased's possessions and to hold onto guilt that kept them connected to the deceased, rather than holding onto memories as a way of continuing attachments.

### Guilt and Self-Reproach

Self-blame, shame, and guilt are common experiences of the bereaved and can affect grief outcomes (Duncan & Cacciatore, 2015). Guilt and

self-reproach—over not being kind enough, over not taking the person to the hospital sooner, and the like—are frequently seen in survivors. Usually the guilt is manifested over something that happened or something that was neglected around the time of the death, something that may have prevented the loss (Li, Stroebe, Chan, & Chow, 2014). Most often the guilt is irrational and mitigates through *reality testing*. There is, of course, the possibility of real guilt, where the person has indeed done something to cause the death. In these cases, interventions other than reality testing would be called for.

### Anxiety

Anxiety in the survivor can range from a light sense of insecurity to a strong panic attack, and the more intense and persistent the anxiety, the more it suggests an abnormal grief reaction (Onrust & Cuijpers, 2006). Anxiety comes primarily from two sources. The first source is *attachment-related anxiety*. This is the fear the survivor will not be able to take care of him- or herself and frequently comment "I won't be able to survive without him (or her)" (Meier, Carr, Currier, & Neimeyer, 2013). Second, anxiety relates to a heightened sense of *personal death awareness*—the awareness of one's own mortality increased by the death of a loved one (Worden, 1976). Carried to extremes, this anxiety can develop into a full-blown phobia. The well-known author C. S. Lewis (1961) knew this anxiety and said after losing his wife: "No one ever told me that grief felt so like fear. I am not afraid, but the sensation is like being afraid. The same fluttering in the stomach, the same restlessness, the yawning. I keep on swallowing" (p. 38).

### Loneliness

Loneliness is a feeling frequently expressed by survivors, particularly those who have lost a spouse and who were used to a close day-to-day relationship. Even though very lonely, many widows will not go out because they feel safer in their homes. "I feel so all alone now," said one widow who had been married for 52 years. "It's been like the world has ended," she told me 10 months after her husband's death. W. Stroebe, Stroebe, Abakoumkin, and Schut (1996) distinguish between *emotional loneliness* and *social loneliness*. Social support can help with social loneliness but does not militate against emotional loneliness due to a broken attachment. The latter can only be remedied by the integration of another attachment (M. Stroebe, Schut, & Stroebe, 2005). Sometimes the *need to be touched* is a correlate of loneliness. This is especially true in cases of conjugal bereavement and often among the elderly (Van Baarsen, Van Duijn, Smit, Snijders, & Knipscheer, 2001).

### Fatigue

Lindemann's patients reported fatigue, and we see this frequently in survivors. It may sometimes be experienced as apathy or listlessness. This high level of fatigue can be both surprising and distressing to the person who is usually very active. "I can't get out of bed in the morning," said one widow. "I am neglecting the house because I am tired all the time." Fatigue is usually self-limiting. If not, it may be a clinical sign of depression.

### Helplessness

One factor that makes the event of death so stressful is the sense of helplessness it can engender. This close correlate of anxiety is frequently present in the early stage of a loss. Widows in particular often feel extremely helpless. A young widow left with a 7-week-old child said, "My family came and lived with me for the first 5 months. I was afraid I would freak out and not be able to care for my child." Helplessness is associated with Locus of Control (internal versus external). Those with more *external* locus of control feel at the mercy of circumstances and less able to exert a sense of control and self-efficacy (Rubinstein, 2004).

### Shock

Shock occurs most often in the case of a sudden death. Someone picks up the telephone and learns that a loved one or friend is dead. Even when the death is expected and follows a progressive deteriorating illness, when the phone call finally comes, it can still cause the survivor to experience shock and disbelief.

### Yearning

Yearning for the lost person is what the British call *pining*. Parkes (2001; Parkes & Prigerson, 2010) has noted that pining is a common experience of survivors, particularly among the widows he studied. Yearning is a normal response to loss. When it diminishes, it may be a sign that mourning is coming to an end. When it does not come to an end, it may be a clinical sign indicating complicated mourning (W. Stroebe, Abakoumkin, & Stroebe, 2010). See Chapter 5 for a discussion of prolonged grief as one of the complications of mourning, and the place of yearning in its diagnosis (Robinaugh et al., 2016).

### Emancipation

Emancipation can be a positive feeling after a death. I worked with a young woman whose father was a real potentate, a heavy-handed,

unbending dictator over her existence. After his sudden death from a heart attack, she went through the normal grief feelings, but she also expressed a feeling of emancipation because she no longer had to live under his tyranny. At first, she was uncomfortable with this feeling, but later she was able to accept it as the normal response to her changed status.

### Relief

Many people feel relief after the death of a loved one, particularly if the loved one suffered a lengthy or particularly painful illness. "The knowing that his suffering, both physical and mental, is over helps me cope," said one elderly widow. This can also occur when the death involves a person with whom the mourner has had a particularly difficult and often lifelong relationship. Sometimes relief is the reaction following a completed suicide after a long series of suicide attempts. However, a sense of guilt often accompanies this sense of relief.

### Numbness

It's also important to mention that some people report a lack of feelings. After a loss, they feel numb. Again, this numbness is often experienced early in the grieving process, usually right after the person learns of the death. It probably occurs because there are so many feelings to deal with, that to allow them all into consciousness would be overwhelming, so the person experiences numbness as a protection from this flood of feelings. Commenting on numbness, Parkes and Weiss (1983) have said, "We found no evidence that it is an unhealthy reaction. Blocking of sensation as a defense against what would otherwise be overwhelming pain would seem to be extremely 'normal'" (p. 55).

As you review this list, remember that each of these items listed represents normal grief feelings and there is nothing pathological about any one of them. However, feelings that exist for abnormally long periods of time and at excessive intensity may portend a complicated grief reaction. This is discussed in Chapter 5.

## Physical Sensations

One of the interesting things about Lindemann's paper is that he describes not only the emotions that people experienced, but also the physical sensations associated with their acute grief reactions. These sensations are often overlooked, but they play a significant role in the

grieving process. The following is a list of the most commonly reported sensations experienced by the people we see for grief counseling:

1. Hollowness in the stomach
2. Tightness in the chest
3. Tightness in the throat
4. Oversensitivity to noise
5. A sense of depersonalization: "I walk down the street and nothing seems real, including me."
6. Breathlessness, feeling short of breath
7. Weakness in the muscles
8. Lack of energy
9. Dry mouth

Many times, these physical sensations are of concern to the survivor, and he or she may come to the physician for a checkup. If so, physicians need to inquire about deaths and losses as part of their diagnostic evaluation.

### Cognitions

There are many different thought patterns that mark the experience of grief. Certain thoughts are common in the early stages of grieving and usually disappear after a short time. But sometimes thoughts persist and trigger feelings that can lead to depression or anxiety.

#### Disbelief

"It didn't happen. There must be some mistake. I can't believe it happened. I don't want to believe it happened." These are often the first thoughts to occur after hearing of a death, especially if the death was sudden. One young widow said to me, "I keep waiting for someone to wake me and tell me I'm dreaming." Another said, "The passing of my husband came as a shock although he had been sick for some time. You are never quite ready for it."

#### Confusion

Many newly bereaved people say their thinking is very confused, they can't seem to order their thoughts, they have difficulty concentrating, or they forget things. I once went out for a social evening in Boston and took a cab home. I told the driver where I wanted to go and sat back while he proceeded down the road. A little later he asked me again

where I wanted to go. I thought maybe he was a new driver and did not know the city, but he commented to me that he had a lot on his mind. A little later he asked again and then apologized and said that he was feeling very confused. This happened several more times, and finally I decided it would not hurt to ask him what was on his mind. He told me that his son had been killed the week before in a traffic accident.

### Preoccupation

Preoccupations can be obsessive thoughts about the deceased. These often include obsessive thoughts about how to recover the lost person. Sometimes preoccupation takes the form of intrusive thoughts or images of the deceased suffering or dying. In our Harvard Child Bereavement Study, surviving parents with the highest levels of intrusive thoughts were those who unexpectedly lost a spouse with whom they had a highly conflicted relationship (Worden, 1996). Rumination is another form of preoccupation. People engaging in ruminative coping think persistently and repetitively about how bad they feel and about the circumstances that precipitated their feelings (Eisma et al., 2015; Nolen-Hoeksema, 2001).

### Sense of Presence

This is the cognitive counterpart to the experience of yearning. The grieving person may think that the deceased is somehow still in the current area of time and space. This can be especially true during the time shortly after the death. In our study of bereaved children, 81% of the children felt watched by their dead parent 4 months after the death, and this experience continued for many of the children (66%) 2 years after the death. Some found this sense of presence comforting, while others did not and were scared by it (Worden, 1996).

### Hallucinations

Hallucinations of both the visual type and the auditory type are included in this list of normal behaviors because hallucinations can be a frequent experience of the bereaved. They are usually transient illusory experiences, often occurring within a few weeks following the loss, and generally do not portend a more difficult or complicated mourning experience. Although disconcerting to some, many others find these experiences comforting. With all the interest in mysticism and spirituality, it is interesting to speculate whether these are really hallucinations or possibly some other kind of metaphysical phenomenon (Kersting, 2004).

There is an obvious interface between *thinking and feeling*, and the current interest in cognitive psychology and cognitive therapy emphasizes this. Aaron Beck and his colleagues (1979) at the University of Pennsylvania found that the experience of depression frequently is triggered by depressive thought patterns. In the bereaved, certain thoughts will pass through the mind such as "I can't live without her" or "I'll never find love again." These thoughts can then trigger very intense, but normal, feelings of sadness and/or anxiety.

## Behaviors

There are a number of specific behaviors frequently associated with normal grief reactions. These can range from sleep and appetite disturbances to absentmindedness and social withdrawal. The following behaviors are commonly reported after a loss and usually correct themselves over time.

### Sleep Disturbances

It is not unusual for people who are in the early stages of loss to experience sleep disturbances. These may include difficulty going to sleep or early morning awakening. Sleep disturbances sometimes require medical intervention, but in normal grief they usually correct themselves. In the Harvard Child Bereavement Study, one-fifth of the children showed some sleep disturbance in the first 4 months after the death of one of their parents. Without any special intervention, this figure dropped to a level not significantly different from that of their nonbereaved matched counterparts 1 and 2 years following the death (Worden, 1996).

After Bill lost his wife suddenly, he would wake up at five o'clock each morning filled with intense sadness and review over and over the circumstances surrounding the death and how it might have been prevented, including what he might have done differently. This happened morning after morning and soon caused problems because he could not function well at work. After about 6 weeks, the disorder began to correct itself, and eventually it disappeared. This is not an unusual experience. However, if sleep disorder persists, it may indicate a more serious depressive disorder, which should be explored (Tanimukai et al., 2015). Sleep disorders can sometimes symbolize various fears, including the fear of dreaming, the fear of being in bed alone, and the fear of not awakening. After her husband died, one woman solved the problem posed by her fear of being alone in bed by taking her dog to bed with

her. The sound of the dog's breathing comforted her, and she continued to do this for almost a year until she was able to sleep alone.

### Eating Disturbances

Bereaved animals exhibit eating disturbances, which are also very common in human mourning situations. Although appetite disturbances can manifest themselves in terms of both overeating and undereating, *undereating* is the more frequently described grief behavior. Significant changes in weight may result from changes in eating patterns.

### Distracted and Absentminded Behavior

The newly bereaved may find themselves acting in an absentminded way or doing things that may ultimately cause them inconvenience or harm. One client was concerned because on three separate occasions she had driven across the city in her car and, after completing her business, had forgotten that she had driven and returned home via public transportation. This behavior occurred following the death of a close friend and eventually corrected itself.

### Social Withdrawal

It is not unusual for people who have sustained a loss to want to withdraw from other people. Again, this is usually a short-lived phenomenon and corrects itself. I saw one young woman shortly after the death of her mother. This single woman was a very sociable person who loved to go to parties. For several months following her mother's death, she declined all invitations because they seemed dissonant to the way she felt in the early experiences of her grief. This may seem obvious and appropriate to the reader, but this woman saw her withdrawal as abnormal. Some people withdraw from friends perceived as oversolicitous. "My friends tried so hard that I wanted to avoid them. How many times can you hear, 'I'm sorry?'" Social withdrawal can also include a loss of interest in the outside world, such as not reading newspapers or watching television. Bereaved children who have lost a parent to death can also experience social withdrawal in the early months after the death (Silverman & Worden, 1993).

### Dreams of the Deceased

It's very common to dream of the dead person, both normal kinds of dreams and distressing dreams or nightmares. Often these dreams serve a number of purposes and may give some diagnostic clues as to where the person is in the whole course of mourning (Cookson, 1990).

For example, for several years after the death of her mother, Esther suffered from intense guilt over circumstances related to the death. This guilt was manifested in low self-esteem and personal recrimination and was associated with considerable anxiety. During one of her daily visits to her mother in the hospital, Esther had left the bedside for coffee and a bite of food. While she was out, her mother died.

Esther was filled with remorse, and although we used the usual reality-testing techniques in therapy, the guilt still persisted. While in therapy, she had a dream about her mother. In this dream, she saw herself trying to assist her mother to walk down a slippery pathway so she would not fall. But her mother fell, and nothing Esther could do in the dream would save her. It was impossible. This dream was a significant turning point in her therapy because she allowed herself to see that nothing she could have done would have kept her mother from dying. This important insight gave her permission to shed the guilt that she had been carrying for several years. Some ways to utilize dreams in grief counseling and grief therapy are presented in Chapter 6.

### Avoiding Reminders of the Deceased

Some people will avoid places or things that trigger painful feelings of grief. They might avoid the place where the deceased died, the cemetery, or objects that remind them of their lost loved one. One middle-aged woman came for grief counseling when her husband died after a series of coronary attacks, leaving her with two children. For a period of time she put all pictures of her husband away in the closet, along with other things that reminded her of him. This obviously was only a short-term solution, and as she moved toward a better adaptation of her grief, she was able to bring out the items that she wanted to live with and display his picture on the piano.

Quickly getting rid of all the things associated with the deceased—giving them away or disposing of them in any way possible even to the point of having a quick disposal of the body—can lead to a complicated grief reaction. This is usually not healthy behavior and is often indicative of a highly ambivalent relationship with the deceased. Ambivalent relationships are one of the *mediators* of mourning described in Chapter 3.

### Searching and Calling Out

Both Bowlby and Parkes have written much in their work about searching behavior. Calling out is related to this searching behavior. Frequently somebody may call out the name of the loved person: "John, John, John. Please come back to me!" When this is not done verbally, it can be going on subvocally.

### Sighing

Sighing is a behavior frequently noted among the bereaved. It is a close correlate of the physical sensation of breathlessness. Colleagues at the Massachusetts General Hospital tested respiration in a small group of bereaved parents and found that their oxygen and carbon dioxide levels were similar to those found in depressed patients (Jellinek, Goldenheim, & Jenike, 1985).

### Restless Hyperactivity

A number of widows in our Harvard studies of bereavement entered into restless hyperactivity following the deaths of their husbands. The woman mentioned previously whose husband left her with two teenage children could not stand to stay at home. She would get into her car and drive all over town trying to find some sense of relief from her restlessness. Another widow could stay in the house during the day because she was busy, but at night she fled.

### Crying

There has been interesting speculation that tears may have potential healing value. Stress causes chemical imbalances in the body, and some researchers believe that tears remove toxic substances and help reestablish homeostasis. They hypothesize that the chemical content of tears caused by emotional stress is different from that of tears secreted as a function of eye irritation. Tests are being done to see what type of catecholamine (mood-altering chemicals produced by the brain) is present in tears of emotion (Frey, 1980). Tears do relieve emotional stress, but how they do this is still a question. Further research is needed on the deleterious effects, if any, of suppressed crying. Martin (2012), who has worked with individuals and families experiencing grief from traumatic events, has written an interesting paper titled "Grief That Has No Vent in Tears Makes Other Organs Weep." This helps us to understand how highly traumatic experiences, emotionally and cognitively unprocessed, may become bodily expressed.

### Visiting Places or Carrying Objects That Remind the Survivor of the Deceased

This is the opposite of the behavior that people engage in to avoid reminders of the lost person. Often underlying this behavior is the fear of losing memories of the deceased. "For 2 weeks I carried his picture with me constantly for fear I would forget his face," one widow told me.

### Treasuring Objects That Belonged to the Deceased

One young woman went through her mother's closet shortly after her mother died and took many of her clothes home. They wore the same size, and although this might seem like an example of someone being thrifty, the fact was that the daughter did not feel comfortable unless she was wearing something that had belonged to her mother. She wore these clothes for several months. As her mourning progressed, she found it less and less necessary to wear clothing that had belonged to her mother. Finally, she gave most of it away to charity.

The reason for outlining these characteristics of *normal grief* in such detail is to show the wide variety of behaviors and experiences associated with loss. Obviously, not all these behaviors will be experienced by one person. However, it is important for bereavement counselors to understand the wide range of behaviors covered under normal grief, so they do not *pathologize* behavior that should be recognized as normal. Having this understanding will also enable counselors to give *reassurance* to people who experience such behavior as disturbing, especially in the case of their first significant loss. However, if these experiences persist late in the bereavement process, they may be indicative of a more complicated grief (Demi & Miles, 1987).

## GRIEF AND DEPRESSION

Many of the normal grief behaviors may seem like manifestations of depression. To shed some light on this, let's look at the debate about the similarities and differences between grief and depression.

Freud (1917/1957), in his early paper "Mourning and Melancholia," addressed this issue. He tried to point out that depression, or melancholia, as he called it, is a pathological form of grief and is very much like mourning (normal grief) except that it has a certain characteristic feature of its own—namely, angry impulses toward the ambivalently loved person turned inward. It is true that grief looks very much like depression, and it is also true that grieving may develop into a full-blown depression. Klerman (Kierman & Izen, 1977; Klerman & Weissman, 1986), who was a prominent depression researcher, believed that many depressions are precipitated by losses, either immediately following the loss or at some later time when the patient is reminded of the loss. Depression may also serve as a defense against mourning. If anger is directed against the self, it is deflected away from the deceased, and this keeps the survivor from dealing with ambivalent feelings toward the deceased (Dorpat, 1973).

The main distinctions between grief and depression are these: In depression as well as grief, you may find the classic symptoms of sleep disturbance, appetite disturbance, and intense sadness; however, in a grief reaction, there is not the loss of self-esteem commonly found in most clinical depressions. That is, the people who have lost someone do not have less regard for themselves as a result of such a loss, or if they do, it tends to be for only a brief time. And if the survivors of the deceased experience guilt, it is usually guilt associated with some specific aspect of the loss rather than a general overall sense of culpability. Even though grief and depression share similar objective and subjective features, they do seem to be different conditions. Depression overlaps with bereavement but is not the same (Robinson & Fleming, 1989, 1992; Wakefield & Schmitz, 2013; Worden & Silverman, 1993; Zisook & Kendler, 2007). Freud believed that in grief, the world looks poor and empty, while in depression, the person feels poor and empty. These differences in cognitive style have been identified by Beck and associates (1979) and other cognitive therapists who have suggested that the depressed have negative evaluations of themselves, the world, and the future. Although such negative evaluations can exist in the bereaved, they tend to be more transient.

However, there are some bereaved individuals who do develop major depressive episodes (MDE) following a loss (Zisook, & Kendler, 2007; Zisook, Paulus, Shucter & Judd, 1997; Zisook & Shuchter, 1993, 2001). The recent *Diagnostic and Statistical Manual* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) allows for this distinction. Zisook and colleagues (2012), who were influential in the dropping of the previous *2-month bereavement exclusion where depression could not be diagnosed in the bereaved until 2 months after the death,* argue that, "the preponderance of data suggests that bereavement-related depression is not different from MDE that presents in any other context; it is equally genetically influenced, most likely to occur in individuals with past personal and family histories of MDE, has similar personality characteristics and patterns of comorbidity, is as likely to be chronic and/or recurrent, and responds to antidepressant medications." If a major depressive episode develops during bereavement, this should be considered a type of complicated mourning—exaggerated grief (see Chapter 5).

At Yale, Jacobs, Hansen, Berkman, Kasi, and Ostfeld (1989), Jacobs et al. (1990), and Jacobs, Nelson, and Zisook (1987) have been interested in depression within the context of bereavement. According to them, "Although the majority of depressions of bereavement are transient and require no professional attention, there is growing appreciation that some depressions, especially those that persist throughout the first year

of bereavement, are clinically significant" (1987, p. 501). They have used antidepressant medication to treat patients whose depression persisted late into the course of bereavement and did not resolve spontaneously or respond to interpersonal interventions. These were usually people who had a history of depression or some other mental health disorder. They found improvement in sleep disorders and appetite disturbance as well as an improvement in mood and cognition. This response suggests a biological dimension to the depression.

A section in the *DSM-5* (APA, 2013) advises that:

> Responses to a significant loss [such as bereavement] may include the feeling of intense sadness, rumination about the loss, insomnia, poor appetite and weight loss which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgement based on the individual's history and the cultural norms for the expression of distress in the context of loss. (p. 95)

One of the functions of the counselor who has contact with people during the time of acute grief is to assess which patients might be undergoing a major depression by using current standard diagnostic criteria from the *DSM-5* (APA, 2013). Patients so identified can then be given additional help such as a medical evaluation and possibly the use of antidepressant medications. Once depression begins to lift through medication, then the focus of treatment changes to the underlying conflicts of the attachment. These conflicts cannot be addressed through medications alone (Miller et al., 1994).

If grief is defined as one's experiences after a loss, then mourning is the process one goes through leading to an adaptation to the loss. In the next two chapters, we look at the mourning process in detail.

## FOR REFLECTION AND DISCUSSION

- In this chapter the terms *grief*, *bereavement*, and *mourning* are defined. How does this distinction make this topic more understandable for you? In what ways would you modify these definitions?
- Looking at the diversity of (a) feelings, (b) physical sensations, (c) cognitions, and (d) behaviors that are typical of normal,

uncomplicated grief, which of these have you witnessed most frequently in your work with bereaved individuals? Which have you experienced yourself in the aftermath of a significant loss?

- Bereaved individuals sometimes report a sense they are *losing their mind*. How do the cognitions and emotions described in this chapter contribute to this sense of *craziness*?
- Behaviors such as carrying around items that belonged to the deceased might cause some well-meaning family members and friends to think the bereaved person needs professional help. How could you reassure your clients about the normalcy of these behaviors?
- What might be some of the problems when treating normal bereavement reactions as if they were the symptomatic criteria for major depressive disorder? How might these problems be significant in clinical practice and why?

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