

CHAPTER 16

Bereavement

Robert A. Neimeyer

CLINICAL PROBLEM

Although bereavement, in the form of the loss of a loved one to death, is a common life transition rather than a clinical disorder, research has documented that adaptation in its wake varies considerably. On the one hand, a substantial minority of the bereaved display resilience, defined as transitory distress with reestablishment of one's emotional baseline within a few months. Others demonstrate an active course of grieving over the course of several months, but ultimately adapt to the changed circumstances of their lives. A few—especially those whose relationships with the deceased were troubled or who experienced the stressors of prolonged caregiving—even display *improved* functioning following the death. But bereavement can also exacerbate distress for those with a history of psychological difficulties such as major depression, as well as trigger a chronic and disabling course of grieving that can last for years if left untreated. This latter condition, variably termed *complicated grief* or *prolonged grief disorder*, warrants clinical assessment and intervention.

Complicated grief (CG) has as its core feature a marked and unremitting preoccupation with the loss, often reflected in overwhelming yearning for the deceased or rumination about the death to a degree that compromises the survivor's functioning in occupational, familial, or broader social roles. Other common symptoms include shock, disbelief and anger about the death, loneliness and isolation, a feeling that a part of the self has also died, and the sense that the future holds little prospect of purpose or fulfillment. Because CG represents an intensification and prolongation of symptoms that might be commonplace in the immediate aftermath of loss, it cannot be reliably diagnosed until several months have passed with little evidence that the survivor is experiencing less anguish and reengaging important life roles. Importantly, CG has displayed "incremental validity" in predicting a variety of serious psychosocial and medical outcomes even after depression and anxiety are taken into account.

Prevalence

Several studies have placed the frequency of CG in nonclinical populations in the neighborhood of 10% of bereaved adults, although risk of the condition varies depending on the nature of the lost relationship and the manner of death. Parents who have lost children and adults who have lost intimate partners are at greatest risk, with a rate of CG as high as 30% in some samples. Similarly, cause of death has been found to predict incidence of CG in various studies, with levels of complication approaching 50% in the case of death of a loved one to suicide or homicide.

Some evidence also suggests that younger widows and widowers report more complications than those who are older.

CULTURAL DIVERSITY ISSUES

A growing body of research has documented CG across a wide range of cultural contexts, despite the diverse customs and rituals shaping the bereavement experience in different countries and ethnic or religious traditions. Within the United States, some studies suggest that African Americans may be at higher risk of CG than Caucasian Americans, although how much of this may be accounted for by differential exposure to violent death, and especially homicide, remains to be determined. Likewise, women report more CG symptoms than men in most studies that make this comparison.

EVIDENCE-BASED TREATMENTS

Quantitative reviews of many dozens of controlled studies raise questions about the efficacy of psychotherapy in mitigating normative grief symptomatology in adults, such as crying or missing the deceased. This is because most of those who are bereaved ultimately adapt well to the loss with or without professional treatment. When grief is profound, unremitting, and complicated, however, there is evidence that specialized forms of psychotherapy can be quite effective. At this point, evidence-based treatments include attachment, coping, cognitive behavioral, and narrative constructivist models, which differ in their emphases but tend to converge in key therapeutic strategies. These include: (a) fostering confrontation with the story of the death in an attempt to master its most painful aspects and integrate its finality into the mourner's internalized models of the deceased, the self, and the world, (b) encouraging engagement with the image, voice, or memory of the deceased to facilitate a sense of ongoing attachment while allowing for the development of other relationships, (c) gradually challenging avoidance coping and building skill in emotion modulation and creative problem solving, and (d) helping the bereaved to review and revise life goals and roles in a world without the deceased person physically in it.

In the first instance, psychotherapists might invite clients to introduce the deceased, perhaps providing some orientation to their relationship with them as a backdrop for a detailed retelling of the event story of the death itself. This form of revisiting of the loss is akin to prolonged exposure treatments for trauma, in which the psychotherapist fosters "containment" of difficult emotions as clients slowly unfold their reactions to witnessing or learning about death, gradually expressing and exploring the troubling images, events, and feelings that they customarily avoid in accounts of the experience to others. Although such retelling across periods ranging from 15 minutes to one or more full sessions is typically highly evocative, it also helps clients achieve a greater sense of mastery over aspects of the story that had previously haunted them. Close review of the story helps them make sense of the experience and assimilate more fully the emotional reality of the loved one's physical absence from their lives. In addition, psychotherapy often facilitates renegotiation of the terms of attachment to the deceased, not so much "letting go" of the loved one as much as finding a sustainable way of maintaining the bond. Symbolic "empty chair" conversations or correspondence with the loved one can provide means of addressing troubling concerns in the relationship such

as caregiver guilt, and ultimately reaffirm love in a way that survives death. As the psychotherapist helps the client identify and surmount cognitive, behavioral, and relational obstacles to addressing the loss and its implications, clients commonly are able to find ways to honor the loved one's presence in their lives and conversations, while reaffirming or reconstructing a life of meaning that was challenged by the death. The Complicated Grief Therapy of Katherine Shear and her colleagues exemplifies one evidence-based therapy that includes retelling, symbolic conversations with the deceased, and revision of life goals, and has been found to outperform interpersonal psychotherapy in a randomized controlled trial.

FUTURE RESEARCH

Although the key features of CG are well documented, more research is needed to document its relationship to such factors as insecure attachment, cognitive and behavioral avoidance strategies, and a struggle to find spiritual and secular meaning in the loss and in one's life in its aftermath, all of which are receiving increasing scientific attention. Unlike static risk factors focusing on the character of the relationship to the deceased or the circumstances of the loss, those linked to renegotiating the bond to the deceased, developing more adaptive strategies for emotion regulation, and reconstructing the meaning of the loss in the context of one's changed life are potentially modifiable, and thus carry clear implications for psychotherapeutic strategies and techniques. In addition, investigators are only beginning to delineate the impact of the psychotherapeutic relationship in providing a surrogate "secure base" as the client reworks his or her attachment to the deceased and other living figures. Further attention to such factors holds promise for the ongoing refinement of grief therapy, whether conducted in an individual, family, or group format.

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