

COMPLICATED GRIEF AND THE QUEST FOR MEANING: A CONSTRUCTIVIST CONTRIBUTION

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ABSTRACT

One of the more important results of the upwelling of research on bereavement in recent decades has been the development of criteria for complicated grief, a disorder whose coherence, correlates and consequences have been subjected to increasing scrutiny. In this article I argue that clinical, conceptual, and evidence-based considerations converge to support the further refinement of such criteria, with a special emphasis on their connection to the protracted and painful quest for meaning that characterizes a subset of the bereaved. As further research supports and extends these current efforts, there is reason to believe that an understanding of complicated grief can make a significant contribution to research, theory, and practice concerning adaptation in the wake of loss.

MARY'S MOURNING

In her first clinical consultation following the loss of her husband nine months ago, Mary¹ describes John's death as "the gut-ripper of her life," the worst of a cascade of losses that have clustered in the last year. Although John had been troubled by vague and misdiagnosed symptoms for a few months, the actual diagnosis of metastatic bone cancer preceded his death by a mere three weeks. As a consequence, she felt "totally unprepared" for the loss of "the man who had been everything to her—her best friend, her lover, her helpmate, her north,

¹ Although names and identifying information have been disguised, this case study in other respects depicts the struggle of an actual client I am seeing in grief therapy.

her south, her east, and her west.” Most of all, Mary felt that with John’s death she had lost her “anchor” in the world, and perhaps significantly in view of the cause of his death, describes her ongoing grief as “bone-shattering.” She literally counts the days since his death, and has never missed a single day of visitation to his graveside in a cemetery over an hour from her home, even in forbidding winter weather that made the drive a life-threatening proposition.

The special intimacy that Mary and John shared through 15 years of marriage contrasted sharply with the “miserable” first marriages each had endured previously. She describes John as a perfect partner—devoted, good-humored, an excellent provider, and her “buffer” from a harsh world. Now, she feels a keen sense of abandonment by the man who promised he would “always be there” at a time of need—such as during the deaths of both her mother, who succumbed to advanced Alzheimer’s, and her beloved aunt, who was lost to breast cancer within three months of John’s death. As a consequence she feels vulnerable and alone, a feeling that has heightened in the context of an angry legal battle with family members over her husband’s estate. This dispute, as well as the general pressure she feels “to be over it already,” leaves her embittered and distrustful of the intentions of others.

Now, Mary only experiences any respite from her grief when she feels John’s “presence.” Her desperate yearning for contact with him was reflected in her hysterical attempt to climb into John’s open casket at the funeral, and her still frequent calls to his answering machine “just to hear his voice.” Sometimes this wished-for contact comes in dreams, as she responds to the sound of his voice saying, “Honey, come snuggle up to me,” or at night when she clearly feels his hand in hers, or patting her side. The most sustained sense of contact came during one of her daily visits to his grave, when she felt surrounded by signs of his heavenly existence in the sunset, a flock of birds, and the whispering of his voice in the wind. Mary confesses that such moments accentuate the loss when she “awakens” to the reality of his death, and that she feels that she will never see him again, except in heaven. Accordingly, she ruminates frequently about death as a release from pain and about the heavenly reunion it could bring, but aside from the vague consideration of taking massive doses of the sleeping pills and anti-anxiety medication she has been prescribed, has no clear plans to suicide.

Mary goes on to say that she feels “so encased in grief that she doesn’t even know who she is anymore.” She sees no vestiges of the outgoing person she used to be, and feels enraged that “God would leave her here without any purpose for being left behind.” Nothing about her present life makes sense to her—as she sums it up, “the quality of my life is gone, and nothing is left but garbage.” In her own words, she “can’t accept that John is gone,” and is left “in shock after losing the foundation he provided.” In many ways she feels much like she did nine days after his death, rather than how she had hoped to feel a full nine months later.

Despite these many problems, Mary does have some resources. She has somehow managed to keep her sales job in the insurance industry, despite a visible deterioration in her performance, and “keeps up appearances” despite her 20 pound weight loss, frequent sleeplessness, and pervasive sadness and anger. Her adult son and daughter from her previous marriage are as attentive as possible, given their great geographic distance, although because of her absorption in her marriage, she “gave up all her other friends.” She did show a spark of pride, however, in producing a handsome laminated memorial card for John that she designed, which she spoke hopefully of using as the starting point for a book about him and about their relationship. As she noted in closing, she didn’t want the memory of John to be “erased,” and she somehow hoped that such a project would help her “get back some of the person she used to be.”

THREE WARRANTS FOR COMPLICATED GRIEF

Existing evidence suggests that most of the bereaved are resilient, ultimately coping well with major loss (Bonanno, 2004; Center for the Advancement of Health, 2004). However, between 10 and 20% of survivors, like Mary, experience unremitting and intense grieving that substantially impairs the quality of their lives (Bonanno, Wortman, & Nesse, 2004) and predicts long-term risks to physical and mental health (Ott, 2003; Parkes, 1996; Prigerson & Jacobs, 2001). My goal in this article is to reflect on three basic warrants for applying a diagnosis of complicated grief in these cases, grounded in clinical, theoretical, and empirical considerations, respectively. Because Prigerson and Maciejewski (2005) provide a systematic overview of the evidence base regarding the etiology, course, and correlates of this disorder and the distinctiveness and coherence of its core symptomatology, I will concentrate here on underscoring its clinical features as I have encountered them in my practice, and then consider a conceptualization of complicated grief as an assault on the bereaved individual’s attachment bonds and world of meaning. Finally, I will conclude with some brief description of the accumulating evidence supporting such a conceptualization, with reference to the ongoing work of my own research group. Thus, my intent is to argue that, with appropriate caution regarding the iatrogenic or deleterious effects of this (or any) psychiatric diagnosis, there is ample warrant for refining such criteria on clinical, conceptual, and evidentiary grounds.

The Clinical Warrant

How do the proposed criteria presented by Prigerson and Maciejewski (2005) square with the clinical presentation of bereaved clients like Mary, who constitute a substantial subset of those who seek consultation with professionals following their loss? My answer, in a phrase, is “remarkably well.” Clearly, Mary meets Criterion A, with its emphasis on symptoms of attachment distress

in the form of yearning and longing for the deceased (Bowlby, 1980), a nearly constant craving for connection with John that finds expression in both waking behaviors (e.g., daily trips to the cemetery, calling his answering machine) and less conscious reveries (e.g., nighttime dreams, hypnagogic “contact”). Although seeking and finding such comfort in connection with her loved one is not in itself pathognomic (Datson & Marwit, 1997), the compulsiveness of this quest and the difficulty in supplementing more concrete forms of bonding (through particular objects or places) with more abstract ones (such as identification with John’s life purposes or comforting memories) may be (Field, Nichols, Holen, & Horowitz, 1999). Indeed, the riveting intensity of this broken attachment remains the focal clinical issue in Mary’s case, both in her self-assessment and in my perspective as her therapist. As she notes, she has lost the anchor and compass of her life with the disruption of the safe haven John provided, and seems unable to navigate through life without him.

Likewise, Mary easily displays the majority of the symptom markers for Criterion B. In her own words she finds John’s death impossible to accept, so central was his presence in her life. Moreover, she reports a clear erosion of trust in the social world, most notable in relation to family members with whom she is in conflict over the estate, but also generalizing to those who support them, or even those who “disenfranchise” her ongoing grief (Doka, 2002; Neimeyer & Jordan, 2002). In session, her suspiciousness regarding others frequently erupts into bitter anger, an emotion that seems at times to serve a protective function in mitigating her contact with her deep grief. Mary frankly acknowledges her inability to “move on” with her life, whether at the level of opening to other relationships, even with friends, or performing fully in her career. She continues to feel “shocked” by John’s death even nine months later, and feels remote and detached from the majority of other people. Most strikingly, Mary paints a vivid portrait of a life bleached of meaning; cut off from a sustaining and comprehensible past, she seems unable to find significance in the present, or project herself toward a purposeful future. The reduced life she now must lead is for her simply “garbage,” the cruel joke of an uncaring God. Perhaps the only symptom under Criterion B that is not strongly in evidence for Mary is agitation, as her dominant affect alternates between anger and abject despair, with correspondingly less diffuse anxiety or hyperarousal. Finally, although she manages to function at at least a minimal level in her work, the constriction of Mary’s life is strongly evident in her broader social world.

Does the presence of these symptoms of complicated grief preclude other relevant diagnoses in Mary’s case? By no means. For example, although she does not meet full criteria for a major depressive disorder, Mary does display significant symptoms of depressed mood, impaired appetite and sleep, and passive suicidal ideation that requires careful monitoring. Given this profile of hopelessness and vegetative symptomatology, a referral for a trial of antidepressant medication

could be indicated. For other patients of mine, like Sara, who struggled with the horrendous death of her brother in the terrorist attack on the World Trade Center (Neimeyer, 2005b), a basic profile of complicated grief also can be compounded with symptoms of post-traumatic stress disorder. But in both instances, central attention to the unique features of complicated grief is called for if therapy is to be helpful, insofar as treatments tangential to the core issues of attachment and loss are less than fully effective even when they mitigate other significant symptoms, as Prigerson and Maciejewski (2005) note.

In emphasizing formal psychiatric diagnoses in cases like Mary's, I do not mean to imply that I regard these as either necessary or sufficient guidelines for treatment. On the one hand, I have often seen people who have struggled with subtle but significant issues in the wake of loss who would meet few, if any of the criteria for complicated grief (or major depressive disorder, anxiety disorder, PTSD, or any other significant diagnosis). For instance, two other clients, Sandra and Chris, both experienced tensions in their families in the wake of parent loss—Sandra because others had difficulty accommodating her newfound “take charge attitude” cultivated during the period of intensive caregiving to an ailing mother, and Chris because she effectively resigned her role as the “family communication satellite” in order to nurse her own grief over her father's death (Neimeyer, 2005a). Others, like Darla, who had lost her 20-year-old son Kyle to an aggressive bile duct cancer some six months earlier, struggle with posthumous relational complications with the *deceased*, such as her trying to hide her tears because her stoic son “would not have wanted to see her cry” (Neimeyer, 2004a). Thus, the interpersonal and intrapersonal conflicts that can follow significant loss can be painfully real and clearly appropriate for therapy, whether or not they satisfy formal psychiatric criteria (S. Rubin, 1999; Walsh & McGoldrick, 2004). I further believe that a diagnosis of complicated grief, while helpful in providing a general orienting framework for treatment, is in itself insufficient to direct therapeutic interventions, which require a delicate grafting onto the salient issues emerging for a given client at a given moment of therapy (Neimeyer, 2001a). These limitations notwithstanding, the development of empirically substantiated criteria for complication goes some distance toward identifying a subset of bereaved persons who are likely to be responsive to grief therapy, which evidence suggests is best reserved for those at risk for negative outcomes (Jordan & Neimeyer, 2003).

The Theoretical Warrant

As the burgeoning literature on grief attests, the field of bereavement studies is in ferment (Center for the Advancement of Health, 2004; Stroebe, Stroebe, Hansson, & Schut, 2001). Much of this surge of activity originates from the development of new models with which to conceptualize the sequelae of loss, combined with the significant extension of older ones. In this section I will

comment on some of these developments as they bear on the conceptualization of complicated grief, with special emphasis on processes of meaning reconstruction in the wake of loss.

As illustrated in Mary's case, much of the core phenomenology of complicated grief arises directly from the sundering of a security-enhancing attachment bond with the deceased, making attachment theory (Bowlby, 1980; Parkes, 1996; Prigerson & Jacobs, 2001; Stroebe, 2002) a highly relevant conceptual context within which to interpret the separation distress that follows intimate loss. Because attachment styles developed in relation to caregiving figures in childhood form the basis for subsequent models of self (e.g., as worthy and competent or unlovable and vulnerable) and others (e.g., as nurturing and available or unresponsive and abandoning) (Guidano, 1991), experiences of childhood neglect and abuse can predispose to various forms of insecure attachment, which can in turn render subsequent experiences of loss of stabilizing relationships deeply threatening to one's basic sense of coherence, safety, and fulfillment. Accordingly, the grief experienced in the aftermath of such loss can be complicated, marked by just the sort of intense and protracted yearning and "brokenness" captured in Prigerson and Maciejewski's proposed criteria. In contrast, favorable experiences of childhood caregiving can lead to the development of secure attachment, which could serve as a buffer against complication in the face of later loss, resulting in grief reactions which, while marked by sadness and distress, do not radically undermine the bereaved person's sense of personal integrity, trust in others, or purpose in living (Neimeyer, Prigerson, & Davies, 2002). Such a model of factors associated with risk and resilience is compatible with recent evidence on the role of developmental and attachment factors in predicting subsequent grief (Silverman, Johnson, & Prigerson, 2001; Uren & Wastell, 2002).

Recent elaborations of attachment theory extend its relevance for an understanding of grief responses, and suggest linkages to other current models of bereavement. For example, several current writers, clinicians, and qualitative researchers have conceptualized grieving in terms of establishing or reorganizing a continuing bond with the deceased, in place of the predominant emphasis of 20th century theorists on breaking such bonds in order to invest in new relationships (Attig, 2000; Klass, Silverman, & Nickman, 1996; S. Rubin, 1999; Worden, 1991). From an attachment theory perspective, not all deaths trigger an effort to retain or reformulate such bonds, but rather only those in which the attachment behavioral system is activated (Field, Gao, & Paderna, 2005), that is, when the bereaved sought to maintain physical or psychological proximity to the other (e.g., a parent or spouse) as a "safe haven" from a threatening world, and a "secure base" from which to venture into new challenges. From the related vantage point of the caregiving behavioral system, the pursuit of a continuing bond can also be intense when the bereaved was motivated to provide protection for another (e.g., a child), and strives to reestablish such a bond psychologically or spiritually

in the wake of his or her death (Field et al., 2005). Typically, then, complicated grief in Prigerson and Maciejewski's (2005) sense might be expected to occur most frequently in contexts in which acute and persistent separation distress is activated in the wake of loss of the critical relationship, and when the bereaved struggles unsuccessfully to reestablish a continuing bond at more abstract levels. A further implication of this analysis, however, is that some forms of insecure attachment, such as those involving avoidance or dismissal of intimacy based on "defensive exclusion" of vulnerable feelings of rejection, might actually militate against the pursuit of a continuing bond with the deceased (Field et al., 2005), thereby mitigating the core yearning and longing symptomatology suggested in the criteria for complicated grief. For these and other reasons, the interface between attachment histories and styles on the one hand and complicated versus adaptive forms of grieving on the other deserves further exploration (M. Stroebe & Schut, 2005).

A further theoretical framework of relevance to complicated grief focuses on struggles with meaning reconstruction in the aftermath of bereavement (Janoff-Bulman & Berger, 2000; Neimeyer, 2001b). From a constructivist perspective (Neimeyer & Raskin, 2000) profound loss challenges the coherence of the bereaved individual's *self-narrative*, defined as "an overarching cognitive-affective-behavioral structure that organizes the 'micro-narratives' of everyday life into a 'macro-narrative' that consolidates our self-understanding, establishes our characteristic range of emotions and goals, and guides our performance on the stage of the social world" (Neimeyer, 2004b, pp. 53-54). In keeping with both cognitive science (Barsalou, 1988) and neuropsychological (D. C. Rubin & Greenberg, 2003) research on narrative processing, human beings are viewed as "wired" to make sense of life in storied form, to integrate autobiographical events into "story schemas" that impart order and meaning to experience (Neimeyer, 2000). Under ideal circumstances, self-narratives function as key resources in *assimilating* bereavement related losses, "emplotting" them as part of a series of significant life events and interpreting them within the broader personal, cultural or spiritual themes that underpin the individual's sense of self. When this is impossible, however, as when the implications of the loss radically disorganize the coherence of the bereaved person's self-narrative or invalidate its thematic substructure, he or she is forced to reconstruct or *accommodate* this very framework to be adequate to present realities. In the latter case, the survivor often faces a painful and protracted struggle to find new purpose and orientation in a life that no longer makes sense, and perhaps even to find a larger significance in the suffering he or she must endure. Such a conceptualization of grieving in terms of the attempt to integrate the loss experience into a resilient or revised self-narrative accords with recent prospective longitudinal research on bereavement adaptation (Bonanno et al., 2004; Neimeyer, 2005c). It is also consistent with fMRI studies of bereaved women (Gundel, O'Conner, Littrell, Fort, & Lane, 2003) that associate acute grief with activation of precisely those

brain structures that subserve autobiographical memory² and visualization areas that have been implicated in narrative reasoning (D. C. Rubin & Greenberg, 2003).

As Mary's case suggests, an anguishing attempt to reconstruct a world of meaning that has been shattered by loss is a central feature of complicated grief. In fact, many of the Criterion B symptoms outlined as diagnostic of the disorder can be viewed as direct or indirect reflections of the decimation of the bereaved individual's system of meaning consequent on the loss of a central participant in his or her self-narrative (Neimeyer et al., 2002). For example, numbness and trouble accepting the loss can be seen as expressions of the inability to assimilate the death into one's previous constructions of reality, and feeling that life is empty or meaningless without the deceased and that it is impossible to move on toward a purposeful future speak directly to the assault on the survivor's sense of significance and continuity. Finally, persistent anger can be seen as a suboptimal means of adapting to the invalidation of existing meanings, by 'hostilely' attempting to impose one's constructions on events (Kelly, 1955/1991). Although the formal criteria for complicated grief (like all psychiatric diagnoses) tend to individualize distress, it is worth emphasizing that the processes entailed in constructing and validating a (new) self-narrative are inherently social, insofar as we necessarily rely on the intimate validation of our sense of self by particular others, as well as communal and cultural discourses of identity that define our social roles both before and after bereavement (Neimeyer, 2005c; Neimeyer et al., 2002). Thus, a broadly narrative framework can provide a helpful heuristic for identifying sources of invalidation that arise not only within the experience of the bereaved person, but also in family, communal, and perhaps even larger contexts of transcendent meanings (Neimeyer & Jordan, 2002).

The Empirical Warrant

Prigerson and Maciejewski (2005) have capably summarized the research programs of the Yale group and those of other investigators that bear on the coherence, correlates, and consequences of complicated grief. In this section I will review some additional findings from our own evolving research program that bear on the topic, with a special emphasis on the search for meaning in the aftermath of devastating loss.

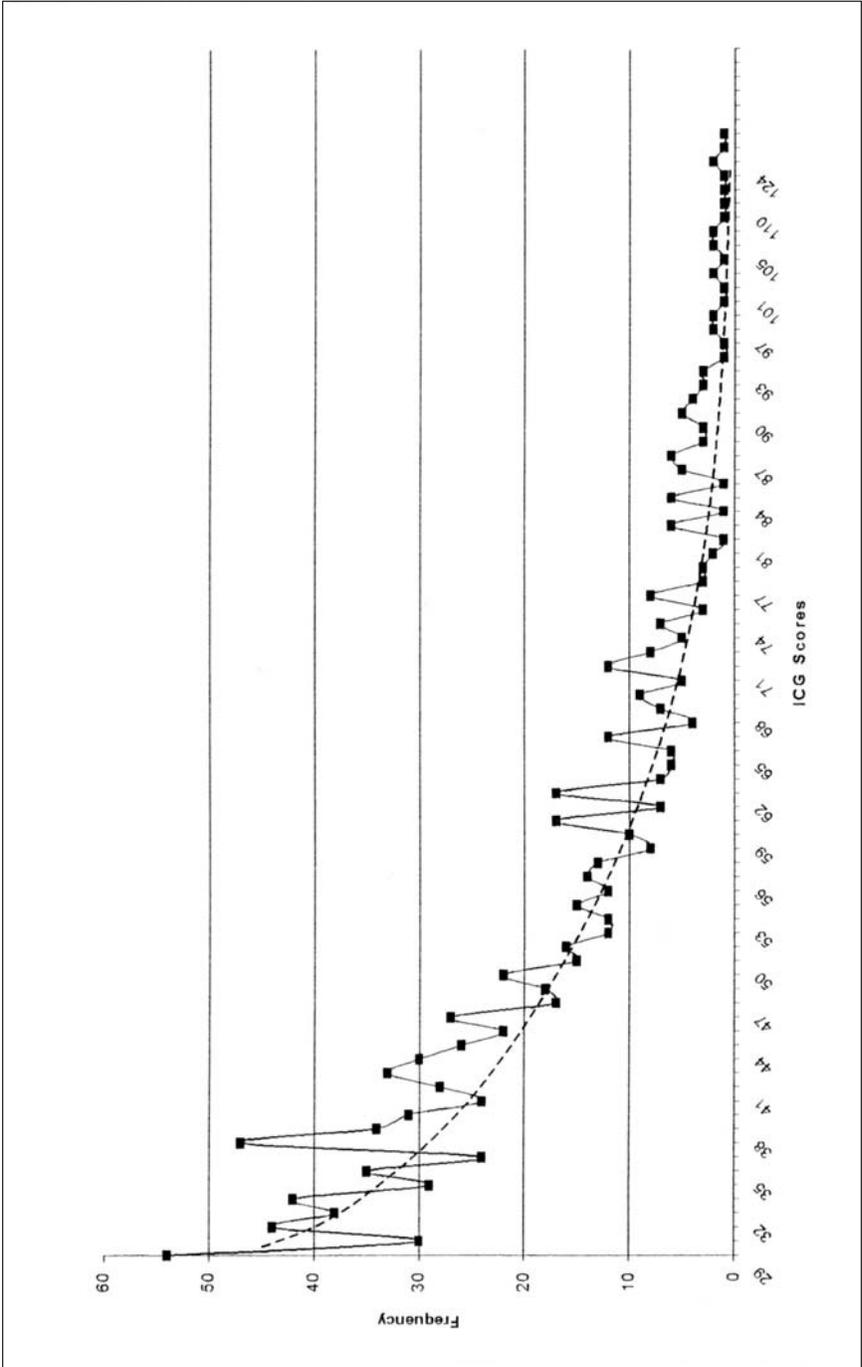
In one study we investigated the relationship between complicated grief symptomatology and sleep-related problems in a group of over 500 bereaved adults and 300 nonbereaved adults in the first two years following their loss of a close friend or relative (Hardison, Neimeyer, & Lichstein, 2005). The sample was diverse in both ethnicity (37% African American) and mode of death, with a substantial subset of deaths resulting from traumatic causes (accident, suicide

² Interestingly, these very areas are deactivated in acute depression, providing further evidence for the distinctiveness of depression and grief (Gundel et al., 2003).

and homicide). Administering both the Inventory of Complicated Grief (Prigerson & Jacobs, 2001) and a detailed assessment of insomnia and associated sleep symptoms, we documented the higher frequency of insomnia (and especially middle insomnia) in the bereaved group, and its significant association with complicated grief symptomatology. As predicted, scores on the ICG were also higher for the traumatically rather than nontraumatically bereaved, just as they were for those who had more intimate relationships with the deceased, and those whose loved ones were younger at the time of death. Moreover, higher reports of complicated grief symptoms displayed a worrisome association with measures of daytime impairment and reliance on drugs and alcohol to induce sleep, suggesting a possible “downward spiral” between bereavement complications and maladaptive means of coping with them. Finally, it was noteworthy that the two strongest predictors of complicated grief symptoms were nighttime ruminations about the deceased and waking from dreams regarding the loved one, hybrid markers of both bereavement distress and insomnia that deserve greater attention on the part of both clinicians and researchers.

A second study recruited a still larger sample of over 1,700 bereaved adults to investigate the relationship between mode of death (natural or violent) on the one hand, and complicated grief and meaning-making processes on the other (Currier, Holland, Coleman, & Neimeyer, 2006). Again, participants completed the ICG, along with the Core Bereavement Items scale designed explicitly to assess symptoms of “normal” as opposed to “pathological” grief (Burnett, Middleton, Raphael, & Martinek, 1997), and a series of ratings of the degree of *sense* they had made of their loss experience, the degree of *benefit* that they had found in it, despite the loss, and the degree and direction of their *identity reconstruction* in the wake of their bereavement (Neimeyer & Anderson, 2002).

Implicit in the conceptualization of complicated grief symptoms is that they, by definition, should be reported less frequently than symptoms of normal grieving; that is, relative to core bereavement phenomena that emphasize sadness, listlessness, crying and thinking of the deceased, symptoms such as purposelessness, a fractured sense of trust and meaning or inability to move forward with life would be expected to be less prominent in a large nonclinical sample of bereaved persons. The size of the sample in the Currier et al. (2006) study permits a test of this prediction in the form of comparing the shapes of the distributions for ICG and CBI scores obtained by participants in our study. As Figure 1 indicates, although both distributions are positively skewed, suggesting a tapering of extreme symptomatology in this sample as assessed by both scales, the distributions for the two sets of items differ appreciably. As expected, the majority of these nonclinical respondents endorse a low frequency of symptoms of complicated grief, with the number reporting greater frequency of such symptoms diminishing steadily across levels of severity. In contrast, the distribution of core bereavement items is more symmetric, more nearly normal in shape, for this



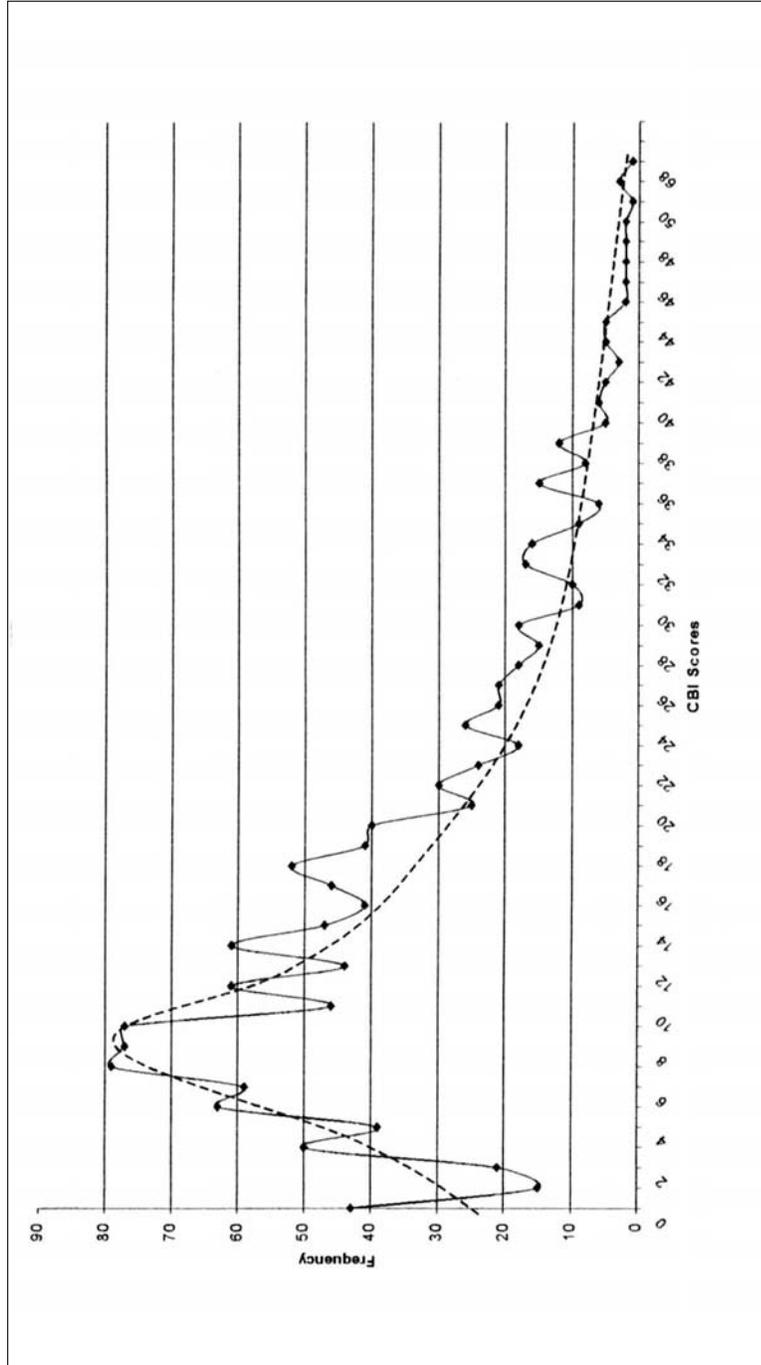


Figure 1. Distributions of scores on the Inventory of Complicated Grief (ICG) and Core Bereavement Items (CBI) for a nonclinical sample of 1,723 bereaved adults.

same group, indicating that moderate levels of these typical grief symptoms are the rule rather than the exception. This difference is compatible with the conceptualization of complicated grief symptoms as reflections of an atypical grief process whose frequency differs notably from more common symptoms of normal grieving.

Our primary interest in this study was assessing the ability of the various grief and meaning-related measures to identify distinctive features of violent and nonviolent (natural death) bereavement, inasmuch as nearly 500 participants in the sample had been bereaved by homicide, suicide or accident. As expected, the Inventory of Complicated Grief proved more robust in differentiating the violent and natural death group than did the Core Bereavement Items, suggesting that it better assesses those features distinctive to traumatic loss (see Figure 2). However, the strongest factor distinguishing the two types of bereavement was sense-making: those persons experiencing the violent death of loved ones (and especially losses through suicide and homicide; see Currier et al. for details) were far more likely to report an unsuccessful struggle to find sense or meaning in the

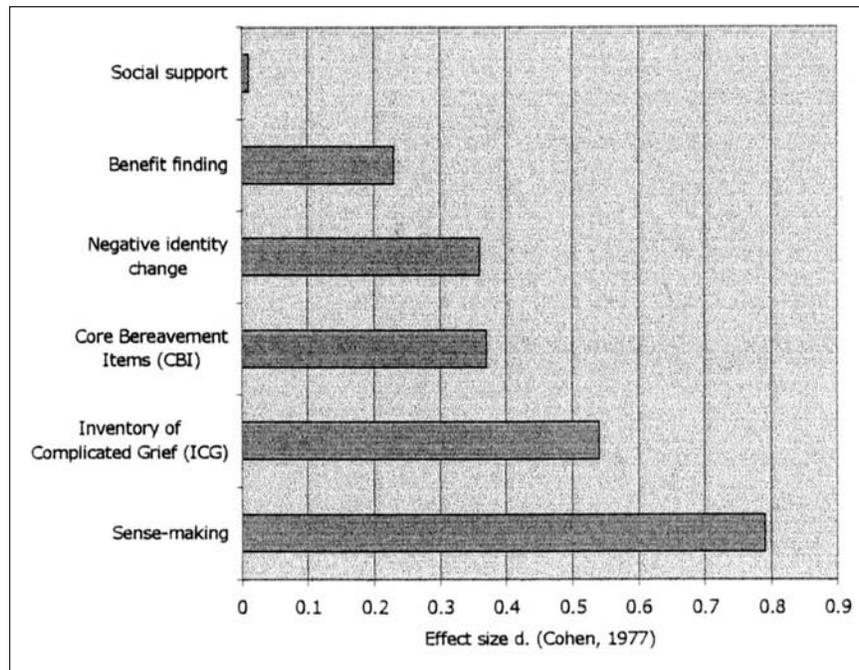


Figure 2. Effect sizes for violent versus nonviolent death on six dependent variables.

experience. Experiencing a shift in their own identity in a negative direction, and an inability to find any benefit or “silver lining” in the dark cloud of their bereavement also characterized those suffering traumatic as opposed to natural bereavement. In contrast perceived social support was unrelated to cause of death, with both groups of bereaved people reporting similar levels of support by others. In summary, the study provided evidence that complicated grief, and particularly a fracturing of sense or meaning, were hallmarks of bereavement for those who lost loved ones by traumatic means.

CONCLUSION

Over the last 20 years, over 4,000 scholarly and scientific papers have been published in the interdisciplinary field of death, dying and bereavement (Neimeyer, 2004c), the majority of which are data-based studies. As a result, we now know more than we once did about how human beings confront and adapt to the reality of their own deaths and those of others. One result of such research has been the development of a richer understanding of bereavement, as new models and methods open the prospect of a more detailed view of how people cope with loss (Center for the Advancement of Health, 2004).

The ongoing refinement of criteria for diagnosing complications in grieving is one outcome of this scientific effort. In this article I have argued that the work of Prigerson and her group helps identify criteria for complicated grief that are readily discernable in clinical practice, that are distinguishable from other difficulties and disorders (such as depression) with which many bereaved also contend, and that can provide at least a preliminary orientation to the sort of symptoms that should be taken as a target of clinical assessment and intervention. I have also suggested that the refinement of such criteria is warranted by recent theoretical elaboration, particularly in terms of conceptual models focusing on suboptimal responses to the loss of a security-enhancing attachment relationship and the decimation of a world of meaning occasioned by profound loss. Interestingly, a point of contact in both sets of models concerns the effort to transform the continuing bond with the deceased in a way that preserves a modicum of consistency in the self-narrative of the bereaved, a narrative interwoven, often surprisingly closely, with the life story of another. And finally, I have attempted to add to the mosaic of empirical findings on complicated grief by drawing attention to its link with other worrisome symptomatology, its distinguishable distribution of symptoms relative to those that characterize normal grief, and its special relevance to more problematic forms of loss. Although much more remains to be learned about the multiple sources of both resilience and complication in the course of bereavement, clinical, theoretical and empirical observations converge to suggest that the diagnosis of complicated grief makes an important contribution to this effort.

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