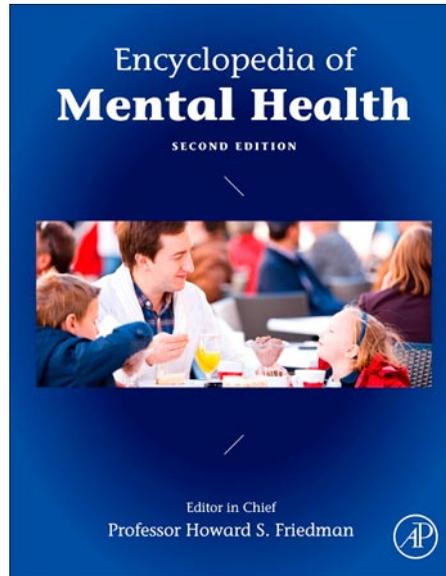


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Bereavement and Grief

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Glossary

Bereavement The condition of having lost a significant other or attachment figure.

Complicated grief Grieving that fails to move forward adaptively as the person integrates the loss, instead remaining intense, preoccupying, prolonged, and life-limiting (also referred to as prolonged grief disorder or traumatic grief).

Decathexis Withdrawal of emotional energy from the one who has died in order to invest it in living relationships.

Disenfranchised grief Grief whose origin is in a socially devalued or stigmatizing loss, or whose expression breaks a culture's implicit rules for legitimate bereavement responses, resulting in social invalidation of the grief or the mourner.

Grief work The hypothesis that mourning entails reviewing, expressing, and exploring one's grief in order to work through the loss and free oneself from "bondage" to the deceased.

Loss orientation The mourner's means of coping with bereavement by confronting the loss, seeking support for

grief, and reorganizing his or her attachment to the deceased.

Meaning reconstruction The mourner's attempt to reaffirm or reconstruct a world of meaning that has been challenged by loss, by making sense of the death and his or her ongoing life in the wake of it, including reconstructing the relationship with the deceased.

Melancholia Freud's term for pathological grief or depression following the death of a loved one, in which the mourner in effect refuses to 'decathect' or let go of the deceased in order to reinvest in living.

Posttraumatic growth The emergence of greater maturity, wisdom, compassion, spiritual grounding, and affirmation of relationships following major adversity.

Resilience A person's ability to recover from adversity, returning comparatively quickly to a baseline level of well-being and effectiveness.

Restoration orientation The mourner's means of coping with bereavement by exploring new roles and goals in his or her changed life after loss.

Introduction

Although bereavement, defined as the loss of a significant person in our lives through death, may be universal, just how we respond to such loss can be remarkably varied. Since grief became a topic of formal psychological theory and research in the early twentieth century, the scientific understanding of people's adaptation to loss has evolved considerably, leading ultimately to a clearer conceptualization of complicated bereavement and a variety of approaches to grief therapy that are attracting a significant evidence base. However, this same literature also documents the surprising resilience of the majority of bereaved people, who manage to adapt to their losses well without professional assistance. This brief article surveys these developments, beginning with the pioneering work of Sigmund Freud.

Mourning and Melancholia: The Psychodynamic View

Writing in the midst of the horrendous daily losses of World War I (WWI) Europe, Freud was the first major theorist to distinguish between mourning (grief) and melancholia (depression), and to describe not only the familiar symptomatology of the former, but also its presumed psychological mechanisms (Freud, 1917/1957). Mourning, for Freud, represented a universal and normal response to the loss of a loved one, as reflected in symptoms of dejection, inhibition of activity, loss of the capacity to love, and withdrawal of interest from the outside world. Resolution of this painful state

normally occurred over time, he theorized, as the mourner gradually recalled, reexperienced and released the psychic energy or libido invested in the lost object (the loved one), resulting in a 'decathexis' or gradual detachment from the deceased. Thus, the process of *Trauerarbeit*, or grief work, served to free the bereaved from emotional bondage to the deceased, so that energy could be invested in new relationships and pursuits.

The second tenet of Freud's theory concerned pathological mourning, which he understood as a refusal to 'let go' of the lost other, and instead incorporate him or her into the mourner's self as a way of 'holding on' to the deceased at the expense of connections to the living. In this form of melancholia, grief became protracted and preoccupying, and the mourner had little emotional energy to invest in other relationships. This suspicion about the pathological implications of identification with the lost love object was carried over by subsequent psychodynamic theorists and researchers (Lindemann, 1944), and is only recently being contested by newer models. Thus, although Freud's grim realism about the need to mourn one's losses and 'move on' can be seen as an understandable response to the catastrophic losses of life in WWI, it continued to shape practices in grief therapy for most of the twentieth century.

From Denial to Acceptance: The Emergence of Stage Theory

The social context of late twentieth century America was characterized by questioning many taken-for-granted social

conventions, from those governing race relations and the role of women, to norms of sexual expression and the deference of the younger generation toward the authority of the older. In this atmosphere of greater openness and skepticism, it was not surprising that the institutional segregation and medicalization of dying that had typified the American way of death for much of the century came under review and revision. One result was the development of modern hospices following the model of St. Christopher's in London, which sought to humanize end-of-life care by attending to the patient and family's emotional and spiritual needs as well as the patient's physical pain. In tandem with this innovation in caregiving, voices within medicine and related fields began to demystify the experience of dying, and offer insights into the psychological processes it commonly entailed.

Certainly the most influential of these voices was Elizabeth Kübler-Ross, a psychiatrist who worked closely with terminal patients grieving the reality of their own pending deaths. Her chief contribution was a popular stage model of adaptation to one's own mortality (Kubler-Ross, 1969), which quickly grew to be the dominant, if not the only, theoretical model of adjustment to dying or bereavement taught to medical and allied professionals throughout North America (Downe-Wambolt and Tamlyn, 1997), and ultimately, throughout the world. Faced with news that curative treatment of their medical condition was futile, Kübler-Ross argued that patients typically responded with denial of this harsh reality, angrily protesting against the diagnosis, the medical personnel delivering it, and perhaps even God or the universe for the seemingly impossible news, before subjectively 'bargaining' for a reversal of their fate through the promise of medical adherence or good behavior. However, as the intractable reality of their deterioration became apparent, she believed that patients tended to succumb to depression, in which they did the 'inner work' of 'letting go.' Ultimately, with appropriate support, Kübler-Ross held that people could come to accept the reality of their dying, drawing on spiritual and secular understandings to view death as an affirmation of the completeness of their lives, or even as a final stage of growth. Perhaps because this simple stage-like model that optimistically sketched the trajectory of denial, anger, bargaining, depression, and acceptance seemed to confer a kind of psychological order on a turbulent transition, it was quickly adopted as a model of the stages of grief following the death of a loved one as well, although it was never grounded in observations of the bereaved, *per se*.

Although Kübler-Ross's intent was to humanize the dying and grieving process rather than to diagnose or pathologize it, the phasic emotional progression of her model also provided a seemingly convenient means of describing where people could experience impasses in mourning, getting 'stuck' in denial, anger, or depression rather than accepting the reality of the death and coming to terms with it. At its best, such a conception could prompt professional caregivers to respect the ambivalence with which people took in 'bad news,' fostering more compassionate conversations that conserved hope while also offering a realistic appraisal of the illness or loss the individual was facing. At its worst, however, the 'one size fits all' depiction of adaptation suggested by the five stages contributed to a tendency on the part of professionals to push the

person to 'move on' to the next phase in adaptation and ultimately accept the hard reality.

Despite the apparently universal appeal of stage theory, scientific research has yielded little evidence supporting its depiction of the grieving process (Holland and Neimeyer, 2010; Maciejewski *et al.*, 2007). For example, at least in cases of natural death, acceptance rather than denial seems to characterize the average response of people from the earliest weeks of bereavement, and anger tends to occur at consistently low levels throughout the grieving process. More fundamentally, the focus of the theory on a small set of largely internal processes combined with an emphasis on 'letting go' as the goal of grieving seems to carry over the assumptions of a psychoanalytic model, to the neglect of other dimensions of adaptation to loss (e.g., cognitive, relational, and cultural), and without considering other possible outcomes of mourning, such as the retention rather than relinquishment of the bond with the loved one. These factors, along with a growing evidence base about the psychosocial and medical impact of bereavement, ultimately gave rise to contemporary theories of grief that carry different implications for adaptation to loss and how this might be supported.

Both Sides Now: The Dual Process Model

By the late twentieth century, a stronger evidence base had begun to accumulate about how people actually do cope with loss, giving rise to a variety of new models of grief that more fully embrace its complexity and individuality. One such theory, formulated by Margaret Stroebe and Henk Schut in the Netherlands, is the Dual Process Model (DPM), which captures the vacillation or ambivalence the bereaved commonly experience between engaging the loss and reengaging life (Stroebe and Schut, 2010). In the loss orientation, Stroebe and Schut theorized that mourners grapple with pangs of separation distress when confronted with reminders of the loved one's death, attempts to rework their attachment to the deceased in light of his or her physical absence, and avoidance of the world's many demands as they are drawn into a world of memory and emotion linked to the loved one. At other points, these theorists propose that the bereaved engage the restoration orientation, as they distract themselves from the pain of the loss by busying themselves with work or other necessary tasks, seek relief in pleasurable activities and people, and begin to redefine those life roles and goals that are no longer viable in the wake of the loss. Significantly, avoidance also plays a role in restoration, as the mourner essentially 'doses' exposure to grief by turning attention to the demands of living. Central to the DPM is the oscillation between these two orientations, which may occur for minutes, hours, or days at a time. Gradually, according to this conceptualization, people typically spend more time in restoration functioning, but engagement with the loss orientation is common for many months into bereavement.

Like other contemporary models of grief, the DPM is also informed by attachment theory, which holds that people develop characteristic styles of relating to significant others based upon their early experiences with caregivers (Bowlby, 1980). From this perspective, people may develop a sense of secure

attachment when they come to feel that others are available and supportive, and that they themselves are lovable and resourceful. However, especially when childhood caregivers are experienced as neglectful, undependable, or potentially abusive, people may develop patterns of insecure attachment marked by anxiety or avoidance in close relationships. Recent evidence suggests that insecure attachment styles of this kind are associated with more complicated, intense grief following bereavement (Meier *et al.*, 2013), as anxiously attached mourners become preoccupied with yearning for the deceased, and avoidant attachment provides a fragile defense against grief, at least when the cause of death is traumatic, as in the wake of suicide, homicide, and fatal accident. Thus, from the standpoint of the DPM, anxious, dependent attachment can contribute to mourners becoming immersed in the loss orientation, whereas avoidant attachment contributes to a tendency to flee into restoration, without sufficiently experiencing and processing the grief. As the DPM continues to inform bereavement research and grief therapy (Shear *et al.*, 2005), it seems likely to attract more evaluation of its distinctive tenets, such as the emphasis on oscillation that can be evaluated through the use of recently proposed measures (Caserta and Lund, 2007).

Two Paths Diverge: The Two-Track Model

A second contemporary model to examine opponent processes in bereavement is the two-track model (TTM) proposed by Simon Shimson Rubin in Israel (Rubin, 1999). However, rather than positing a vacillation between two different modes of coping, as in the DPM, Rubin argues that the bereaved commonly move down two tracks simultaneously, much like a train moves forward on two rails. On the 'biopsychosocial track,' mourners contend with somatic distress and disruptive emotions resulting from the loss, struggle with concentration in their work lives, experience a diminished sense of self, and changed and challenged connections to others in their social world. At the same time, they also engage the 'relational track,' in which they characteristically retain and reconstruct their relationship to the deceased, through revisiting memories, sharing stories, preserving a sense of closeness, and engaging in shared or private rituals of remembrance. Thus, while fully acknowledging the physical, emotional, and social dimensions of coping with loss, the TTM draws particular attention to how mourners continue to engage their 'continuing bond' with their loved one (Klass *et al.*, 1996) as a normal component of the grieving process.

The TTM also provides a convenient conceptualization of problems in bereavement, focusing attention not only on the distinctive biopsychosocial difficulties that might be faced by a particular mourner (e.g., sleep disruption, severe loneliness or self-blame, and poor work performance), but also on issues that arise in the context of his or her ongoing relationship to the deceased (Rubin *et al.*, 2011). For example, a bereaved parent might struggle with a sense of profound guilt in relation to the death of an infant to unknown causes, feel that moving forward with life would be a betrayal of the child, or find it too painful to draw close to the child's memory, and so throw him- or herself into constant work. Significantly, problems on

this track could easily generate or reinforce problems of a biopsychosocial kind, as nightmares involving the deceased contribute to early waking and insomnia, or preoccupation with maintaining ties to the dead prevent full participation in other tasks and relationships. Evaluating the client's functioning on both tracks and how each influences progress on the other, therefore, provides a helpful frame for grief counseling and therapy. The development of a measure of both tracks as well as a third having to do with trauma-specific symptomatology should help promote more research on the TTM going forward (Rubin *et al.*, 2009).

Making Sense of Loss: Grief and the Reconstruction of Meaning

A final contemporary perspective on bereavement holds that "a central process of grieving is the attempt to reaffirm or reconstruct a world of meaning that has been challenged by loss" (Neimeyer, 2002). In this meaning reconstruction view advanced by Robert Neimeyer and his associates, the death of a loved one can be viewed as challenging the life stories of survivors, undermining the web of relationships and meanings that gives life its significance. From this perspective, mourners face two narrative challenges: (1) to process the event story of the death in an effort to 'make sense' of what has happened and its implications for the survivor's ongoing life, and (2) to access the 'back story' of the relationship with the loved one as a means of reconstructing a continuing bond (Neimeyer and Thompson, 2014). In a sense, then, the bereaved are prompted to 'rewrite' important parts of their life story to accommodate the death, and project themselves into a changed, but nonetheless meaningful future, one that retains continuity with the past shared with the loved one. When mourners are successful in fitting the loss into a framework that gives it secular, spiritual, or practical significance, they find ways of adapting to the unwelcome transition; but when the loss decimates their assumptive world by violating their sense of justice, order, control, and continuity, their grief can be complicated and prolonged. In this sense, complicated grief (CG) is seen as a crisis of meaning.

In keeping with this meaning reconstruction view, a good deal of research has demonstrated a link between an inability to find meaning in the loss and intense, prolonged and complicated grief in groups as varied as bereaved young people, parents, older adults, and survivors of homicide, suicide, and other violent deaths (Neimeyer, 2014). In contrast, higher levels of sense making about the loss have been found to prospectively predict higher levels of well-being among widowed persons (e.g., interest, excitement, and accomplishment) 1–4 years later (Coleman and Neimeyer, 2010), and success over time in integrating the loss into one's meaning system is associated with a significant reduction in CG symptomatology (Holland *et al.*, 2010).

Future research on meaning and mourning can draw on any of several measurement methods. For example, the 'Integration of Stressful Life Experiences Scale or ISLES' (Holland *et al.*, 2010) assesses the extent to which the bereaved respondent finds 'comprehensibility' in the loss, and retains or regains a secure 'footing in the world' in light of it. A short-form of this

same instrument also has been shown to share its psychometric strengths, including its validity in predicting health and mental health outcomes even after background factors, relationship to the deceased, cause of death, and CG symptoms are taken into account (Holland *et al.*, 2014). Alternatively, the 'Inventory of Complicated Spiritual Grief' (Burke *et al.*, 2014) represents a specialized scale to evaluate struggles in religious meaning making following a loss, with subscales bearing on 'Insecurity with God' and 'Disruption in Religious Practice.' Finally, investigators have constructed detailed and reliable coding systems for categorizing the meanings made by mourners (e.g., valuing life, impermanence, and personal growth) to study their relation to bereavement adaptation (Gillies *et al.*, 2014; Lichtenthal *et al.*, 2010). A meaning reconstruction view has also extended the range of creative strategies incorporated within grief therapy, a topic considered in more detail below.

The Reality of Resilience

Most bereavement research has focused on problematic adaptation to loss and grief. However, this type of difficult grief occurs in a minority of bereaved individuals, thus skewing expectations of difficulties inadvertently regarding individuals who are coping adequately with their loss. In addition, research measures that track the grief experience of participants are typically designed to identify problematic areas rather than good coping, growth, and resilience. Few, if any, grief measures will ask about laughter and moments of joy, but almost all of them will ask about sadness, crying, and loneliness (Bonanno *et al.*, 2011).

Researcher George Bonanno's work proposes that humans have a remarkable capacity for resilience that helps to guide them through the sadness of loss and grief. He argues that most people possess significant positive coping and inner resources and that the majority of individuals who experience a significant loss will eventually continue with their lives in ways that will be fulfilling and meaningful (Bonanno, 2009). Bonanno's main premise is that the focus in bereavement research has been upon those few who suffer with a dysfunctional form of grief, which is misleading and does not acknowledge that the majority of bereaved individuals do not require professional intervention. He also cautioned that this way of thinking and contextualizing grief gives no consideration of the range of possible responses that might fall in between those that are labeled as either 'normal' or 'abnormal' grief. Allowing a shift in a view from one that has been focused on identifying dysfunction to one that is focused on resilience and coping offers the opportunity to look at grief in a way that is less pathologically oriented.

Other researchers have examined the possibility that profound experiences of loss and suffering can serve as a catalyst for growth and positive change, with an enhanced appreciation for and improved quality of one's relationships, future outlook, view of one's self, appreciation of life, and depth of religious beliefs and commitment (Currier *et al.*, 2012). Indeed, the concept of posttraumatic growth has been applied to bereaved individuals who have endured the pain of grief and found increased strength and appreciation for life

on the other side of their suffering (Calhoun and Tedeschi, 2006).

Grief Counseling and Therapy

One of the most important aspects of grief that differentiates it from other forms of clinical distress is that the grieving process itself is generally viewed as an adaptive response and not a form of pathology (Winokuer and Harris, 2012). Grief is the normal, natural response to loss. It is important to bear in mind that although the grieving process may involve a tremendous amount of upheaval and angst, the primary focus of grief counseling is to facilitate the unfolding of the healthy and adaptive aspects of the process, trusting that this support will eventually help the bereaved individual to reenter life in a way that is meaningful.

The normal grieving process is naturally a painful time, when the many layers of loss must be attended, and the resulting readjustment that occurs can be very difficult. The general tendency is to attempt to intervene when people are hurting and struggling after a significant loss. However, the current research on the efficacy of therapy and the appropriate time to intervene with grief indicates that most people navigate their grief with good support and do not need clinical intervention that is directed at correcting a dysfunctional response (Currier *et al.*, 2008; Schut, 2010). For those who have simply lost a loved one, the evidence suggests that professional intervention is unlikely to be effective unless the individual feels that help is needed, and so actively seeks it.

Most of the techniques that are put forward by clinicians who spend a great deal of time supporting bereaved individuals serve the purpose of facilitating the grieving process through exploration of the story related to the loss and the lost loved one(s), processing feelings that arise in association with the exploration, and providing opportunity for the bereaved individual to rebuild the assumptive world that has been assaulted by a significant loss event (Neimeyer, 2012; Winokuer and Harris, 2012).

Bearing Witness and Presence

Clinicians who work with bereaved individuals emphasize the essential component of learning to sit with people who are hurting and allow them to experience their grief without interference. Because the grieving process is viewed as adaptive, one of the most powerful 'interventions' is to learn when to intervene and when to allow the process to unfold. There are many references to mindfulness-based awareness and cultivation of presence in the therapeutic environment with bereaved individuals. In practices such as mindful awareness, clients and clinicians both can learn how to engage with suffering and difficult feelings without being overwhelmed or flooded by their intensity (Winokuer and Harris, 2012).

Rituals

Rituals usually involve an action that is initiated on the part of the bereaved individual to give a symbolic expression to

certain feelings or thoughts (Lewis and Hoy, 2011). Rituals can provide a way for bereaved individuals to express and contain strong feelings, and they often give a sense of order and control within a situation where an individual has felt very out of control and impotent. Rituals can be created privately by a client, cocreated by a client with a counselor, or culturally established through family and social contexts. Rituals can also offer an opportunity to create meaning from what has happened. In addition, rituals often provide a means of connection to the individual who is now gone, as the symbolic nature of the ritual often ties in to the continuing bond that may exist with the deceased loved one, and it may nourish a sense of the deceased's presence that is ongoing in some way with the client. In North America, the funeral is one of the most common rituals in which bereaved individuals engage.

Expressive Arts

Expressive arts may involve music, visual art, drama, poetry, dance, and creative writing in myriad ways to allow bereaved individuals to explore aspects of their experience that are difficult to put into words or express in traditional talk-oriented therapy (Thompson and Neimeyer, 2014). Grief is often experienced in ways that defy linear thinking. The use of expressive arts may facilitate engagement at an emotional or bodily level, and these same artistic forms may also provide a way to contain the intensity of the process and represent it through various arts media.

Narrative Therapy and Meaning Reconstruction

Many current bereavement researchers and practitioners argue that meaning reconstruction is a central process involved in grief (Neimeyer, 2001). In this approach, human beings are seen as the "weavers of narratives that give thematic significance to the salient plot structure of their lives" (Neimeyer, 1999). When a significant loss occurs, the life narrative of the person can become fragmented and incoherent. Narrative techniques assist bereaved individuals to rewrite the narrative of their lives in a way that allows for an explanation of what has occurred within the context of personal meaning and congruence in relation to how they now see the world, others, and themselves. Examples of narrative therapies might include letter writing to the deceased loved one, creating metaphorical stories that address issues of loss (Neimeyer, 2012), and clustering feelings or associated ideas with a central theme (Winokuer and Harris, 2012).

When Grief is Complicated

Although the point is made in the previous section that the majority of bereaved individuals do not require professional intervention, for a small group (approximately 10–15%) of bereaved individuals, grief can continue unabated for a prolonged time, negatively affecting their ability to function and cope (Shear *et al.*, 2011). The terminology used to describe grief that has somehow gone wrong can be confusing. Grief that has gone awry is sometimes referred to as CG, prolonged

grief disorder, or traumatic grief in the published literature, although the loss itself may not be associated with a traumatic death. These terms are often used interchangeably; their origin and association vary slightly depending upon the backgrounds of the researchers who first proposed the discrete criteria for what can be termed 'difficult grief.'

People with this condition experience prolonged acute grief symptoms and struggle unsuccessfully to rebuild a meaningful life without the deceased person. Typical CG symptoms include persistent feelings of intense yearning or preoccupation with the deceased, shock, disbelief, and anger about the death, difficulties with trust, and engagement in behaviors and activities to try to either avoid reminders of the loss or to feel closer to the deceased (Shear, 2010). People with CG often ruminate or obsess over the various circumstances of the death, their relationship with the deceased person, or over the events since the death and their feelings and reactions since that time (Prigerson *et al.*, 2009). These researchers provide evidence that this type of disordered grieving is a serious and potentially debilitating condition. It can impair daily functioning and quality of life and increase the risk of physical or mental illness. Its most worrisome symptom is hopelessness, or a feeling that life is not worth living, raising the chance of suicide.

Further research regarding effective treatments for CG suggest that therapy can be very helpful to people with this condition. Such therapies have included CG Treatment (Shear, 2010), cognitive behavioral therapy (Boelen *et al.*, 2007), and narrative and meaning reconstruction-based approaches (Neimeyer *et al.*, 2010).

Grief in the Social World

Much of the research and theoretical explanations of grief have tended to be focused on the intrapsychic processes of grief as experienced by individuals. However, there is now a much greater awareness and appreciation of the interaction that occurs between individuals and the social context in which they reside and where their experiences occur. All individuals come from and exist within certain family systems, organizational systems, and even social and political structures. These social systems can profoundly influence individual experiences of loss and the manifestation of grief (Neimeyer *et al.*, 2014).

It has often been said that grief is related to the innate tendency of human beings to form attachments. This proclivity to attach identifies human beings as primarily social in nature, needing the acceptance of and affiliation with others in order to feel safe and secure within the world. Thus, the social messages and beliefs held by the dominant group to which an individual belongs will have a powerful influence upon how that person perceives himself or herself and also upon how the experiences of that individual will be interpreted and validated or invalidated. The social context of the bereaved, whether it be a peer group, a family system, a specific culture or ethnic group, a workplace environment, the medical care system, or even society-at-large, can profoundly affect how bereaved individuals experience and express grief.

'Disenfranchised grief' refers to times when some aspect of a loss or the grieving process violates a socially accepted rule

regarding grief or the expression of emotion (Doka, 2002). These social rules may determine when a death carries some type of stigma, such as deaths related to acquired immunodeficiency syndrome or to suicide. Social rules also may pertain to how long an individual is 'allowed' to grieve a loss, what types of loss are acceptable and deserve grief, who can rightfully grieve for a specific loss, and what grief 'should' look like in accordance with social norms related to gender, sanctioned relationships, the expression of specific emotions, and the intensity and length of the grief response?

In the context of bereavement, separating out social expectations of how bereaved individuals are expected or should respond to events versus how they actually do respond or need to respond can be an important element in supporting the unfolding of the grieving process. While often providing support and comfort to bereaved individuals, social groups, and rules may also have the potential to suppress adaptive, but socially uncomfortable or stigmatized responses. For this reason, it is important to recognize that individuals who experience ongoing emotional pain after significant loss events may live in a society or social system that can perpetuate this pain through rigid social rules that neither allow for the validation of these losses, nor the opportunity to engage meaningfully in an adaptive grieving process (Harris, 2011).

Finally, it is important to appreciate the diverse ways that normal, healthy grief can be manifest. Influences such as culture, ethnicity, race, socioeconomic and political status, gender, and age may all play specific roles in how grief is understood and the ways that meaning can be reestablished after a significant loss occurs.

See also: Attachment. Cognitive-Behavioral Psychotherapy. Mindfulness. Posttraumatic Growth. Posttraumatic Stress Disorder. Psychodynamic Psychotherapy. Resilience. Self-Regulation. Separation Anxiety

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