A Brief Overview of Complicated Mourning

By Rev. Terri Daniel, MA, CT

In December of last year, I gave a presentation at a chapter meeting of a national support group for bereaved parents. After my talk, one of the group members -- a man in his early 50s whom I will call Richard -- told me this story:

> "My son was murdered six years ago. I think it's important for people to know that such things happen, and that life is unfair, so wherever I go, I tell people about my son. When I go to the grocery store or the bank, and the clerk says, "Have a nice day," I tell them that I *never* have a nice day because my son was murdered. When they reply with, 'I'm so sorry,' I say, 'Thank you, but you'll never understand until your own child is murdered.' That's how I cope with my grief. I'm angry, and I intend to stay that way. "

It was hard for me to decide what was most disturbing about his comments; his determination to remain angry, or his need to project his pain onto strangers by inviting them to envision their children being killed. I acknowledged that his anger was indeed understandable, but the decision to remain angry was a choice he was making, and that there are other options that could be explored. His answer was, "I'm not interested in other options. This is how I *want* to feel. Anger *is* my choice."

In a related example, a man that I will call Sam lost his toddler son in a car accident. His wife -- under the influence of alcohol -- was driving the car, and the child was not in a car seat. I met Sam three years after the incident, and he told me that he had been visiting the boy's grave daily, where he prayed, begged and bargained with God to bring his son back. He was obsessed with the idea that God could provide this miracle because Sam believed that Satan had caused the death, and therefore God could reverse it.

Both of these examples illustrate a maladaptive response to loss that has come to be known by several terms, including *complicated grief, complicated mourning* or *prolonged grief disorder*. Noted grief theorist Therese Rando defines complicated mourning as "A generic term indicating that, given the amount of time since the death, there is some compromise, distortion or failure of one or more of the processes of mourning."[1] She identifies those processes as the "Six Rs of Mourning," and in the chart below we can see how each process became complicated for Richard and/or Sam:

[1] Therese A. Rando, *Treatment of Complicated Mourning* (Champaign, IL: Research Press, 1995), 12.

Rando's Six Rs of Mourning [2]
1. Recognize the loss - Without acknowledging the reality of the death, a healthy mourning process cannot commence.[3] Sam had not really accepted that his son was dead, and constructed a fantasy in which the death could be reversed.
2. React to the separation by fully experiencing the pain rather than avoiding it. Both Sam and Richard were able to feel their pain and express their emotions, but both men directed their pain and anger outward onto the external world. Sam projected his pain onto God and Satan, and Richard pulled strangers into his misery. Both strategies are avoidance mechanisms.
3. Recollect and re-experience the deceased and the relationship - Sam wrote a detailed memoir about his son's life and death, though it focused primarily on anger at his wife, whom he referred to as "the devil's whore." Richard shared the story of his son with the world, but in a context of hopelessness and bitterness.
4. Relinquish old attachments to the deceased and to the old world - Sam clung to these attachments by visiting the grave daily and holding on the hope that his son could return to him. Both men were unable to move into a new world oriented toward restoration rather than toward loss.[4]
5. Readjust to the new world without forgetting the old - Sam's new world was focused on his negotiations with God. Richard created a new world in which he felt it was his duty to share his experience with others, warning them of their own vulnerability to child loss.
6. Reinvest energy in allowing the lost relationship to take a new form - Sam and Richard both equated the duration and intensity of their suffering as validation for the depth of their love they have for their sons. Allowing that to shift would have meant a diminishment of that love. Both men reinvested their energy in anger rather than in healing.

Both Sam and Richard were socially isolated and alienated from friends and family. Sam functioned well at his job, but working and visiting his son's grave were his primary activities. Richard attended monthly support group meetings, but used them more as a forum for venting his anger than for seeking support. His words upset the other members, and he frequently disrupted the meetings.[5]

In a 2003 study of prolonged grief reactions in widowed adults, Horowitz and his research team found empirical criteria that could characterize complicated grief as a diagnosable mental disorder. Their study addressed the debate about whether "prolonged and turbulent" grief responses are pathological enough to be included in *The Diagnostic and Statistical Manual* (DSM) of the American Psychiatric Association. The researchers concluded that seven possible

[2] Ibid. 393-448.

[3] Ibid. 393

[4] Margaret Stroebe, Henk Schut, "The Dual Process Model of Coping with Bereavement: A Decade On" *OMEGA - Journal of Death and Dying*, Volume 61, Issue # 4 (December 1, 2010). 68.

[5] Interview with support group chapter leader, December 10, 2017

symptoms could potentially serve as diagnostic criteria for a specific disorder.[6] These symptoms included:

. Unbidden memories or intrusive fantasies related to the lost relationship
. Strong spells or pangs of severe emotion related to the lost relationship
. Distressingly strong yearnings or wishes that the deceased were there
. Feelings of being far too much alone or personally empty
. Excessively staying away from people, places or activities that remind the subject of the deceased
. Unusual levels of sleep interference
. Loss of interest in work, social, caretaking, or recreational activities to a maladaptive degree[7]

Additional symptoms may also include [8]

. Extreme focus on the loss and reminders of the loved one
. Intense longing or pining for the deceased
. Problems accepting the death
. Numbness or detachment
. Preoccupation with your sorrow
. Bitterness about your loss
. Inability to enjoy life
. Depression or deep sadness
. Trouble carrying out normal routines
. Withdrawing from social activities
. Feeling that life holds no meaning or purpose
. Irritability or agitation
. Lack of trust in others

These recommendations contributed to a significant change in the next edition of the DSM. In the previous edition, the criteria for diagnosing major depression contained an exception for bereaved individuals that excluded their symptoms from being considered in a diagnosis of major depressive disorder, since those symptoms were typical of bereavement and within normal limits. But that exclusion was removed in the new edition (DSM 5), so that extreme bereavement could be diagnosed and treated as a recognized disorder.

This is a controversial change. Some experts argue against it because it allows normal bereavement to be medicalized, which could encourage some practitioners to prescribe

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[6] Mardi J. Horowitz et al., "Diagnostic Criteria for Complicated Grief Disorder," *FOCUS* 1, no. 3 (July 1, 2003). 904.

[7] Ibid. 909.

[8] Deborah Khoshaba Psy.D., "About Complicated Bereavement Disorder," *Psychology Today*, last modified September 28, 2013, accessed April 29, 2018, http://www.psychologytoday.com/blog/get-hardy/201309/about-complicated-bereavement-disorder-0.

antidepressants as treatment. Others are in favor of the change because bereavement can often *lead to* clinical depression.[9]

How We Got Here: The Evolution of Contemporary Grief Theory

Sigmund Freud's 1913 essay *Mourning and Melancholia* formed the foundation of a "grief work" theory that remained in popular use by psychotherapists for decades. Freud proposed that the lengthy and ongoing process of grieving should ultimately result in emotional detachment from the lost object. This process was part of a dynamic in which one directs psychic/emotional energy toward a particular object or person, which Freud referred to as "cathexis." In doing this grief work, the griever strives to pull that energy away from the lost object in order to separate from the connective bonds, memories and feelings that cause pain, with the ultimate result being the severance of the attachment.[10]

This model influenced therapists and grief theorists for nearly 50 years, until research methods were refined and assumptions about grief were challenged .[11] Rather than rooting grief studies exclusively in psychoanalysis, as social, cultural and religious attitudes began to shift the 1960s, so did interpretations of existing grief research. Ideas such as stage theories, the belief that all bereaved people experience distress, and the necessity of Freud-style grief work were questioned,[12] and these ideas were replaced with updated theories. Today's researchers propose that the old grief work model does not address the full range of the grief experience or the various types of processing that can occur, and may only apply to grievers who are experiencing severe symptoms. Today it is generally agreed that detachment from the deceased is not the ultimate goal, but instead, healing occurs by creating a new relationship that integrates the deceased into the continuing life of the griever.[13]

Complicated vs. Normal Grieving

Horowitz et al defined normal grieving as having the ability to tolerate distressing moods and turbulent thoughts with an eventual return to equilibrium. By contrast, complicated grief contains extremes that can impair functioning to the point where equilibrium is out of reach,

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[9] Ronald Pies, "The Bereavement Exclusion and DSM-5: An Update and Commentary," *Innovations in Clinical Neuroscience* 11, no. 7–8 (2014). 19.

[10] John Archer. *The Nature of Grief: The Evolution and Psychology of Reactions to Loss* (London: Routledge, 2001). 16

[11] Ibid. 21

[12] Ibid. 23

[13] Laura Matthews and Samuel Marwit. "Complicated Grief and the Trend Toward Cognitive-Behavioral Therapy." *Death Studies* (28, no. 9 November 2004). 852.

and the grief response becomes psychopathological.[14] These two ends of a spectrum speak to an individual's capacity to be resilient. The American Psychological Association identifies certain inner qualities that may contribute to that capacity, which include:

. The capacity to make realistic plans and take steps to carry them out.
. A positive view of yourself and confidence in your strengths and abilities.
. Skills in communication and problem solving.
. The capacity to manage strong feelings and impulses.[15]

How these skills and qualities develop in an individual is a topic for another paper, but for our purposes, it is important to note that possession of these skills transcends culture, religious beliefs and the specific circumstances of the loss.

Strobe and Schute proposed a model that recognizes how bereaved individuals engage in a double process that involves both coping with the loss and making adjustments in their lives to adapt to that loss. In this dual process model, the griever's energy is constantly oscillating back and forth between "loss orientation" and "restoration orientation."[16] When grief become complicated, as it did for Richard and Sam, the two processes are out of balance, with more focus on loss than on restoration.

The APA defines resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress." These responses are not considered unusual or extraordinary, and should not necessarily be interpreted as a denial or suppression of pain.[17] It's also important to recognize that these responses can be influenced by the griever's cultural norms or religious beliefs. For example, Bonanno observes that a griever's guilt feelings can be exacerbated by a belief in divine punishment, which contributes to complicated grief and increased pain.[18] Bonanno also notes that resilience is not well supported in the modern Western way of grieving,[19] and that when grieving or traumatized people show "only minor

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[14] Mardi J. Horowitz et al, "Diagnostic Criteria for Complicated Grief Disorder," *FOCUS*. 1, no. 3 (July 1, 2003). 904.

[15] "The Road to Resilience," *www.Apa.Org*, accessed January 24, 2018, www.apa.org/helpcenter/road-resilience.aspx

[16] Margaret Stroebe, Henk Schut, "The Dual Process Model of Coping with Bereavement: A Decade On" *OMEGA - Journal of Death and Dying*, Volume 61, Issue # 4 (December 1, 2010). 57.

[17] Ibid

[18] George A. Bonanno, *The Other Side of Sadness: What the New Science of Bereavement Tells Us About Life After Loss*, Reprint edition. (New York: Basic Books, 2010). 98.

[19] George A. Bonanno, "Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive after Extremely Aversive Events?," *The American Psychologist* 59, no. 1 (January 2004): 20–28.

and transient disruptions in their ability to function," psychologists sometimes find it to be an unusual or even pathological response.[20]

Rando identifies the following high-risk factors that might lead to complicated grief: [21]

Rando's high-risk factors	Selected Examples
Sudden or unexpected death (especially when traumatic, violent or mutilating)	Murder, suicide, natural disaster, war.
Death from a lengthy illness	A caregiver feeling guilty for experiencing a sense of relief after the death occurs.
The mourner's perception of the death as preventable	School shootings, drug overdose, suicide, or a caregiver's belief that he/she could have done more to prevent an illness or death.
A pre-morbid relationship with the deceased that was markedly angry, ambivalent or dependent	Death of an abusive spouse or a loved one from whom the mourner was estranged.
Prior or current mourner liabilities, including (a) unaccommodated losses and/or stresses and (b) mental health problems	Unresolved grief from prior losses, loss of self/identity, unfinished business with the deceased.
Loss of a child	All of the above, plus assumptions that children should outlive parents.
The mourner's lack of social support when the deceased's lifestyle choices are perceived as socially unacceptable.	Grieving an abortion, or a death caused by drug overdose or suicide, or the death of someone killed while perpetrating a criminal act.

Conclusion

Matthews and Marwit point out that cognitive therapy can be helpful in assisting the griever to move back and forth between restoration and loss orientation by helping the griever to experience a sense of control over anxiety, uncertainty and a fractured sense of self.[22] From a spiritual care perspective however, uncertainty and a fractured sense of self can be rich territories for exploration when our fundamental assumption about reality are thrown into chaos. Those assumptions, which Janoff-Buhlman calls "the bedrock of our conceptual system"[23] include these basic beliefs about life:[24]

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[20] George A. Bonanno, *The Other Side of Sadness: What the New Science of Bereavement Tells Us About Life After Loss*, Reprint edition. (New York: Basic Books, 2010). 101.

[21] Therese A. Rando. *Treatment of Complicated Mourning*. (Champaign, IL: Research Press, 1995). 453.

[22] Laura Matthews and Samuel Marwit. "Complicated Grief and the Trend Toward Cognitive-Behavioral Therapy." *Death Studies* (28, no. 9 November 2004). 858

[23] Ronnie Janoff-Bulman. *Shattered Assumptions*, (New York, The Free Press,1992).5.

[24] Ibid, 6.

1. The world is benevolent (for example, life is inherently good, people are basically good).
2. The world is meaningful (life makes sense; good things happen to good people).
3. The self is worthy (I am a good, moral person, worthy of love and protection).

We cannot survive and thrive without holding on to these assumptions and using them to help us create a sense of safety in the world. Without them, we would not take risks, including the risk of loving someone or something that we might lose. Bulman tells us that when the assumption of safety is shattered, we experience "conceptual disintegration,"[25] which can render our normal coping mechanisms ineffective. This massive shake-up in our understanding of how the world works can take us in one of two directions. We can either accept the loss and begin constructing a new world based on what Janoff-Bulman refers to as "powerful new data,"[26] or we can cling to the old world -- as Richard and Sam have done -- thereby skipping Rando's 4th and 5th tasks, which are necessary if the grief process is to be healthy. If we are not able to oscillate between loss and restoration, the grief process will become complicated.

The ability to recognize that grief exists on a dynamic, flexible spectrum rather than within a static structure is paramount to our evolving understanding of loss, trauma and bereavement.

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[25] Ibid. 93

[26] Ibid, 93

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