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Grief

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Synonyms

Sorrow (due to someone's death)

Definitions

- Grief: the emotional experience of the psychological, behavioral, social, and physical reactions that the bereaved person may experience as a result of the death of a loved one.

Introduction

Grief is frequently described as a normal reaction to bereavement, which in turn is considered a normal part of life, an event which sooner or later affects most people. Grief reactions are diverse, varying across time and between people (s). There are, for example, personality and other individual differences. Nevertheless, certain regularities characterize bereavement-related phenomena. First, it is important to note that most people adjust over the course of time to the loss of a loved person (most are "resilient," see below). Yet the experience is often typified as harrowing, as associated with suffering; the person is described as "grief stricken" or "grieving." There are similarities too between people (at least within Western cultures) in the wider range of psychological, behavioral, social, and physical reactions experienced. Of concern at the health care level, bereaved persons are at risk of physical and mental illnesses, even (though more rarely) excessive mortality. Given such potential detrimental ramifications, grief and bereavement have become topics of specific scientific investigation, with knowledge accumulating across recent decades. Therefore, in this entry, an overview of research on grief and bereavement is provided, focusing on the key questions relating to health and well-being that scientists have endeavored to answer.

The Nature, Course, and Consequences of Grief and Grieving

Manifestations of normal grief. First of all, it is important to note that adjustment to bereavement is not confined to the calendar year that is commonly regarded as the expected duration of intense grief. The phenomena summarized next can, on the one hand, be of shorter duration or, on the other, sometimes last for years, waxing and

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waning over time. Furthermore, they may or may not be experienced at all (grief being long understood as a complex syndrome, Averill 1968). Affective reactions include sadness and distress, anxiety, guilt, anger, yearning, loneliness, crying, and fatigue. Behavioral ones include agitation, fatigue, crying, and social withdrawal. Cognitive ones include lowered self-esteem, self-reproach, suicidal ideation, and memory/concentration problems. Physiological/somatic ones include appetite/weight changes, sleep disturbances, exhaustion, changes in drug intake, and immunological and endocrine changes (Stroebe et al. 2007).

The course of grief. The highly influential, so-called stage theories (for application to bereavement, see Kübler-Ross and Kessler 2005: denial, anger, bargaining, depression, acceptance, known as the DABDA model) were postulated to describe the pattern of reactions that bereaved people are said to go through over time during bereavement. Professionals and lay persons alike have understood these to be the "correct" course to overcome grief. However, this is countered by contemporary scientific understanding: there is neither empirical evidence nor theoretical grounding for such stages. In fact, studies with prospective, longitudinal data have demonstrated great variation in trajectories of grief, with the kind that somewhat resembles the suggested stages emerging as not common. Furthermore, the expectation that people should conform to stages can be harmful to those who do not do so (Stroebe et al. in press). Therefore, the DABDA model should not be used as a framework to guide understanding of grief and grieving, neither by practitioners nor by others supporting the bereaved – and the bereaved themselves should not feel they are grieving "wrongly" if their reactions deviate from the DABDA sequence.

There are other viable theoretical models. To illustrate: understanding of the course of grief over time has owed much to Bowlby's (1980) attachment-theory-based approach. Bowlby described phases of grief, ones which evolve (gradually, flexibly) from initial shock, through yearning and protest, followed by despair and, finally, toward acceptance of the loss. Importantly, (1) he linked these time-related changes to a separation process, one that serves the intended purpose of regaining proximity to the loved, absent person; (2) he described how adjustment to loss is a function of the (in)security of attachment to the lost person, thus identifying an important individual difference in adjustment. The separation process pertains to other contexts too where attachments are disrupted, but where (unlike bereavement) proximity can then be restored.

Interindividual differences in grief can be understood from other theoretical perspectives too. To illustrate, like attachment theory, another generic perspective, namely, cognitive stress theory, has been applied specifically to bereavement (Folkman 2001), offering a framework for understanding the links between the stress of bereavement and health consequences. Bonanno and Kaltman's (1999) four-component model and Stroebe and Schut's (1999) Dual Process Model of Coping with Bereavement are both bereavement-specific models within which personality and individual differences can also be placed.

Complications following bereavement. It is by now well accepted that most people are quite resilient (Bonanno et al. 2011); despite suffering associated with the range of reactions and symptoms described above, most manage to adjust to their loss over the course of time with the help of those around them and without the aid of psychotherapeutic or medical intervention. However, for a minority (percentages vary according to type and circumstances of loss), complications in the grief process do occur; furthermore, there is higher risk of mental or physical health debilities among bereaved compared with non-bereaved persons.

Grief complications frequently reflect extreme forms of the symptoms just described, being characterized by features such as (1) persistent, intense longing and yearning for the deceased, intrusive thoughts or images, emotional numbness, extreme anger or guilt relating to the loss, a sense of emptiness, and reactivity in response to bereavement cues and/or (2) avoidance of people and places associated with the loss, relating to the intense distress those reminders evoke. In the

current *Diagnostic and Statistical Manual of Mental Disorders* (APA 2013; DSM-5), complicated grief [which can be defined as a deviation from the normal (in cultural and societal terms) grief experience in either time course or intensity of specific or general/reactions or symptoms of grief] is labelled persistent complex bereavement disorder and assigned to the category requiring further scientific research; it is not an established diagnostic category. Much debate hinges around the question whether it should become one (for an overview see Stroebe et al. 2013). Furthermore, the question whether intense grief (e.g., as frequently found among samples of bereaved parents) necessarily reflects complications must also be considered (parents' extreme levels of grief may conceivably reflect a "normal" reaction to an extremely harrowing type of loss).

Additional consequences of bereavement. Grief should not be considered "a disease" (cf. Stroebe 2015). However, as indicated already, bereaved persons do also suffer from physical and mental health problems (more than non-bereaved counterparts). Again, prevalences vary but estimates typically indicate elevations for significant minorities (e.g., 10–20 % reaching clinical levels for depressive symptoms). Rates are higher for medication use (e.g., increase in medical consumption) and hospitalization. Bereaved persons consult their physicians more frequently (symptoms of anxiety and tension being frequent reasons), although – worryingly – research has also shown that many fail to seek medical help when they need it. Psychological symptoms and mental ill-health excesses are also wide ranging, including suicidal ideation, intense loneliness, insomnia, anxiety, depression, somatic complaints, and social dysfunction. Recent research has extended investigation to broader ramifications than health-related ones, including social (e.g., relationships and divorce) and workplace (e.g., absenteeism) consequences. For example, research has shown that death of a child increases divorce risk among parents (Lynstad 2013). Further extensions are called for (e.g., family level adjustment: impact on family life; how families cope together – or apart – through (non) interactions).

Can the health consequences illustrated above reach such extremes that they threaten the life of the bereaved person? Is there really such a thing as a *broken heart*? Research on the mortality of bereavement suggests that bereaved persons can actually die themselves as the result of losing their loved one (this occurs only in a small number of cases) (cf. Stroebe et al. 2007). Much of this research focused on mortality risk among widow/ers but has recently also documented increased mortality among bereaved parents compared with non-bereaved controls. Here again, excesses occur across different causes of death, ranging from an increased risk of heart disease itself to suicide and alcohol-related causes, lung cancer, accidents, and violent deaths. This diversity of death causes suggests that the "broken heart" phenomenon may relate to psychological distress such as extreme loneliness, longing, and yearning, on the one hand, and to threatening secondary effects, such as changes in social ties, living arrangements, eating habits, and economic support on the other.

Risk factors. Who suffers particularly from such negative consequences as those described above? The so-called risk factors associated with increased vulnerability are as varied as the consequences just described, with situational, intrapersonal, interpersonal, and coping factors all impacting on bereavement outcome (for a review: Stroebe et al. 2007). Recent research has moved toward finer-grained definitions and analyses (e.g., of coping processes), which show how such risk factors impact on bereavement in complex ways. For example, Eisma (2015) examined the role of ruminative coping style (i.e., repetitive, recurrent, self-focused thinking about past negative experiences and/or negative mood) in adjustment to loss, finding this to be maladaptive.

Adding to complexity, the various factors listed above interact with each other to affect adjustment. To illustrate, personality-related features and circumstances subsequent to bereavement have been shown to interact in influencing adjustment of a child to the death of a parent: In one study adequacy of ongoing parental care (e.g., warmth and discipline) and personal characteristics of the child (e.g., self-efficacy beliefs; high

self-esteem) emerged as important predictors of later adjustment (for review, see Luecken 2008). How risk factors relate precisely to the different health outcomes outlined above remains to be clarified in further research.

Support and treatment. Recent research has borne out a concise conclusion by Parkes (1998) regarding the provision of psychotherapeutic intervention, namely, that there is "no evidence that all bereaved people will benefit from counseling and research has shown no benefits to arise from the routine referral to counselling for no other reason than that they have suffered a bereavement (p. 18)." Primary prevention (i.e., that available to all bereaved, irrespective of whether intervention is indicated) can, however, be helpful when the initiative is left with the bereaved individual (Schut et al. 2001). Research has also shown benefits for those at risk and for those with grief complications (Wittouck et al. 2011). Clearly, some bereaved persons may also need medical support for the physical ailments indicated earlier, as well as professional or informal help for other bereavement-related ramifications (e.g., sorting the finances, legal complications, work-related difficulties).

Closing Remarks

In bereavement research, a major goal is to try to make sense of enormous differences between people (and subgroups) in grief and grieving, to search for patterns and underlying mechanisms that help account for differences in adaptation to loss. On a theoretical level, the availability of new perspectives on coping with grief and grieving was already noted, and the need to move beyond so-called stage theory also stressed. There is currently still a lack of an overriding, integrative model to understand the complex phenomena and manifestations of grief and grieving. However, it has become evident that contributions stem from a variety of disciplines, ranging from psychological, sociological/cultural, evolutionary, neurological/physiological, and medical/gerontological approaches. The question arises, then, whether such integration is possible and whether it is really necessary.

Contemporary developments in empirical research have added to knowledge about individual variations (although research on personality differences still merits expansion, cf. Stroebe et al. 2007). For example, the quality of assessments of grief and grieving is improving (e.g., beyond paper-and-pencil measures) and, relatedly, better identification of vulnerable subgroups of bereaved people enables provision of more appropriate help to (only) those who need it (Wittouck et al. 2011). Some directions for future research have also already been indicated (e.g., establishing the precise links between risk factors and specific health or other outcomes; family level investigation and examination of interpersonal stressors and coping processes). Others include the need for further physiological/neurological expansion, understanding specific needs/concerns of the bereaved elderly (in aging societies), and examination of cultural variations within and beyond Western societies and of refugee and migrant groups (dealing with multiple additional traumas).

In closing, in the current context, it is instructive to consider the state of knowledge about grief in historical perspective: If ones looks at Averill's (1968) review of the nature and significance of grief nearly half a century ago or Parkes' (1972) in-depth exploration of the health impact of bereavement, then both theoretical and empirical advancements in the study of grief become evident. At the same time, the roots of contemporary knowledge can be clearly traced to such early scholarly contributions – just as, one hopes, future developments may build on the contemporary body of knowledge that has also been outlined. As highlighted in this article, not least among such improvements in both bereavement research and practice would be the relegation of stage theory to the historical shelves, and reorientation toward conceptual frameworks (such as those illustrated earlier) that can help explain individual differences in people's experience, and identify those who are in need of support.

Cross-References

- ▶ Attachment Theory
- ▶ Bereavement
- ▶ Emotion Regulation
- ▶ Loneliness
- ▶ Negative Events
- ▶ Rumination
- ▶ Sorrow
- ▶ Trauma

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