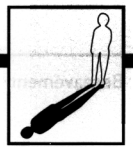

Bereavement

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Absent Grief A complicated form of grief characterized by the nonappearance during bereavement of overt symptoms typical of grief, coupled with the continuation of life as though the event had not occurred (note that absence of symptomatology does not always indicate mental disorder).

Bereavement The situation of a person who has recently experienced the loss of someone significant through that person's death.

Chronic Grief A complicated form of grief characterized by long-lasting presence of symptoms associated with intense grief (e.g., rumination, preoccupation with thoughts of the deceased, depression) and absence of apparent progress in coming to terms with the loss of a loved one.

Delayed Grief A complicated form of grief in which the individual shows little or no sign of grieving early on in bereavement, but does so at a later point.

Grief The primarily emotional (affective) reaction to the loss of a loved one through death, which incorporates diverse psychological (cognitive, social/behavioral) and physical (physiological/somatic) manifestations. Grief is a normal reaction to loss, not an illness or psychiatric disorder, although it is associated with higher risks of these disorders.

Grief Counseling The facilitation through counseling of the process (tasks) of normal, uncomplicated grieving to alleviate suffering and help the bereaved to reach a healthy completion within a reasonable time framework.

Grief Therapy Specialized techniques of intervention for bereaved individuals to guide an individual with an abnormal or complicated grief reaction (e.g., chronic or delayed grief) toward a normal coping process.

Grief Work The cognitive process of confronting the reality of a loss through death, of going over events that occurred before and at the time of death, and of focusing on memories and working toward detachment from the deceased.

Mourning The social expressions or acts expressive of grief, which are shaped by the practices of a given society or cultural group (e.g., mourning rituals).

Pathological Grief A deviation from the norm (i.e., that could be expected, according to the extremity of the particular bereavement event) in the time course or intensity of specific or general symptoms of grief (see also chronic, delayed and absent grief). "Complicated grief" is also frequently used to denote such deviation.

BEREAVEMENT is a life event that, while comparatively rare in childhood, sooner or later, is part of nearly everyone's experience: increasingly across the life span, people have to face the death of their par-

ents, siblings, partners, friends, or other close loved ones. Mortality statistics underline this. According to figures compiled in the 1980s, in one single year in the United States alone, more than 2 million people can be expected to die. Infant mortality rates are estimated at 40,000 a year, while more than 16,000 children between the ages of 1 and 14 and as many as 38,000 young people between the ages of 15 and 24 lose their lives. As such, bereavement can be viewed as a normal, natural human experience, one that most people manage to come to terms with over the course of time. Nevertheless, it is associated with a period of intense suffering for the majority of people and with an increased risk of mental and physical health detriments. Adjustment can take months or even years, and is subject to substantial variation, both between individuals and between different cultural groups. Furthermore, while most people eventually recover from their grief and its accompanying symptoms, for a few, mental and physical ill health is extreme and persistent. For this reason, bereavement is a concern not only for the planning of preventive care, but one that is of clinical relevance. It has far-reaching implications too for well-being within families (e.g., potential long-term effects on mental health of losing a parent in childhood; increased frequency of divorce among parents who have lost a child) and for policy making at governmental level (e.g., economic support programs). Over the past few decades, scientific study of the symptomatology, mental and physical health consequences, and ways of coping with grief has continuously expanded. This research—in the past (although this is changing now), mainly on adults, and focused on spousal bereavement—is working toward the identification of persons early in bereavement who are likely to suffer detrimental consequences, and toward designing programs to provide preventive care for those most at risk. Headway has also been made in developing intervention programs for persons suffering from complicated forms of grief. The current state of knowledge with respect to the consequences and care of the bereaved is the focus of this article.

I. INTRODUCTION

Bereavement refers to the situation of a person who has recently experienced the loss of someone significant—notably a parent, partner, sibling, or child—through that person's death. In everyday language, the term bereavement is used interchangeably with grief or mourning. Conceptual distinctions have, however, been made in the bereavement and emotion literatures to differentiate these terms. Thus, grief is taken to be the primarily emotional reaction to the loss of a loved one, while at the same time it is recognized as incorporating a myriad of psychological and physical reactions. Negative affect is dominant, particularly in the early days of loss, although this is balanced by more positive emotional reactions such as relief (e.g., at the end of suffering through terminal illness or strife).

Given the above description of grief, it becomes evident that grieflike reactions can follow other types of loss, such as the loss of a livelihood, loss of a job, loss of physical functioning, or divorce. Mourning, on the other hand, is specific to bereavement, referring to the social expressions or acts expressive of grief during bereavement, which are shaped by the practices of a given society or cultural group, such as funeral rites, the wearing of a specified color of clothing, or rituals bringing together family members at specified times across the duration of bereavement. It is noteworthy that the traditional psychoanalytic school defines these terms differently, using the term mourning synonomously with the way grief has been defined above. The reason for this can be found in the original German formulation: the word "*Trauer*" used by Freud and from whom psychoanalytic definitions derive, refers to both the experience as well as the expression of grief. [*See* GRIEF AND LOSS.]

II. THE SYMPTOMATOLOGY OF GRIEF

The scientific study of the impact of bereavement on mental health goes back to a classic paper written in 1917 by Freud, entitled "Mourning and Melancholia." This paper was a landmark in the analysis of distinctions between normal and complicated forms of grief. It was not until much later that a systematic analysis of the range of symptoms typically associated with bereavement was published, by Lindemann, in 1944. Current understanding still owes much to this early formulation. Thus, patterns of normal grief responses, reflected in itemizations in assessment instruments (see below) typically cover the following dimensions: Affective manifestations include depression, despair and dejection, anxiety, guilt, anger and

hostility, anhedonia and loneliness. Behavioral manifestations include agitation, fatigue, crying and social withdrawal. Cognitive manifestations include preoccupation with thoughts of the deceased, lowered self-esteem, self-reproach, helplessness and hopelessness, a sense of unreality, and problems with memory and concentration. Physiological and somatic manifestations include loss of appetite, sleep disturbances, energy loss and exhaustion, somatic complaints, physical complaints similar to those that the deceased had endured, changes in drug intake, susceptibility to illness and disease.

While there is lack of evidence specifically on cross-cultural differences in these dimensions, studies from related areas, such as depression research, and clinical experience lead one to expect cultural differences in the relative frequency of symptoms across these different dimensions, for example, more somatization of grief in non-Western cultures.

Finally, while it has become familiar to talk about the "symptomatology" of grieving, following early writers in the field, it is important to remember that grief is a normal reaction to bereavement and not a physical illness or psychiatric disorder, even though it is associated with higher risks of these disorders.

III. PHASES OR STAGES OF GRIEF

Understanding of the course of grief owes much to the work of John Bowlby, whose analysis of attachment and separation processes, documented in his three-volume monograph, *Attachment and Loss,* and his observations with respect to the close relationship between manifestations of grief and time since death, led him to suggest "phases" or "stages" of grief. Phasal conceptualizations typically postulate a succession from an initial stage of shock, with associated symptoms of numbness and denial, through yearning and protest, as realization of the loss develops, to despair, accompanied by somatic and emotional upset and social withdrawal, until gradual recovery, which is marked by increasing well-being and acceptance of the loss. Durations vary, but generally the first two phases are suggested to last up to a number of weeks, and the third, intense grieving phase may last several months or even years. There is considerable cross-cultural variation in the duration of the phases across time, which has to do with mourning customs and cultural norms.

There has been wide acceptance in scientific as well as in applied fields of such phasal descriptions. However, these have been understood too literally. Almost without exception—and this certainly is the case for Bowlby's original formulation—phases have been introduced as descriptive guidelines, but have been regarded as set rules or "prescriptions" regarding where the bereaved ought to be in the "normal" grieving process. Care must also be observed in applying such labels as "resolution" or "completion" of grief, because the bereaved do not "get over it and back to normal," but rather adapt and adjust to the changed situation and generally succeed in reaching a new equilibrium.

Recently developed "task models" take more account of the richness of idiosyncratic manifestations of grief than do phasal models. Well-known, and much used in counseling and therapy, is Worden's model, in which the grief process is taken to encompass four tasks, namely, accepting the reality of loss; experiencing the pain of grief; adjusting to an environment without the deceased; and "relocating" the deceased emotionally and moving on with life. It should be emphasized that not all grieving individuals undertake these tasks and, again, they will also be dependent on cultural factors (e.g., in societies where reverence of ancestors is customary, "relocation" takes place in a very different way: the deceased is in a sense still present).

IV. NORMAL VERSUS PATHOLOGICAL GRIEF

Because grief is a normal reaction to the death of a loved one, it does not usually require the help of professional counselors or therapists. However, as noted above, a minority of bereaved people suffer from complicated forms of grief. It must be stressed that distinctions between normal and complicated grief are difficult to make, first of all, due to the lack of clarity with regard to the definition of complicated grief (or, for that matter, of normal grief to begin with). One reason for this is that categorization systems have largely been empirically, rather than theoretically, derived. Another is that complicated grief is not a single syndrome with clear diagnostic criteria. A third reason is the complexity involved in setting a cut-off point between what is "normal" in grieving and what is not (e.g., cultural patterns that view tearing one's hair as

a normal symptom of grief, are not accepted in Western cultures). Fourth, perhaps most difficult is the overlap and causal sequencing of pathological grief with other mental disorders, such as affective or anxiety disorders.

These problems make any effort at definition questionable, but there are grounds enough to state that time course and intensity of symptoms are dimensions on which complicated grief can primarily be assessed. Delayed, chronic, absent, and prolonged grief, as well as unresolved, maladaptive, conflicted, distorted, neurotic, and dysfunctional grief frequently reflect these dimensions (they last too long or too short, have too little or too great an intensity, or commence too late). It is frequently the case that complications of grief manifest themselves with regard to certain symptoms, while others remain at an unproblematic level or duration.

Given the variety and richness of individual manifestations of grief, and the problem of defining even the parameters of normal grief, at the present state of knowledge the following definition appears to be useful: Pathological grief is a deviation from the (cultural) norm (i.e., that could be expected to pertain, according to the extremity of the particular bereavement event) in the time course or intensity of specific or general symptoms of grief. Subtypes of pathological grief have been distinguished in the scientific literature that are in accordance with this general definition. Thus, chronic grief is characterized by long-lasting grief, and an absence of signs that the individual is making any progress in the process of coming to terms with loss. Chronic grief is frequently associated with depression, guilt feelings, self-reproach, social withdrawal, and continued preoccupation with thoughts of the deceased. Absent grief is characterized by the nonappearance of symptoms typical of grief. The person continues with life as though nothing has happened. It is important to note that the absence of symptoms of grief does not, per se, indicate pathology. In delayed grief the bereaved person shows little or no sign of grieving at first, as in absent grief, but later on, symptoms of grief do become apparent, and indistinguishable at this later time from those of normal grieving.

V. MEASUREMENT OF GRIEF: DIAGNOSTIC INSTRUMENTS

In the last couple of decades a number of self-report questionnaires have been developed for the measurement of symptoms of grief. Most of these inventories have been developed for the categorization of the range of symptoms of grief in adults. Frequently used batteries include Sanders, Mauger and Strong's Grief Experience Inventory, and Faschingbauer, Zisook and DeVaul's Texas (Revised) Inventory of Grief. Over the years more specific measures have also been developed, such as Toedter, Lasker and Aldaheff's Perinatal Grief Scale, to assess grieving among parents who have suffered loss during pregnancy or the loss of a newborn baby, and Hogan's Sibling Inventory of Bereavement, designed for adolescent siblings of someone who has died.

There are limitations with respect to the application of such instruments for the assessment of grief. They are in general more appropriate for research purposes than for clinical use. Individual assessment needs to take account of variables beyond those evaluated through psychometric instruments that are based on self-reports. Furthermore, there are shortcomings with respect to the establishment of psychometric qualities and establishment of norms. Grief is also a process, and as such cannot be assessed according to normality versus deviation without taking the dimension of length of time of bereavement into account.

For the reasons outlined above, many researchers and professionals in clinical practice rely instead on diagnostic interviews to derive an assessment of the course that grieving is taking. Alternatively, many of them use general diagnostic instruments such as the Symptom Check List (SCL-90), the General Health Questionnaire (GHQ-28), or depression lists such as the Beck Depression Inventory or the Zung. In the context of traumatic bereavement, Horowitz, Wilner and Alvarez's Impact of Event Scale is frequently used for the assessment of posttraumatic stress symptomatology.

VI. HEALTH CONSEQUENCES OF BEREAVEMENT

Cases of pathological grief are comparatively rare, the overwhelming majority of bereaved persons undergoing tolerable levels of symptomatology that decline as time passes. Nevertheless, the bereaved are indeed at greater risk than the nonbereaved of suffering from a variety of mental and physical ailments and disorders, including depression, anxiety disorders, somatic complaints, and infections. Some of these ailments are

most closely associated with recent bereavement, others extend over a longer time span.

How prevalent are health problems following bereavement? With respect to psychological reactions, only in a minority of cases are these so severe as to require professional intervention, or to reach levels equivalent to diagnostic criteria. To illustrate: in one study of bereaved adults in The Netherlands by Schut and his colleagues, published in 1991, although 50% reached the criteria for diagnosis of Posttraumatic Stress Disorder at one of four points of measurement within the first 2 years of bereavement, only 9% met this level at all four points. These were participants in a cohort study of bereaved people, who were not undergoing treatment. In a further small community sample study in Germany, Stroebe and Stroebe investigated the adjustment of widows and widowers under retirement age. Forty-two percent reached depression levels equal to or above a well-established cut-off point for mild depression on the Beck Depression Inventory, at approximately 6 months after their loss (as opposed to 10% of a comparable married group). Two years after loss, this had reduced to 27%, but as such was still significantly higher than for the married. Again, these were not treated cases. [*See* DEPRESSION.]

Nevertheless, large-scale statistics do show higher rates of psychiatric illnesses among bereaved as compared with nonbereaved individuals, as evidenced in general in- and outpatient admission statistics and in diagnostic-specific figures across a broad range of psychiatric categories. Some studies have found that, for widows, rates fall most frequently within the depressive disorder category (rates for widowers are, however, also highly excessive within this category), whereas widowers have the additional very high risk of succumbing to alcohol-related disorders. Although such statistics are typically available for conjugal bereavement, there are good reasons to argue that the patterns found both for mental and physical health debilities following death of a spouse are reflected in other types of losses, such as loss of a child.

Physical health detriments are also excessive among recently bereaved people compared with nonbereaved counterparts, both males and females being affected. They suffer not only from a variety of physical symptoms and illnesses, but they also have higher rates than nonbereaved individuals for disability and use of medical services, such as consultations with doctors, use of medication, and hospitalization.

The risk of mortality from many causes, notably suicide, is also higher among bereaved persons than among the nonbereaved. There is some evidence that this bereavement–mortality relationship generalizes beyond spousal loss, affecting parents, children and other family members, but more reliable and extensive statistics are available for spousal loss. Cross-sectional mortality tables showing marital status patterns from many countries of the world indicate that widowed persons in general have higher death rates than comparable married individuals, and that these excesses are greatest for younger adults and for males. This identifies younger widowers as a particularly high-risk group. While such statistics are subject to artifacts (e.g., selection), longitudinal studies have confirmed this pattern, indicating that the relative excess compared with nonbereaved, during the first year or two of bereavement, is frequently greater than 40%. Although this percentage sounds alarmingly high, it must be remembered that actual numbers of deaths per year are few, particularly in young age groups. To give a typical example, if the mortality risk of the widowed had applied to the married population of The Netherlands in the years from 1986 through 1990, then 356 more men and 123 more women per 100,000 person years would have died.

Recent research has shown biological links between grief and the increased risks of morbidity and mortality described above. Physiological theory and research have concentrated on the identification of mechanisms by which loss may affect the immune system, lead to changes in the endocrine, autonomic nervous, and cardiovascular systems, and that help to account for increased vulnerability to external agents. Recently, for example, physiological changes have been identified in the immune system following bereavement. This approach should facilitate understanding of individual differences in health outcome of bereavement: Why are some individuals more vulnerable than others? There may be predisposing risk components of a physiological nature. Another approach to answering this question has been the search for complicating and mitigating factors, which is the topic of the next section.

VII. BEREAVED PERSONS AT RISK OF POOR ADJUSTMENT

Much research effort has been put into identifying so-called "risk factors," to understand why people are affected in very different ways, and why some people

(i.e., high-risk groups) suffer debilitating and/or lasting consequences while others do not. It has become clear from the above descriptions that a range of effects, including diverse psychological, physical and social functioning is involved. Thus, a "risk factor" is one that increases vulnerability across a spectrum of variables: one person may succumb to mental health problems while another may die prematurely following bereavement.

High-risk subgroups of bereaved persons have been identified and can be classified according to: sociodemographic variables, personal factors (e.g., a history of mental disturbance; personality/relationship characteristics), causes and circumstances of death (e.g., sudden death; child loss), and circumstances of bereavement (e.g., lack of social support; additional stresses). These variables have been identified by investigators—admittedly with differing levels of empirical robustness, as we will indicate below—as associated with poor bereavement outcome, at least within Western cultures. In general, one might assume intercultural similarities, although culturally specific patterns might be expected on some variables, for example, widowers may be less exceptionally vulnerable in societies with very different male–female roles/relationships.

Next, we consider what is known so far about relative risk of succumbing to detrimental effects according to the four categories of risk factors.

A. Sociodemographic Factors

Considerable attention has been paid to gender differences. Mothers have generally been found to react more overtly and for a longer period than fathers, following the death of a child. This may be related to gender differences in expressiveness and to differences in styles of coping among men and women, with men adopting the role of strong supporter for a deeply grieving partner. In the case of conjugal bereavement, there is growing evidence that widowers are relatively more vulnerable than widows to ill health, ranging from relatively higher excess rates (compared with still married counterparts) on depression, mental illness, physical symptomatology and, best established so far in the literature, from mortality.

Many investigators have concluded that there are systematic differences in health outcome according to age: younger bereaved persons have been found to be more at risk than older persons. Mortality statistics are supportive of this. A number of explanations, which are not mutually exclusive, have been put forward. For example, death for younger persons is a comparatively unexpected, often unprepared-for event, and the shock of loss is therefore all the greater. In the case of partner loss, death of a younger person is also untimely and tragic, rather than occurring "in the fullness of time." Furthermore, some of the variance may be accounted for by such factors as joint unfavorable environments or life-style, joint risk from dangerous activities such as reckless driving being more associated with younger than older age groups (what caused the death of the loved one, is a risk factor for the survivor).

Ethnic or cultural group differences in bereavement have been the topic of insufficient research to identify specific patterns of similarity versus differences with respect to health consequences. Certain general conclusions can, however, be drawn. In particular, it can be stated with some degree of certainty that grief is universal, in the sense that loss of a close, loved person causes personal upset and has been shown to affect the mental and physical health of persons in very different cultures across the world. Manifestations are, however, remarkably different (e.g., somatization in symptomatology, or continuing of bonds with and sense of presence of the deceased in cultures different from our own) and ways of coping, particularly outward expression of grieving, vary greatly and according to local norms and customs. With respect to physical morbidity and mortality, although there is also evidence of elevated risks in other cultures, comparisons between cultures are very hard to draw, given the differences in, for example, patterns of interpersonal relationships (e.g., remarriage), in health care, in diagnostic systems and in recording of national statistics. [*See* ETHNICITY AND MENTAL HEALTH.]

Does religion help the bereaved? Although the religious bereaved themselves frequently identify their religious and spiritual convictions as a source of strength, evidence that belief in God, in an afterlife, and in reunification with the deceased after death have not been systematically pinpointed as ameliorating the distress of bereavement: nonreligious persons have been found to be as well-adjusted as their religious counterparts in a number of studies. It seems plausible that the nonreligious turn to other sources for support and strength. For some religious people, death of a loved one shakes their faith, if, for example, God is seen as a powerful force that allowed the death to occur. [*See* RELIGION AND MENTAL HEALTH.]

B. Personal Factors

So far, perhaps the most striking feature to emerge consistently from empirical research is that high levels of distress in the course of bereavement are best predicted by a high level of distress early after loss. While this may reflect the mediating role of a number of different variables, such as those to do with features of the death itself, it points to individual differences in the ability of bereaved persons to come to terms with their loss. Whatever the background factors responsible, extreme distress in the early days of bereavement is a highly relevant indicator of the potential need for intervention.

The quality of the relationship with the deceased person has been found to lead to differences in the impact of bereavement. Most noticeable, ambivalence and dependence in the (marital) relationship are associated with more intense and longer lasting grief reactions. This is somewhat surprising, because one might predict that harmonious, loving, compatible relationships would be the ones most clearly identified as leading to a broken heart and dreadful loneliness. It is, of course, difficult to differentiate between close relationships in this sense of the word, and dependent ones. The outcome patterns are complex too: it does not always seem to be dependent survivors who are the ones to be more affected, for those who have adopted the care-giving role in a relationship with a more dependent partner can suffer as much as the latter during bereavement.

We have already discussed (see Section VI) that prior psychiatric debility may be a contributing factor to the development of complicated grief. In some cases, bereavement exacerbates already existing health conditions. A personal history of mental and/or physical health problems is associated with increased risk of ill health effects during bereavement. Adding to this picture, the occurrence of prior losses, possibly ones that have been multiple or occurred chronically, can put a person at very high risk.

More research needs to be conducted on the impact of personality and other individual factors on adjustment to loss, for example, the role of different styles of attachment, or of general negative affectivity. Research has, however, recently focused on the mediating role of different ways of coping in adjustment to loss. For example, analyses of the impact of confronting and working through grief on recovery did not show unequivocal support for their effectiveness in the Tubingen Longitudinal Study. Similarly, structural analyses of the link between expression of emotions and psychological distress in the Utrecht Study by Schut and his colleagues suggested independent development of the two phenomena. These studies thus call into question the so-called grief work hypothesis that has long been accepted by the psychoanalytic and attachment theory schools (see Section VIII). Others, such as Bonanno in the United States, are currently examining the role of such coping mechanisms as denial and the presence of positive emotions in grief. The thrust of their argument is that these are not necessarily indicators of poor adjustment or signs of trouble to come, but that they may indeed be adaptive processes. [*See* INDIVIDUAL DIFFERENCES IN MENTAL HEALTH; PERSONALITY.]

C. Causes and Circumstances of Death

Some investigators have found sudden, unexpected deaths of loved ones to be associated with more intense and longer lasting grief reactions. In some studies, the difference according to expectedness of loss is not very large. It seems likely that expected deaths also carry a great burden of care giving during the final illness, leading to exhaustion and physical neglect of personal health while concentration is focused on the terminally ill loved one. This would bring high risk on bereavement.

In the study in Germany by Stroebe and Stroebe, reported above, it was also found that the type of death interacted with personal characteristics of the bereaved individual to affect good versus poor outcome. Those widowed persons who had experienced a very unexpected death of a loved one (less than a day's forewarning) and who, in addition, were persons who had low internal control beliefs (i.e., they did not think that they had control over what happened to them, or that matters in general were within their own control) were the ones who remained highly distressed over the first 2 years of bereavement. Expected death experiences had generally better recovery profiles, regardless of personal control beliefs, as had sudden death ones among persons with high internal control beliefs.

Undoubtedly, there is some confounding between the circumstances of death and its cause, in determining impact on the bereaved survivor. However, several causes have been found to be independently related to

specific or more intense grief reactions. Thus, homicide is generally found to be an extremely traumatic loss, associated with Posttraumatic Stress Disorder. Death from suicide is often associated with guilt and stigma. Death from AIDS is complicated not only by stigmatization, but also by the fact that, within the gay communities where prevalence is high, such deaths are also chronically, multiply occurring and the bereaved themselves are also at high risk. Multiple losses have been found to lead to long-lasting grief reactions and depression.

Is the type of relationship with the deceased (child, spouse, parent, etc.) associated with different types and/or intensities in grief reactions? Catherine Sanders has researched this question in some detail, as described in her 1989 monograph, *Grief: The Mourning After Dealing with Adult Bereavement.* The loss of a child emerges as the most devastating of losses in industrialized societies, not only for parents, but also, some studies have shown, for grandparents. Siblings also suffer greatly from the loss of a brother or sister, not least because of difficulties arising from the fact that their parents are also grieving, and problems in communicating and understanding each other's grief —as indeed can be the case with grieving parents, whose styles of grieving may be very different. Due to preoccupation with their own grief, parents may also fail to realize the impact of loss on their surviving children. In fact, the death of a child can pose a serious threat to the marital relationship and family harmony.

The loss of a parent in childhood combined with difficult subsequent circumstances during upbringing, can trigger problems during adulthood. A renewed high-risk period could be expected after the death of another loved person at this later stage of life.

D. Concurrent Circumstances during Bereavement

Among researchers investigating the concurrent life circumstances of bereaved persons, focus has been on the impact of social support on ameliorating the effects of loss, and on the burden of additional stressors during bereavement. The general social support literature has clearly shown that those who are "buffered" from stress through the presence and help of others have fewer health problems. Thus, one would expect such positive effects during the stress of bereavement. Subjective accounts by bereaved people also confirm that they feel helped and supported by family and friends. It is also intuitively convincing that the distress of bereavement will be ameliorated by the support and understanding of others. However, well-controlled studies have not unequivocably confirmed this. The work of Weiss (see, for example, his monograph, *Loneliness,* published in 1973) has suggested a reason why, and this has received some empirical confirmation: those grieving the loss of a loved one feel deeply lonely, even in the presence of others. While others can indeed help with certain tasks, there can be no replacement for the lost loved one, at least not early on in bereavement. As bereaved persons themselves report, they remain desperately lonely, even though they are not alone. An additional reason for the limited advantages that have been found for social support is that social interactions are frequently reported to be nonsupportive, even when intended otherwise, and that these actually serve as a supplementary source of stress. [*See* LONELINESS.]

Dominant among additional problems that add to the burden of bereavement are economic difficulties, which can lead to the need to move to a different house or to gain employment—which then, in and of themselves, create additional stress. A drop in financial resources has indeed been found to be related to poor bereavement outcome. Financial difficulties can become an additional source of stress during conjugal bereavement, where income (or comparable resources such as household care) provided by the deceased person has been lost on that person's death. Not surprisingly, given that men are still more often the main breadwinners, this is particularly a problem among widows, exacerbating their adjustment difficulties, and accounting, as some studies have shown, for part of the variance associated with poor adjustment.

In conclusion: further methodologically sophisticated research on the above risk factors, and, in particular, better understanding of mediating processes is still needed. For example, what is the impact on bereaved people of administering euthanasia to a dying loved one, or, how does the multiple occurrence of loss among communities having to deal with AIDS and accompanying stigmatization affect adjustment to bereavement? How is the grief of small children different or similar to that of adults, and what are the special risks for them?

VIII. THEORETICAL APPROACHES TO BEREAVEMENT

A. Psychoanalytic Theory

Theoretical explanations of psychological reactions and ways of coping with grief owe much to psychoanalytic theory. Freud's "Mourning and Melancholia," mentioned above, has remained influential theoretically, its impact being evident in the work of Lindemann, Bowlby, Parkes, Raphael, Jacobs, and other major figures in the field. According to psychoanalytic theory, when a loved one dies, the bereaved person is faced with the struggle to sever the ties and detach the energy invested in the deceased person. The psychological function of grief is to free the individual of his or her ties to the deceased, achieving the gradual detachment by means of a process of grief work. Grief work implies a cognitive process of confronting the reality of loss, of going over events that occurred before and at the time of the death, and focusing on memories and working toward a detachment from the deceased. Since Freud, the notion that one has to work through one's grief has been central in the major theoretical formulations on grief and in principles of counseling and therapy. The major cause of pathological grief, according to Freud, is the existence of ambivalence in the relationship with the deceased preventing the normal transference of libido from that person to a new object. [*See* PSYCHOANALYSIS.]

B. Attachment Theory

Bowlby's attachment theory emphasizes the biological rather than the psychological function of grieving. The biological function of grief is to regain proximity to the attachment figure, separation from which has caused anxiety. In the case of permanent loss this is not possible, and such a response is dysfunctional, in the sense that reunion cannot be achieved. However, Bowlby also argued for an active working through the loss. Like Freud, Bowlby sees the proximal cause of pathological grief in the relationship with the lost person. However the distal cause is childhood experiences with attachment figures. These experiences are assumed to have a lasting influence on later relationships. For example, frequent separation from attachment figures in childhood can lead to anxious attachment in later relationships, which results in chronic grief, a pathological reaction consisting of an indefinite prolongation of grief over the death of a partner. [*See* ATTACHMENT.]

C. Stress Theory

Stress theory, like attachment theory, has had a tremendous impact on bereavement research. Such an approach is reflected in the influential work of Horowitz and his colleagues, whose interest and analysis spans not only bereavement, but traumatic life events in general (see, for example, his influential 1986 book, *Stress Response Syndromes*).

The basic assumption of stress theory is that stressful life events play an important role in the etiology of various somatic and psychiatric disorders. This approach has received much impetus through the work of Lazarus & Folkman, whose volume, *Stress, Appraisal and Coping,* appeared in 1984. More specifically, it is assumed that a stressful life event may precipitate the onset of a physical or mental disorder, particularly if predisposition toward that disorder already exists. The intensity of stress created by a life event depends on the extent to which the perceived demands of the situation tax or exceed an individual's coping resources, given that failure to cope leads to important negative outcomes. Coping may either be directed at managing and altering the problem that is causing the distress (problem-focused coping) or it may be directed at managing the emotional response in order to reduce emotional distress and to help maintain one's emotional equilibrium (emotion-focused coping). Stress theory provides the theoretical underpinning for the so-called "buffering model," which suggests that high levels of social support (a coping resource) protect the individual against the deleterious impact of stress on health. Furthermore, research has identified neurophysiological mechanisms linking stress with various detrimental consequences to the immune, gastrointestinal, and cardiovascular systems. [*See* COPING WITH STRESS; PSYCHONEUROIMMUNOLOGY; STRESS.]

IX. INTERVENTION FOR THE BEREAVED

The distinction has been made in the literature between grief counseling and grief therapy. While, in practice, the division between the two types of intervention is hard to judge, it is nevertheless useful for

the purposes of clarification of the range of support programs that are available and appropriate to assist bereaved persons through their grief process.

A. Grief Counseling

Grief counseling has been defined by Worden as "helping people facilitate uncomplicated, or normal, grief to a healthy completion of the tasks of grieving within a reasonable time frame." Emphasis is thus on general support, the offering of comfort and care, help with secondary stresses that occur, and encouragement of appropriate grief and mourning. The role in such support of the informal network is supplemented through pastoral care workers, doctors, voluntary organizations such as Widow-to-Widow or Cruse (often those who have themselves suffered a loss being involved in the counseling of recently bereaved persons), and health care professionals (e.g., social workers and psychologists).

To illustrate, one type of voluntary counseling for bereaved persons is so-called "self-help" aid as offered in Widow-to-Widow programs. Silverman was a major pioneer of this movement, and in an early paper, written in 1975 with her coauthor Cooperband, she described the principle behind self-help groups, that grieving persons may be best helped by others who have been through and mastered their bereavement themselves, as follows:

> The evidence points to another widow who has coped and accomodated as the best caregiver. Very often the first question a widow helper is asked is, "How am I going to manage?" The second question is, "How did it happen to you?" The new widow seems to be seeking a role model, someone with whom to identify. This other widow can be a friend, a neighbour, or a relative. She offers an opportunity to talk with someone who indeed really understands. She can provide perspective on feelings; she provides a role model; she can reach out as a friend and neighbour—not someone defined as concerned with abnormal or deviant behaviour.

An important aspect that was not emphasized in this description is the training of volunteers, and the availability of advice and guidance of a skilled and experienced professional to back up such voluntary aid. These days, such assistance is typically planned and organized within voluntary programs.

Is such help really effective in alleviating the pain of grief? Most participants report beneficial effects, but this does not mean, of course, that it would benefit all bereaved people. In fact, those who find no use for such a program are the most likely to have dropped out, and be lost to impact assessment figures. Clearly, too, self-reports of effectiveness are a far step from an objective evaluation of the impact of a self-help program on the course of recovery, for example, with respect to its impact on specific mental and/or physical health variables.

B. Grief Therapy

Grief therapy, also as defined by Worden, refers to "those specialized techniques . . . which are used to help people with abnormal or complicated grief reactions." Most experts see grief therapy as appropriate in cases where the grief process has "gone wrong," when grief work fails to be undertaken and completed successfully, that is, according to the late grief therapist, Ramsay, when "the 'normal' reactions of shock, despair, and recovery are . . . distorted, exaggerated, prolonged, inhibited, or delayed."

Thus, broadly speaking, while grief counselling would be appropriate for normal grief, grief therapy would be indicated for pathological grief. It is important to note that expert knowledge is necessary to evaluate whether the special techniques of therapy are necessary in a particular case, or whether the bereaved person's grief will be alleviated with the aid of counseling.

What are the goals of grief therapy? According to the grief work hypothesis, complications in the grieving process occur when the individual is unable to face up to or process the reality of the death. Avoidance of some aspect of the loss itself or of one's emotional reaction to it lies at the heart of problematic adjustment. For example, there is lack of or insufficient confrontation with emotions to do with the loss because of the fear that the intensity of these will be intolerable. Likewise, some bereaved continue to cling to, and talk about the deceased in order to remain closely bonded to him or her. This too can be interpreted as avoidance: the presence of such preoccupation serves the purpose that one does not have to face the reality of the loss. Systematic dealing with avoidance reactions is a common feature in psychotherapy programs for pathological grief.

Recently, we have drawn attention to the one-sidedness of the notion of working through grief in grief intervention. Alongside confrontation, the bereaved

also have to adjust to changes in the current environment. These include the need to take on new roles, a changed identity, and the need to develop skills that are lacking due to the absence of deceased. Such so-called "restoration" tasks have so far been neglected in descriptions of therapy programs, as has the need to take "time off" from grieving.

Nevertheless, a wide variety of therapy programs have been developed to stimulate confrontation with painful associations to do with grief. These differ in the main with respect to the degree of directiveness with which confrontation is forced. Next we give brief descriptions of the major approaches.

Within behavior therapy techniques of systematic desensitization or "flooding" have been used, the intention in therapy being to break down defense mechanisms and unleash intense emotional reactions. These have proven useful, and effective for the treatment of pathological variants of grief. Cognitive (behavior) therapy and rational emotive therapy integrate behavior therapy techniques, but are directed toward certain ideas or assumptions that the bereaved have, which create additional emotional difficulties, such as perceived personal shortcomings in interacting with the terminally ill person. Therapy in such a case might be directed toward disputing the impossible demands that one places on oneself at such a harrowing, exhausting time. When the client ultimately accepts the reinterpretation, it should be possible to proceed to a stage where feelings can be expressed. [*See* BEHAVIOR THERAPY; COGNITIVE THERAPY.]

Psychodynamic therapy focuses on conflicts within the grieving individual. In the case of complicated grief concentration is on working through conflicts within the previous relationship, both with respect to positive and negative aspects. Psychodynamic therapy can also be oriented toward selective strengthening of the ego, which takes the form of facilitating emotions (e.g., aggression or guilt feelings).

Within the last decade, creative therapy (in combination with other forms of therapy) has also been increasingly applied to the treatment of pathological grief. This technique is particularly useful—among children and adults—when the bereaved person is unable to express his or her grief well in words. This can have to do with "inappropriate" feelings for which verbal expression might be inhibited because they are not socially acceptable, such as aggression or desire for revenge. The idea is that self-censoring is lowered in creative therapy through the use of symbolic images, use being made of techniques such as drawing, painting, or working with clay, and also using music or photos.

Hypnotherapy is almost exclusively used in cases of traumatic loss, for example, following accidents, disasters or murder deaths. As such, what is being treated is posttraumatic stress disorder, focus being placed on the dissociation of the traumatic experience from normal consciousness. The latter process is assumed to inhibit the normal coping process. Phases in such therapy are (1) identification of the avoided traumatic memory; (2) neutralization of the trauma; and (3) therapeutic revision (this phase is not always necessary). The pain that is associated with the traumatic event is then neutralized or substituted by positive or neutral emotions or images. [*See* HYPNOSIS AND THE PSYCHOLOGICAL UNCONSCIOUS.]

Somewhat similar to hypnotherapy is guided imagery therapy. Again, three phases are involved: (1) reliving; (2) revising; and (3) revisiting. These phases lead to the breaking down of barriers, through which the client is able to confront the reality of the loss experience.

Certain procedures cross the barriers of different therapeutic interventions. Thus, the use of leave-taking ceremonies are frequently used in directive types of therapy. These involve rituals during which, for example, possessions of the deceased person will finally be disposed of through burning or burying the article. When carefully embedded within the context of a more general therapy program, such techniques can be enormously helpful. Likewise, bibliotherapy, the reading of selected publications can be effective in the treatment of pathological grief. Reading and discussing (auto)biographies can be very facilitating, in that they show how normal certain grief reactions are. The bereaved remember similar feelings of their own and recognize that these are common to bereavement.

Also common to all therapy forms is the assumption that the client will ultimately come to the (cognitive and emotional) realization that loss is irrevocable, and that leave must be taken from the deceased. This does not mean that the deceased is forgotten or banished from one's thoughts, but rather than the deceased is displaced, in the sense of finding a new place, in the bereaved's existence. And, most of all, it means the revival of personal experiencing without the continued presence of the deceased loved one.

Finally, we need to consider the effectiveness of therapy programs in general. Few methodologically sound research projects have been conducted to evaluate interventions for pathological grief. Those that are available in the literature indicate that behavior therapy, cognitive therapy, hypnotherapy, and psychodynamic in general all have postive outcomes with respect to guiding pathological forms toward normal ways of grieving. More research is needed to assess the relative effectiveness of the different forms of therapy.

X. SUMMARY AND CONCLUSIONS

There is no doubt that the loss of a loved person causes deep suffering and that the costs to health can be extreme. These consequences are reason enough for bereavement to have become the subject of considerable scientific study. Much is now known about typical manifestations of grief, and about factors that complicate the course of grieving over time. Progress has also been made in the planning and implementation of services for recently bereaved individuals, and for those whose grieving process runs a complicated course. Much can be done within the community and through health care professionals to promote adjustment to bereavement and prevent the development of pathological forms of grief. For the comparatively small number of persons for whom grief takes a complicated course, specific intervention programs have been designed that help to reduce extreme consequences and restore grieving to a normal course that will, eventually, result in adjustment to life without the loved person.

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