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COMPLICATED GRIEF: A CONCEPTUAL ANALYSIS OF THE FIELD

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ABSTRACT

A great deal of research, notably by Prigerson and colleagues (e.g., Prigerson & Jacobs, 2001; see Prigerson & Maciejewski, this issue) and Horowitz and colleagues (e.g., Horowitz, this issue; Horowitz, Bonanno, & Holen, 1993), has recently been conducted with the purpose of establishing criteria for the designation of Complicated Grief (CG) as a mental disorder for inclusion in DSM-V. Some dissenting voices have been heard from teams of researchers adopting different approaches and/or using different criteria and diagnostic categorizations. We argue the need for a conceptual framework as a starting point for understanding the different positions on this CG–DSM controversy. This analysis is used as a tool to evaluate the questions posed by the Editor of this Special Issue, Colin Murray Parkes: (1) Should Complicated Grief be regarded as a psychiatric disorder? (2) Does the syndrome described by Prigerson and colleagues meet the required scientific criteria? Discrepancies emerge between scholars in the ways that they have conceptualized and assessed complicated grief and associated disorders: Examination of the positions of researchers within the framework reveals five systematically different approaches. We argue that potential criteria and diagnostic categorization systems emerging from the different perspectives need to be considered. General implications of DSM-V (non)inclusion are summarized.

INTRODUCTION

The DSM is ostensibly a non-theoretical categorization system with an emphasis on phenomenology, etiology, and course as defining features of mental disorders.

Nevertheless, classification reflects the influence of theoretical understanding. An example relevant to our current concern is the formulation of diagnostic criteria for Posttraumatic Stress Disorder (PTSD) (American Psychiatric Association (APA), DSM-IV, 1994). There is close parallel between these selected criteria and the theoretical analysis of Horowitz (1986) in his classic monograph "Stress Response Syndromes."

It seems likely that adoption of a specific conceptualization of Complicated Grief (CG) will influence perceptions of its status as a psychiatric disorder[1]. Two specific questions arise with respect to the proposed new category of CG: (1) how does the theoretical position affect perception of CG as a psychiatric disorder and / or perception of the need for a new diagnostic category in DSM-V? (2) How does it determine the formulation of diagnostic criteria?

In this article, we first provide a framework for classifying the different theoretical approaches. We base this on an earlier analysis (Stroebe, Schut, & Finkenauer, 2001), summarizing the main parameters of the framework, extending the previous discussion and, most importantly, deriving the inferences for psychiatric diagnosis of CG. Then we give examples of the placement of contemporary researchers within this framework, including that of Prigerson and colleagues (e.g., Prigerson & Jacobs, 2001; Prigerson & Maciejewski, this volume) who are among the main proponents for including CG as a mental disorder in DSM-V. We demonstrate how the contrasting positions have implications for decisions with respect to psychiatric diagnosis and selection of criteria. Finally, adopting a broader perspective, we note (dis)advantages of a new diagnostic category of CG and briefly evaluate the relative merits of particular sets of proposed diagnostic criteria.

A CONCEPTUAL FRAMEWORK

By definition, persons who come under consideration for potential diagnosis of CG have to have lost a significant person in their lives. If the nature of the bereavement event is drastic, horrendous, or shocking, then it is generally considered to classify as a traumatic event. While the two types of events—bereavements and traumas—overlap in the case of traumatic bereavements, they can also be distinct phenomena, in that some bereavements are not traumatic (e.g., a loved one may die peacefully after a long and fulfilling life), and in that some traumatic events do not entail bereavement (e.g., nobody has died in an otherwise dreadful accident). Clearly, there are potentially different implications associated with the three domains (trauma, traumatic bereavement, and

[1] We adopt the term "Complicated Grief" to follow current usage (CG is, however, frequently linked specifically to Prigerson and colleague's symptoms list and diagnostic criteria), but note that "pathological grief" has frequently been used synonymously. Also, it is noteworthy that Prigerson has used the term "traumatic grief" for CG in earlier publications.

non-traumatic bereavement) for pathology. It becomes of interest to establish where and how different scholars have focused their attention within these domains. The interface of the life events of bereavement and trauma thus forms the basis for our conceptual analysis, as depicted in Figure 1.

In order to summarize the main parameters, Figure 1 distinguishes between the types of event—bereavement versus trauma—(Category A) and scientific analyses of the manifestations associated with the two events (Categories B-F). In the following overview, we compare the phenomena and manifestations of trauma and bereavement separately, before discussing the overlap between them (for more extended description, see Stroebe et al., 2001).

1. Types of Events

Category A has been described already as incorporating the life events themselves. An important question is whether bereavement from "normal," non-horrific circumstances satisfies conditions put forward in the definition of traumatic events, such as in DSM-IV, for example.[2] Were it to do so, there would be no justification for placing bereavement in the right portion in Figure 1 (and our conceptual framework would not be useful). There are, in fact, good reasons to argue that bereavements occurring under normal, non-traumatic circumstances would be excluded from definitions of traumatic events. For example, there is emphasis in DSM-IV on the extremity and nature of the bereavement event as a defining characteristic for incorporation among traumatic events, the event of a death being linked (in the same sentence) to the phrase "extreme traumatic stressor," and later on to the specification ". . . learning about the sudden, unexpected death of a family member . . ." (APA, 1994, p. 424). Thus, non-traumatic bereavements such as the example given above—of the quiet death of an elderly person—would not be included in the definition of traumatic events. According at least to the current DSM system, the "traumatic bereavement" category excludes those bereavements that are not outside the range of usual human experience, are not extremely traumatic types of stressors, and are not sudden and unexpected. Jacobs's (1993) statement that "…trauma is not universal and inevitable like bereavement" (p. 356) emphasizes the difference in the relative "normality" of the two types of events, a distinction that should have implications for psychiatric diagnosis.

It is apparent from Figure 1 (Category A) that there are also events that classify both as a trauma and a bereavement, this category comprising "traumatic bereavements" or "traumas that include bereavement." According to our conceptualization, traumatic bereavements are those that occurred in highly impactful circumstances, that are neither universal nor an inevitable part of normal life.

[2] It is important to keep in mind that the experience of a trauma can, *but does not necessarily*, lead to the development of disordered symptomatology.

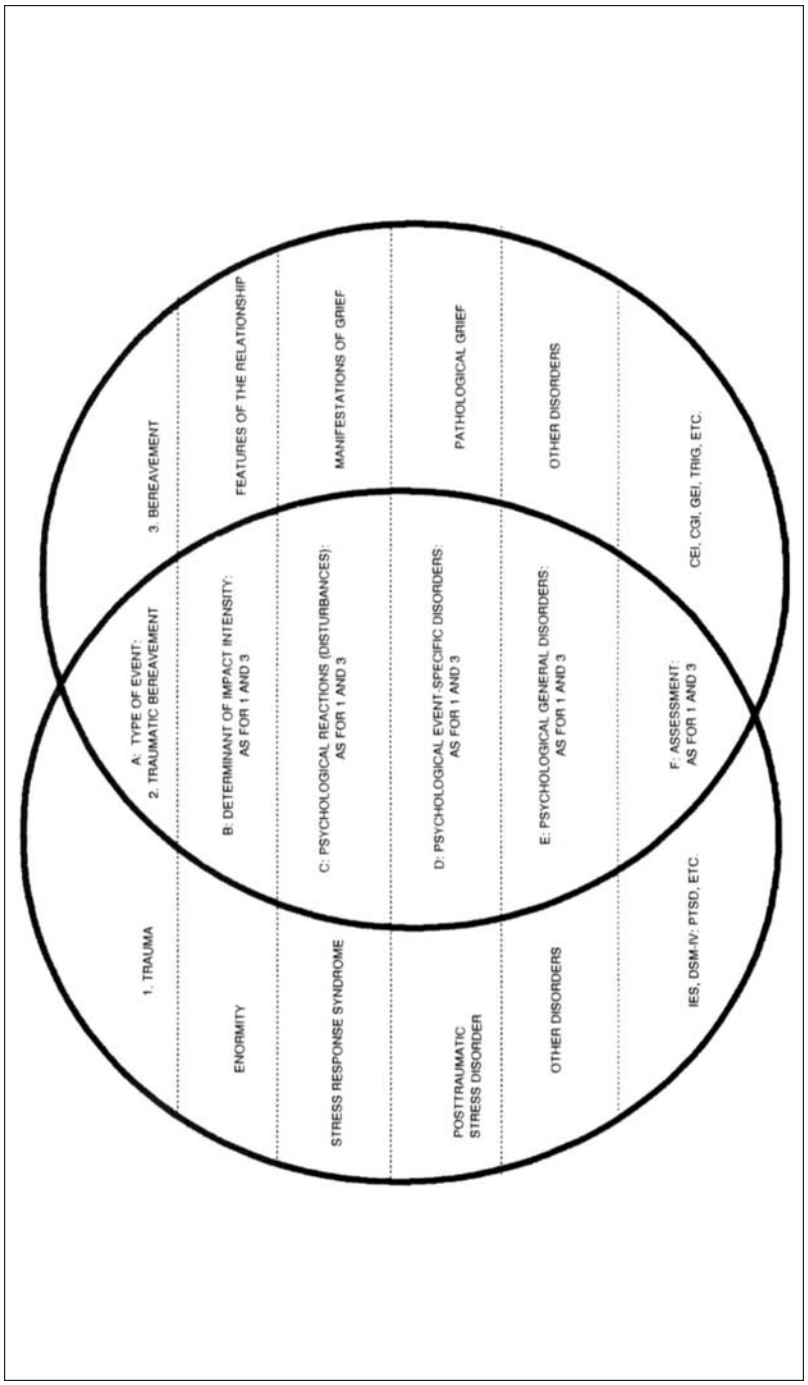

Figure 1. The interface of bereavement and trauma.

Thus, traumatic bereavement is defined in terms of the nature of the event, not in terms of the personal reaction. The nature of reactions to traumatically-occurring bereavements are likely to be systematically different from those following non-traumatically-occurring bereavements. We return to this later.

2. Determinants of Impact Intensity

Different criteria have been used as the basis for evaluations of the intensity of the impact of the two types of events (Category B). Generally speaking, determinants of the extremity or impact intensity of a trauma have much to do with the enormity of the event. For example, the greater the level of severity of exposure to stressors, the greater the impact on the individual (Green, 1994). In principle, one could also argue similarly for bereavements: The enormity of the event is a strong determinant of impact intensity, at least in the case of traumatic bereavements. However, research in the bereavement field has identified features of the relationship, including closeness and type of relationship to the deceased person, as critical with respect to the intensity of the bereavement reaction (e.g., Bowlby, 1980; Klass, Silverman, & Nickman, 1996; Rubin, 1999; Sanders, 1989). Attributes of the relationship thus feature as central components in determining intensity of reactions to bereavement, more than "enormity" of the event in non-traumatic bereavements. We are not claiming that non-traumatically occurring bereavements cannot be enormously impactful. Rather, we are emphasizing that non-traumatic bereavement reactions are likely to incorporate different phenomena and manifestations than those following traumatic life events. The focus on enormity in trauma and relationship in bereavement reflect fundamental differences in the nature of the two stressors, which correspond to differences in the nature of reactions and disorders of normal psychological functioning associated with the two events.

In traumatic bereavements, the intensity of reactions would be expected to be a function of both stressor enormity and relationship to the deceased. These two dimensions seem closely in line with empirical investigation by Prigerson and her colleagues of "traumatic distress" and "separation distress" components of CG (e.g., Prigerson, Shear, Frank, & Beery, 1997; Prigerson, Maciejewski & Roseneck, 2000).

A key question concerns the nature of this combination of bereavement and trauma: is it additive in the sense that symptoms just cumulate, or, as Nader (1997) argues, is it interactive/incremental, in the sense that there is intensification of the symptoms which are frequently characteristic reactions to a bereavement, on the one hand, and a trauma, on the other hand? A further point that needs to be stressed is that our analysis does not exclude other potential determinants of the impact of a bereavement, such as personality or pre-existing psychiatric disorder. We shall see later how these can be incorporated.

3. Psychological Reactions (Disturbance)

The events of bereavement and trauma both precipitate psychological disturbance (upset and arousal) in most individuals, which would be classified as "normal" reactions (Category C). However, patterns of response differ: normal reactions following a traumatic event have been described in terms of a "stress response syndrome," a dominant feature of which is intrusion versus avoidance (Horowitz, 1986). The reaction to bereavement—grief, on the other hand, is said to incorporate a broad range of emotional, cognitive, and behavioral manifestations (Parkes, 1996; Stroebe & Stroebe, 1987). Despite the different categorizations, there is some overlap in types of reactions (e.g., intrusion of memories, sleep disturbance, anxiety), which is not surprising, since grief symptoms lists typically include reactions to traumatic bereavements. Further to this, Simpson (1997) has identified common features to non-bereavement trauma, and non-traumatic bereavement (e.g., guilt and shame, lasting search for meaning). However, Raphael and Martinek (1997; see also Kleber & Brom, 1992) identified differences in typologies associated with trauma and bereavement. For example, in trauma, intrusions, memories and preoccupations have to do with the scene of the event, whereas in bereavement they have to do with the deceased person. Thus, in the exclusive category of non-bereavement trauma, anxieties associated with the traumatic occurrence itself are critical, whereas in the exclusive category of non-trauma bereavement reactions are focused around the ongoing affectional bond. Following traumatic bereavement both posttraumatic stress and grief symptoms are likely to be present, with the former possibly interfering with the latter (Raphael, Middleton, Raphael, Martinek, & Misso, 1993; Schut, de Keijser, van den Bout, & Dijkhuis, 1991).

4. Psychological Disorders (Life Event Specific)

This category of psychological (or psychiatric) disorders (Category D) is basic to the current interest. Psychological disorders are precipitated in some (but by no means all) individuals following traumas and bereavements. Despite the attention that Posttraumatic Stress Disorder (PTSD) has received since its introduction into the DSM system in 1980 (cf. Figley & Kleber, 1995), it is important to remember that other anxiety disorders have also been linked to the occurrence of traumas (Green, 1994). It has been suggested that anxiety disorders are the most prominent category of disorders following traumatic experience (Rando, 2000).

Bereavement-specific complications occur following this type of loss: Grief itself may take a complicated course. Three types of complication have been identified, namely, inhibited grief (i.e., absent or minimal), delayed grief (characterized by late onset, and intense), and prolonged, chronic grief (Jacobs, 1999; Parkes, 1996; Parkes & Weiss, 1995). Recently there has been some debate about the existence of inhibited or absent grief (e.g., Bonanno, Wortman, & Nesse, 2004)

although such complications are well-recognized by grief therapists and other researchers alike (e.g., Middleton, Moylan, Raphael, Burnett, & Martinek, 1993; Parkes & Weiss, 1983; Sireling, Cohen, & Marks, 1988). Clearly, absent grief is a difficult phenomenon to investigate, not least because it is hard to distinguish from no or low grief (i.e., when the deceased person is simply not missed or grieved for). In general, though, there is by now ample evidence that grief itself may take a complicated course.

Although both trauma and bereavement have specific pathologies (both of which may occur in the case of traumatic bereavements), the status of PTSD and CG in diagnostic systems is not equivalent, the former being a separate diagnostic category, the latter not. This non-equivalent treatment may be due to the fact that trauma is generally considered to be beyond the range of normal human experience, whereas bereavement is considered part of the normal human experience.

5. Psychological Disorders (General)

We already noted the development of anxiety disorders following traumas. Comorbidity with PTSD is frequent in the sense that (a) anxiety or other disorders may simply co-occur after the event, or (b) a disorder may already be present before the event and possibly become exacerbated (Middleton et al., 1993). In addition, traumatic life events may bring about an increase in the risk of other disorders (Keane & Wolfe, 1990), their manifestations being directly associated with occurrence of the traumatic experience (Rando, 2000). Bereavement also places the individual at high risk of mental disorders, including Major Depressive Disorder, MDD, anxiety disorders, and substance abuse (e.g., Clayton, 1990, for depression). A further diagnostic category that would seem relevant is "Adjustment Disorders" (AD), defined as "the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors" (APA, DSM-IV, 1994, p. 623). It is noteworthy that DSM-IV excludes "normal" death of a loved one from AD classification, noting that "Bereavement is generally diagnosed instead of Adjustment Disorder when the reaction is an expectable response to the death of a loved one" (p. 626). However, if the reaction is more excessive or more prolonged than would be expected, AD may be considered appropriate. As for disorders associated with traumas, so may co-morbidity associated with bereavements follow different pathways (co-morbidity as co-occurrence; co-morbidity as amplifier; co-morbidity as secondary symptom) (cf. Chorpita & Barlow, 1998).

There is clearly a range of disorders associated with bereavement, in addition to PTSD. The complex associations of trauma and bereavement with the various diagnostic categories need to be taken into account when considering whether CG can or should be placed within them (e.g., PTSD, MDD, or even, perhaps, AD). Is there really justification for a separate category of mental disorder?

6. Assessment

Although various types of instruments are available to measure reactions to trauma, the "Impact of Event Scale" is probably the most frequently used. It incorporates the subscales of intrusion and avoidance (Horowitz, Wilner, & Alvarez, 1979) and, more recently, hyperarousal symptoms (Weiss & Marmar, 1997). Higher scores indicate greater intensity, with the possibility of PTSD (see the diagnostic criteria for PTSD in DSM-IV, APA, 1994, pp. 427-428) replacing the less intense stress response syndrome.

Likewise, various quantitative instruments are available for the assessment of grief reactions (for a comprehensive review, see Neimeyer & Hogan, 2001). These include the Texas Revised Inventory of Grief (TRIG) (Faschingbauer, 1981; Faschingbauer, Zisook, & De Vaul, 1987), the Grief Experience Inventory (GEI) (Sanders, Mauger, & Strong, 1985/1991), and the Inventory of Complicated Grief (ICG) (Prigerson & Jacobs, 2001, previously called the Inventory of Traumatic Grief). The ICG is probably becoming the most used these days. Various sets of criteria have been developed for cases of possible pathology (e.g., Horowitz, Bonanno, & Holen, 1993; Horowitz et al., 1997; Jacobs, 1993; Prigerson & Jacobs, 2001).

In addition, generic measures of (non)psychiatric symptomatology are used in both the trauma and bereavement domains, enabling examination of other symptom clusters such as depression and anxiety. For example, administration of the Beck Depression Inventory (BDI) (Beck, 1967) gives an indication of the extent of depressive symptomatology (enabling comparison with other clinical or non-clinical subgroups). Furthermore, diagnostic criteria for these related disorders are detailed in the DSM system.

An important question emerges for current concerns: To what extent do such instruments/criteria assess complications associated with (a) non-traumatic bereavement versus (b) traumatic bereavement?

CATEGORIZATION OF DIS0RDERS BY RESEARCHERS

There is general consensus among researchers and clinicians about the existence of psychological complications resulting from bereavement. However, there are differences between researchers with respect to the types of complications that they have identified and with respect to the placement of complicated grief—if at all—within a diagnostic system such as the DSM. Next we examine how researchers have categorized normal and complicated grief, and how they have related these phenomena to normal stress response syndromes, PTSD and other disorders. The framework of Figure 1 can be adapted to systematize the various positions taken (see Figure 2).

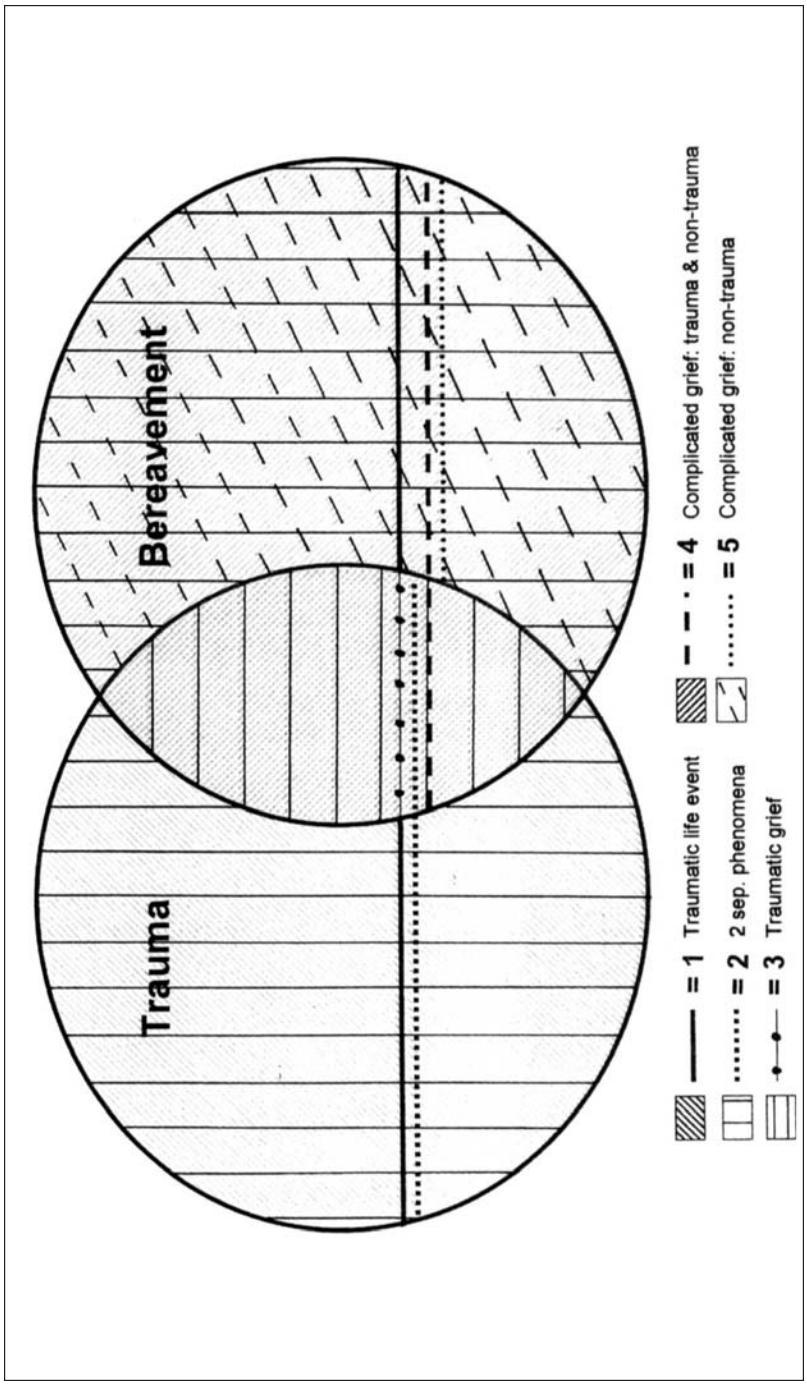

Figure 2. Conceptualizations of complicated grief.

1. Bereavement is a Traumatic Life Event

This position represents the whole left-hand orb in Figure 2. It basically views bereavement as falling within the general category of traumatic life events, for which the existing diagnostic system would offer adequate classification for cases of complication. Simpson (1997) and Figley, Bride, and Mazza (1997) are major proponents of this view. They consider both non-traumatic and traumatic bereavements to be traumas, which should be analyzed within the framework of trauma theory. The emphasis here is, then, on common phenomenology and manifestations following a bereavement or other types of trauma.

Not surprisingly, proponents of this position argue that complicated grief should be incorporated within the DSM classification system's diagnostic category of PTSD.

2. Bereavement and Trauma are Two Separate Phenomena

Some investigators have found it useful to focus on the phenomena associated with trauma and with bereavement as two separate sets of phenomena (they focus on the two separate portions rather than the overlapping portion in Figure 2). This is not to say that bereavement could never lead to post traumatic stress reactions, but rather that the manifestations and phenomena associated with trauma and bereavement need separate consideration. In Raphael's (1997) words, "two different reactive processes occur" (p. 31). Raphael and Martinek (Raphael, 1997; Raphael & Martinek, 1997), for example, describe these phenomena in terms of specific, frequently contrasting core reactions (e.g., affective reactions, avoidance phenomena, reactive processes including facial expressions). They argue that the phenomena differ in important ways. In terms of pathology, they argue that trauma leads to traumatic stress reaction and perhaps the development of PTSD, while bereavement leads to grief and perhaps chronic grief disorder. The two different sets of phenomena interact in traumatic bereavement. The survivor would be expected to experience both types of reactions, either together or alternately. Raphael and Martinek (1997) postulate some interference between the two types of reaction (e.g., comforting memories may be disturbed by recollection of disfigurement at death).

Pynoos and Nader (1988) provided supportive evidence for this approach. They conducted a study among school children who had experienced a sniper attack. Differences in grief and traumatic reactions were identified. They found that severity of exposure was associated with PTSD symptoms, while emotional closeness to a child who had been killed predicted grief reactions. Thus, even though the two types of symptoms interact to increase intensity in traumatic bereavement, it seems fair to say that bereavement (grief) and trauma (trauma reactions) are understood by these investigators to be different human experiences, even when precipitated by a single event (see also Eth & Pynoos, 1985), with

different associated pathologies, namely, PTSD and complicated grief. Thus, these teams of investigators would not argue for the creation of a new, separate category of complicated grief for traumatically occurring bereavements.

3. Traumatic Grief: Bereavement and Trauma Intersect

Some investigators have focused on the intersection of trauma and bereavement—thus, the overlapping portion in the center of Figure 2—for which, they argue, a distinct diagnostic category of "traumatic grief" needs to be created. Rando (2000) described traumatic bereavement as "one variation of complicated mourning," contending that any differences between uncomplicated acute grief and traumatic stress response are primarily in content and degree, and not necessarily in underlying, dynamic processes. Similarly, Green (2000) argued for more exploration of the overlap in trauma and bereavement, noting that, ". . . while there are clearly some differences in reactions to bereavement and trauma, and the process of recovery from them, the two areas may not be as distinct as we have been treating them" (p. 14). Green (2000) suggested that concentration should be focused on "unnatural" or traumatic death, to provide both conceptual and empirical links between the fields. Following this line of argument, pathology would be associated with the mode of death that makes a bereavement more or less traumatic. Complications within the sphere of non-traumatic bereavement are clearly not the focus here.

4. Complicated Grief Incorporates Non-Traumatic and Traumatic Bereavements

By contrast, some investigators have included the range of non-traumatic as well as traumatic bereavement experiences in developing their frameworks for complicated grief, thus, the whole of the right hand orb in Figure 2. The work of two major teams of researchers, Prigerson and colleagues (e.g., Lichtenthal, Cruess, & Prigerson, 2004; Prigerson & Jacobs, 2001; see Prigerson & Maciejewski, this issue) and Horowitz and colleagues (e.g. Horowitz, this issue; Horowitz, Bonanno, & Holen, 1993; Horowitz et al., 1997), falls within this approach. Given the centrality of these analyses for current concerns, we describe them next in somewhat more detail.

Both of these teams have developed criteria for the potential designation of complicated grief as a mental disorder for inclusion in DSM-V (for a comparison of the two sets of criteria, see Jacobs, 1999). According to this general approach, complicated (or "traumatic") grief is a function of the intensity and symptomatology of distress. For example, Jacobs (1993) made the case that ". . . it is possible to conceptualize trauma and loss as separate experiences and distinct processes . . . each experience is distinctive and potentially leads to a unique type of clinical complication," but went on to add: "However, in some ways, loss and trauma resemble each other. . . . These similarities establish common ground

for both loss and trauma that argues for their inclusion together as stress-related disorders" (p. 356). Developing this line of argument more recently, Prigerson and Jacobs (2001; Prigerson, this issue) have made a strong case for the establishment of a distinct clinical entity of CG, one that is separate from PTSD and other disorders. As such, CG would be a unified syndrome distinct from bereavement-related depression and anxiety and distinct too from normal reactions to bereavement. CG is not claimed to be specific to traumatic bereavement, the relevant criterion being that the person has "experienced the death of a significant other." As described by Prigerson and Jacobs (2001), symptoms are understood to fall into two categories, separation distress (relating to missing the deceased person) and traumatic distress (feelings of shock, dissociation, etc.). Prigerson and Jacobs (2001, see also Prigerson, this issue) argue that there is unity among these two types of CG symptoms and conclude that a single category is appropriate. Following our own conceptual framework, there would be good reason to argue that these so-called "dual elements" (Prigerson & Jacobs, 2001) could be separately defined in relationship to (a) traumatic bereavement experience (traumatic distress) and (b) non-traumatic bereavement experience (separation distress).

Similarly to Prigerson and Jacobs (2001), Horowitz et al. (1997; see also Horowitz, this issue; Horowitz et al., 1993) included non-traumatic and traumatic bereavement in their formulation, defining the experience for inclusion as "Bereavement (the loss of a spouse, other relative, or intimate partner)," and not separating the types of complication that might be associated more particularly with traumatic types of bereavement on the one hand, from non-traumatic types on the other. In contrast to Prigerson and Jacobs (2001), however, diagnostic criteria consisted of intrusive and avoidant symptomatology specifically about the relationship with the deceased person (see the other entries in this special issue for further consideration of these contrasting sets of criteria). Given these criteria and the other parameters described above, it is not clear why Horowitz and colleagues propose a new category of CG, rather than an extension of PTSD event criteria.

5. Complicated Grief in Non-Traumatic Bereavements

An independent consideration of complications associated with non-traumatic bereavement has been conspicuously absent in recent years. This approach would include only the right portion of the right-hand orb in Figure 2, rather than, as above, joining this with traumatic bereavement. As such, it would focus on the possibility that complications in the grieving process can occur in the absence of a traumatic bereavement experience.

Earlier analyses paid great attention to possible complications of this nature. Following the work of Parkes and Weiss (1983) and Raphael (1983), a previous categorization of pathological forms of grief by Jacobs (1993) developed criteria for different types of complications, namely, delayed/absent, inhibited/distorted,

and chronic grief. Although this approach was superceded by his creation with Prigerson of their CG category, Jacobs (1999) still acknowledged the possibility that the former categorization system may be important: He argued that these may reappear as subtypes of traumatic (i.e. complicated) grief following further investigation. We return to this issue below.

There is evident similarity between this position and position 2 above (which considers trauma and bereavement complications as two separate diagnostic categories). However, researchers here have tended to focus exclusively on the phenomena and manifestations of complicated grief that are unique to "normal" bereavement experiences. In other words, they examine how grief may run a complicated course even in the absence of traumatic circumstances. Sometimes they identify predispositional factors that my underlie complicated forms of grief (see, e.g., Parkes & Weiss, 1983; Raphael, Minkov, & Dobson, 2001). In particular too, they seek to identify subtypes of complications in grieving, such as those mentioned above.

CONCLUSIONS

Prigerson and Jacobs (2001) claimed that there is consensus about the symptoms to be proposed for complicated grief by diverse psychiatric researchers and experienced clinicians, leading to ". . . a general agreement about the type of symptoms that a disorder of grief would comprise" (p. 616). They suggest that a clinical profile displaying many common features among the "agreed on" symptoms emerges from this general agreement. By contrast, our analysis above suggests considerable diversity and potential for disagreement. As we have seen, researchers can be divided into proponents of five different positions. These have delineated and defined complications associated with bereavement in different ways. Different implications associated with each of these positions emerge with respect to the categorization of complicated grief as a mental disorder. To summarize the five implications for diagnostic categorization:

1. CG should be incorporated within the DSM classification system's diagnostic category PTSD.
2. Two separate categories are needed, PTSD (for traumatic bereavement) and CG (for non-traumatic bereavement).
3. A new category of "traumatic grief" (specifically for disordered grieving following a traumatic bereavement) should be developed.
4. A new category of CG covering non-traumatic and traumatic bereavement experiences is called for.
5. Complicated grief is an entity separate from trauma, following non-traumatic bereavement: CG alone should be the focus and concern in developing a new category.

We noted the placement of both the Prigerson and Horowitz teams within the fourth position above. Despite strong arguments by these investigators for the need to create a new category and in terms of their own criteria/typologies of symptoms, the question arises whether this is the only or the best approach.

Consider two alternatives: Is there not a strong—but currently neglected—case to be made for a focus on complicated grief exclusive to trauma manifestations (i.e., position 5) or for complicated grief following non-traumatic bereavements to be considered separately from complicated reactions to traumatic bereavement (i.e., position 2; position 3)? Prigerson and Maciejewski (this issue) argue that separation distress and traumatic distress symptoms form a unidimensional construct. Nevertheless, by mingling the two (position 4) sensitivity to different types of complicated reactions (due to intensity of the trauma, on the one hand, and problems to do with the lost relationship, on the other) may be lost. In line with this "separationist" argument, Raphael et al. (1993) have emphasized that, in cases of complicated reactions to a traumatic bereavement, PTSD symptoms will need to be dealt with (in intervention) before aspects to do with grief can be attended to.

Furthermore, we noted three potential subtypes of complicated grief, including chronic, delayed and inhibited grief. Prigerson and Jacobs (2001) acknowledged the similarity of their own CG syndrome (albeit including the traumatic distress component) to that of chronic grief. They noted an omission from their diagnostic category of subtypes such as delayed or inhibited grief. Yet, these subtypes of grief make considerable theoretical and clinical sense (cf. Stroebe, Schut, & Stroebe, 2005) and would seem to merit inclusion. Taken together, there seems good reason to argue the case for complicated grief (position 2) to be considered separately from traumatic grief (position 3). Of course, in cases of traumatic bereavements, both reactions could be present. It is evident too, that we have divided sharply between the two, whereas in reality, the boundaries will not be so clear-cut. Nevertheless, we believe that the division is important to make and that it is well-founded in theory. Traumatic reactions have to do with the intensity of the life event (following stress theory) while bereavement reactions have to do with the nature of the relationship with the deceased person (attachment theory).

Turning from diagnostic criteria to the more general concern about inclusion of complicated grief in a diagnostic system of mental disorders: We have expressed our concerns about this in detail elsewhere (Stroebe, van Son, Stroebe, Kleber, Schut, & van den Bout, 2000). We still hold these views, which we will not repeat here. However, a couple of issues need to be addressed. Prigerson and Maciejewski (this issue) counter-argue one of the main points we made about "pathologization," namely, the concern that, by creating a new diagnostic category, the death of a loved one will be placed in the realm of psychopathologies (also cf. Walter, this issue). This should not be termed the "stigmatization strawman," as Prigerson and Maciejewski (this issue) put it, but a real concern.

Prigerson and Maciejewski argued partly on the basis of bereaved respondents' reactions to a question about receiving the diagnosis of disordered grief. Practically all of the respondents said that this would be a relief and a help if they knew they met criteria for CG. However, there is much more to this issue. For example, Prigerson and Maciejewski (this issue) could as well note the very real concern about potential withdrawal of the family when diagnosis and treatment for CG take place (cf. Stroebe et al., 2000). In one study, the role of the social network was shown to decrease during and after grief counseling, compared to a non-intervention control group (de Keijser, 1997). Furthermore, respondents may not have CG, and it may be as important to accept that "normal" grief includes severe suffering which, unless there is complication, cannot be accelerated or alleviated (cf. Stroebe, Schut, & Stroebe, 2005; Walter, this issue).

There are other reasons why inclusion of CG within a system such as the DSM needs very careful consideration. For example, as noted earlier, bereavement is different from trauma in terms of the (un)naturalness of the two life events. Bereavement is a normal life event with—sometimes—complicated reactions. Arguments that PTSD is in DSM, therefore CG should be, seem somewhat dubious. It is worth considering whether bereavement could not be accommodated within PTSD (for traumatic bereavement reactions) and an adapted bereavement-inclusive category of Adjustment Disorder (for complicated grief reactions) (i.e., position 2). Prigerson and Jacobs (2001) rejected this possibility, but without considering an adapted AD category: they simply pointed out that CG cannot by definition and criteria be included within the present category AD. Alongside AD categorization, related disorders would need to be considered for co-morbidity.[3] Prigerson and Maciejewski (this issue) are zealous in arguing the need for a new category of CG as a mental disorder. Their reasons for urgency are well-taken: obviously, one wants to develop ways to promote well-being among the significant minority of bereaved persons who suffer complications following bereavement. Nevertheless, there are a number of concerns that need continued discussion, and there are alternatives to the categorization system developed by Prigerson and colleagues that need further consideration.

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[3] A possible alternative to AD in the placement of CG would be under an extension of the new DSM-IV (APA, 1994) category "Reactive attachment disorder" (RA) which currently applies to infancy and early childhood. The subtypes of RA, so-called inhibited and disinhibited types, are not hard to relate to disturbances in adult attachment patterns, ones that—one might assume—would lead to complications when an attachment figure dies. Furthermore, DSM-IV affirms that the disorder may follow a continuous course (i.e., into adulthood) if the environment is not appropriately supportive.

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