21 Complicated grief

Assessment of scientific knowledge and implications for research and practice

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Our objective in compiling this edited volume has been to provide an up-to-date, state-of-the-art account of scientific research on complicated grief (CG), one that is hoped to be useful for researchers, practitioners, and policy makers alike. We have included diverse contributions, representing contemporary research and thinking from a variety of disciplines and perspectives. Scientific and societal issues have been addressed throughout, and it will have become evident that our authors have at times come to different conclusions on fundamental issues. In this concluding chapter, we reflect on the research presented in this volume, to summarize developments, highlight implications, and indicate current understanding – as well as gaps in our knowledge – regarding CG. We try to draw together the different lines of argument, so that readers can form their own conclusions about scientific knowledge on CG and associated implications for research, practice, and policy.

We order discussion mainly according to the themes of each part of the volume, given that these reflect our chosen scope. We cover a range of general issues suggested by the contributions, and we highlight topics which merit further scientific attention.

The nature of complicated grief

A fundamental question that we wanted to explore in compiling this volume was: *What is CG?* Is it a specific disorder or an overarching term for several different disorders? Can we describe its defining features/symptoms? Although there appears to be quite some similarity between authors' conceptualizations, what has emerged is that there is still a lack of a well-accepted, standard definition for CG or agreement on a set of diagnostic criteria (if it is to be considered a mental disorder). There does seem to be considerable – at least implicit – agreement that CG denotes a *syndrome*, that is, a pathological condition, one that merits the attention of health care professionals. In this section, we focus on the concept of CG per se; in the next, we discuss the related issue of CG as a mental disorder.

CG definition

Some authors have basically followed the lead of Prigerson and her colleagues, conceptualizing CG as one specific disorder, prolonged grief disorder (PGD), using the scale of assessment and criteria derived from her extensive body of research, both of which have evolved over time. Others have criticized this approach as being too narrow, potentially leaving out subtypes of CG (we return to this below). Boelen, van den Hout, and van den Bout, following PGD, define CG as:

> a clinical condition that encompasses specific grief reactions (including separation distress, difficulties accepting the loss, and moving on without the lost person) that cause significant distress and disability at least 6 months after the death occurred. Symptoms of PGD are distinct from normal grief, bereavement-related depression, posttraumatic stress disorder (PTSD), and other anxiety symptoms and syndromes, and, if left untreated, associated with significant impairments in health and quality of life. (Chapter 16)

Others adopt definitions along the lines of the definition set out in Chapter 1:

> a clinically-significant deviation from the (cultural) norm (i.e., that could be expected to pertain, according to the extremity of the particular bereavement event) in either (a) the time course or intensity of specific or general symptoms of grief and/or (b) the level of impairment in social, occupational, or other important areas of functioning. (Stroebe, Hansson, Schut, & Stroebe, 2008, p. 7)

Boerner and colleagues add further specifications to this latter definition, incorporating avoidance processes, self-redefinition problems, and difficulties forming new relationships. Rando has perhaps the broadest definition, covering four types of CG presentations: symptoms, syndromes, diagnosable mental or physical disorders, and death.

Hopefully, as researchers continue to work toward further conceptual clarity, a robust definition (and operationalization) and possibly typologies/subtypes of CG will emerge.

Normal versus CG

To increase understanding of CG, it has sometimes been considered in relation to normal grief (NG; some prefer to label this uncomplicated grief). For example, Dyregrov and Dyregrov discuss patterns of NG and CG in children (noting that this distinction is actually much more difficult to make for children). Three defined features that were mentioned above to characterize CG are deviations/differences (from NG) (1) in intensity, (2) in quality, and (3) in duration. These have been subject to critical scrutiny in this volume; we consider each of the three next.

Questions about intensity relate to whether CG is simply a higher (or even lower) level of symptoms or a distinct syndrome with different symptoms. Wakefield notes that some bereaved people have to deal with greater and deeper challenges than others, and that this does not make an intense response automatically into CG. Along similar lines, Rynearson, Schut, and Stroebe argue that, even if higher scores on a CG scale represent greater impairment (indicated on a continuous measure of intensity of grief symptoms), this does not constitute a classificatory diagnosis of CG. The question then is: What is classificatory CG? Again, different aspects have been considered, relating to intensity. O'Connor, from a physiological perspective, writes that it is still unknown whether CG represents merely acute grief in a bereaved person whose process of adaptation has been interrupted, or a wholly other process than non-complicated adaptation. She mentions in conclusion that most affective disorders are better described on a continuum than as discrete categories and that CG may well turn out to be similar in this regard. The physiological perspective may have potential to answer this question, but O'Connor cautions that we should not expect a one-to-one correspondence between any particular physiological or neurobiological marker and CG. However, "by measuring these markers, we may see what contributes to poor adaptation or what the physiological predictors of CG are" (Chapter 15).

If CG phenomena/symptoms are qualitatively different from NG this would lend plausibility to the claim that CG symptoms are "pathognomonic for a disorder with a distinct etiology" (Chapter 8). Wakefield points to statements of other researchers that support this view but argues that most have failed to find distinct symptomatology. So Wakefield, although not denying that some grief disorders might exist, queries whether CG has distinctive, pathognomonic symptoms separating it from normal grief; there is according to him little support for a categorical conceptualization of NG and PGD. According to Burke and Neimeyer, contemporary research suggests that grief can be evaluated on a continuum ranging from low-level normative grief to a severe grief disorder, but these authors cautioned that lack of a genuine cut-off point, at which grief responses are considered in need of treatment, necessitates the use of personal or consensual judgments about a given griever's level of impairment and distress. Equally, viewing NG and CG as symptomatically different is associated with difficulties too. For example, Burke and Neimeyer argue that, if some individuals grieve in a diagnosably disordered manner (i.e., with different symptomatology from NG), there is potential for them to be socially and personally stigmatized.

Is CG distinguished from NG by incorporating a longer duration of basically normal symptoms? Wakefield argues that interminability (at 6 or 12 months) is not a valid criterion for CG, describing it as a scientific myth. He cites Bowlby, making the point that NG is of much longer duration than is generally acknowledged and arguing that to forget this warning pathologizes normal grief. By contrast, Boerner and colleagues identify two trajectories indicative of CG, namely their so-called chronic post-loss distress and chronic pre- and post-loss distress trajectories, which they contrasted with uncomplicated patterns described as resilient and improved trajectories.

It becomes clear from our chapters that understanding of the role of intensity, quality, and duration of symptoms in CG can (and needs to) be deepened in future research and that different disciplines, from philosophers to neurophysiologists to (cultural) psychologists, have a part to play in this endeavor.

Subtypes/variety of CG patterns

A lot of discussion has surrounded the issue of whether there are subtypes of CG, and what form(s) these might take. We noted that the PGD/CG approach of Prigerson and colleagues has sometimes been considered too narrow (e.g., by some clinicians, as noted by Rando). In the context of considering subtypes of CG, Boelen and Prigerson's statement deserves consideration: "criteria . . . should cover the many different forms the clinical picture of PGD/CG may take" (Chapter 7). Thus it becomes evident that this team of researchers acknowledges variety, if not explicitly subtypes. CG can comprise different combinations of symptoms, leaving room for the identification of subtypes (although it is more difficult to see how absent grief could be included within the PGD framework).

Furthermore, many researchers have identified subtypes of NG and CG. For example, attachment theory describes insecurities of attachment that mirror onto subtypes of CG. Interestingly, these subtypes were described long before attachment theory came to have such an influence on the bereavement research field. Mikulincer and Shaver describe how attachment insecurities are involved in complicated patterns of grief. Dyregrov and Dyregrov mention subtypes of CG among children, based on Bowlby's classification, but note the lack of recognition of trauma, a subtype that they add. Likewise for adults, Raphael, Jacobs, and Looi identify traumatic grief as the coexistence of grief and trauma phenomena, and the different reactive phenomena that may follow these different stressor experiences. Bonanno and colleagues built up a research program to investigate types of grieving in a fine-grained manner, and distinguish chronic grief from chronic depression. In addition to describing different CG trajectories, Boerner and colleagues take understanding beyond the one pattern of NG (previously understood as moving from a period of distress to recovery). Exceptions to that pattern used to be considered CG, but these investigators showed how other patterns can also be uncomplicated, notably a pattern that resembled resilience.

One of the most debated issues in subtypes concerns absent/delayed/inhibited grief. Most consider it to be a CG phenomenon, but others have emphasized that such absence need not always represent CG. Some research teams have reported little empirical confirmation of this subtype of CG, particularly the team of Boerner and colleagues – who actually nevertheless acknowledge the existence of a subtype of delayed/absent grief (they also stress that exhibiting hardly any grief reactions can be a form of NG). Mikulincer and Shaver make a strong theoretically based case for two subtypes of CG, including absent grief, based on Bowlby's attachment theory analysis: Whereas attachment anxiety is said to underlie chronic mourning, attachment-related avoidance contributes to the absence of grief. There is acknowledgement that apparent absence of grief may reflect a real absence of

distress. This used to be difficult to distinguish from CG but Mikulincer and Shaver report their sophisticated experiments, which have supported this distinction well. Furthermore, they provide empirical evidence linking attachment insecurities to CG. Their conclusion was unequivocal: "Overall, these findings emphasize that researchers should take seriously Bowlby's (1980) cautions about assessing grief responses among avoidant people, because 'in all studies except those using the most sophisticated of methods, it is easy to overlook such people and to group them with those whose mourning is progressing in a genuinely favorable way'" (Chapter 14, quoting Bowlby, 1980, p. 211). Dyregrov and Dyregrov discuss the phenomenon of postponed grief in children, an aspect that may be rather special among children, being related to the fact that they lack emotional tolerance. These authors suggest that children attempt to regulate their grief in tolerable doses and use more avoidance than adults.

In sum, there is a need for scientists to come to agreement on the existence of various subtypes of CG and to develop methods of assessment that could better identify and map these (particularly, absent grief).

Subgroup differences in CG

Clearly, one size does not fit all. Throughout the book it has become evident that there are variations in manifestations and phenomenology, and in appropriate assessment for and treatment of CG across different groups of bereaved people. Perhaps most strikingly, this is true for different cultures, as Rosenblatt's chapter has made amply clear, as in the opening sentence of Chapter 3: "Psychiatric diagnostic categories and psychiatric standards for what is normal and healthy and what is not are saturated with the standards of Western culture." Rosenblatt has raised questions about the possibility of a universal definition of CG. Although separation distress is recognized by many as a universal emotional response, following Rosenblatt's line of reasoning, since there are no universal manifestations of grief, there cannot be a universal definition of CG. So should CG usage/exploration be restricted to Euro-American cultures? This would seem a deplorable state of affairs, not least because of the pluralistic nature of society in the twenty-first century. Scientific investigation should strive for culturally appropriate understanding of CG; extension is needed to incorporate a worldwide perspective. This point extends to treatment issues. For example, as Kissane points out, the application of family therapy will require different approaches in countries where family traditions are strong and decision making family centered. Finally and importantly, Rosenblatt's cultural perspective makes one aware that we cannot consider scientific research on CG in a vacuum. For example, we need to be aware that psychological treatment sometimes takes place in the context of economic, political, or environmental turmoils.

The chapters selected to cover two within-culture subgroups, bereavement of children and adolescents and that following violent death, serve to illustrate the uniqueness of CG in different subgroups. For example, children form more misinterpretations than adults, as they lack life experience and direct access to

information about what happened. It seems highly plausible, especially in the light of the research on adults by Boelen and colleagues, that misinterpretations would be closely linked with high risk of CG. This needs further investigation in children. It remains of concern too that children are not mentioned in the proposals for a new grief disorder.

Evidently, there is considerable room for expansion of research with regard to understanding CG within specific subgroups of bereaved people.

Prevalence of CG

Given the difficulties in defining CG, distinguishing it from NG, demarking different subtypes and establishing patterns of similarities across subgroups, it is understandably difficult to talk about prevalence of CG in any simple terms. Yet, with some consistency, it has been reported that CG occurs in only a significant minority of individuals. Reported prevalences vary considerably (because of differences in types of loss, sample characteristics, criteria for assessment, etc.). Not surprisingly perhaps, the percentage of psychiatric outpatients who meet criteria for CG is higher than for the bereaved in general (Chapter 19). Indications are that those bereaved following a violent death have still higher prevalences of CG (Chapter 20), but more studies are needed (much more research following this type of death has been on PTSD). Unresolved is the issue whether these higher prevalences are to be conceptualized as reflecting intense, lengthy NG or really indicating CG (and detailing still unspecified forms of CG). Suggestions are that, for other specific subgroups too, prevalence is likely to be much higher, but in general there is reasonable consistency between the research on the prevalence of CG and that on resilience. Boerner and colleagues report that most bereaved persons are resilient. Most suffer from normal grief and some have consistent minimal distress.

In our view, one must be extremely cautious in making statements about the prevalence of CG, or in generalizing from any one set of prevalence figures – which are frequently presented in terms of simple percentages – to other samples or populations, particularly in view of the lack of agreement on precisely how to define and/or operationalize CG.

Different conceptual/theoretical approaches

Different theories and models have been employed in this volume to understand the phenomena and manifestations of grief and grieving, and to guide clinical treatment and various sorts of intervention.

One of the most frequently cited theories for understanding phenomena and for guiding intervention for CG is attachment theory. It figures prominently in diverse chapters, not surprisingly, given that it is a theory of interpersonal relationships and that bereavement involves the loss of a close relationship. Mikulincer and Shaver describe the relevance of this theory's basic postulates, relating it specifically to CG. In particular, they demonstrate how theory can be embedded in empirical research, making use of all kinds of methodologies and paradigms.

This theory is also drawn on by Dyregrov and Dyregrov for understanding CG in children. Raphael and colleagues link CG to disruption of the attachment to the deceased, suggesting an ongoing, complicated attachment of the bereaved to the deceased person. The stressor is regarded as being the disruption of the attachment, its loss. O'Connor draws on attachment theory too, emphasizing the role of the attachment figure in physiological as well as psychological regulation. She describes the attachment-specific stress response involving physiological systems when separated from the attachment figure, relating these reactions specifically to CG. Kissane and colleagues draw on this theory to frame their family therapy perspective.

Cognitive (stress) approaches of various sorts also figure prominently. These range from more general ones such as Boelen and colleagues' theoretical basis and specific model following CBT principles for CG (treatment), to identification of specific cognitive processes, such as Watkins and Moulds's focus on repetitive thought (RT). Other approaches within this category that have provided frameworks for understanding CG include meaning construction (e.g., Kissane et al.) and the narrative (e.g., Rynearson et al.) perspective. Stress theories have been employed at different levels and for various purposes, including traumatic stress theory (Raphael et al.) and general stress response theory (O'Connor).

Contrasting with the cultural perspective of Rosenblatt are psychiatric/medical model approaches (e.g., Raphael et al.) and physiological/neurological/biological/genetic ones (e.g., O'Connor; Cooper). To illustrate, in the latter category, O'Connor points out that underlying aspects of the body's stress response show promise in distinguishing CG from non-CG or CG from PTSD. Her work demonstrates that CG is a physiological as well as psychological reaction (and that different theories can be called on at the same time). She argues that this stress response may specifically include CG symptoms. If these symptoms are mediated by attachment, she reasons, then understanding the physiology and neurobiology of attachment will assist in treating the CG response to bereavement. Such lines of research are still in their infancy; much needs further exploration, including answers to questions such as: What genetic vulnerabilities constitute a risk of CG after bereavement (see O'Connor)? Is CG a biological dysfunction (see Cooper)?

It will have become evident that some investigators employ more than one theoretical approach and that the CG field in general is characterized by diversity in theoretical approaches. Indeed, a continuation of theoretical pluralism may be helpful or even essential in the coming years, given the complexity of the nature of CG, as already indicated.

CG as a disorder and diagnostic categorization

Another fundamental question in this volume has been whether or not CG should become a formal mental disorder in the DSM. What are the arguments for and against this? Many disciplines, from philosophical to psychiatric ones, contribute to this debate. The issue is particularly topical now, given that – as we go to press – CG is a candidate for inclusion in the new edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* (DSM-5).

Definition of CG as a mental disorder

Some authors have reflected on the concept of mental disorder in general, in their efforts to consider CG as such a category. Providing a general perspective, Cooper raises issues from her philosophical perspective: What is a (mental) disorder? What is a dysfunction? She presents different viewpoints: on the one hand the key question is not whether CG is a mental disorder, but whether it can helpfully be treated by health care professionals; on the other hand, she also maintains that CG could plausibly be considered a disorder, which was in line with her general conclusion.

Psychiatric accounts are naturally linked with the DSM system. DSM-IV defines a mental disorder as a

> clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (APA, 1994, p. xxi)

Boelen and Prigerson basically follow the DSM definition of diagnostic disorder, basing their conclusions (that empirically based PGD can be defined as a formal disorder) on five taxonomic principles for establishing the validity of a mental disorder; they argue that these criteria are met and that it should therefore go into DSM. Wakefield, however, basing his arguments on the same taxonomic principles, presents other lines of reasoning (e.g., that DSM presents impairment as a necessary condition for disorder, not one that is sufficient by itself) and concludes that PGD cannot be seen as a mental disorder in terms of DSM. However, he argues that some form(s) of complicated grief exists, remarking that, since any biological response can malfunction, it is plausible that some grief disorders exist. However, in his view, these other potential grief disorders have not yet been detected.

We return to the above debate in the following section, but here we would like to stress that, although our authors are in substantial agreement about the existence of CG as a mental disorder, it must be kept in mind that most bereaved people do not suffer from it. Even though acute grief is extremely painful and debilitating, it usually does not need clinical intervention.

Current DSM status: criteria and problems

Currently, there is lack of agreement on criteria for CG inclusion in the DSM-5 system. Boelen and Prigerson include the three different sets of criteria that have been proposed, namely, for PGD, CG, and bereavement related disorder, in their Table 7.1. A lot of discussion continues, as reflected in the pages of our volume.

Empirical validation of the different systems is a major concern, with Boelen and Prigerson pointing to the extensive research basis for PGD/CG, but also recognizing the need for further study (e.g., search for diagnostic algorithms that

best distinguish those who are at risk from those who are not; examination across heterogeneous groups of bereaved). Strong voices of dissent about PGD are also heard. For example, Rando rejects a category based on PGD alone, regarding it as a subtype in an overarching category.

A major issue is still whether or not CG should go into DSM at all. Boelen and Prigerson argue that PGD meets the definition of a mental/psychiatric disorder and should therefore be included in DSM system. Others support this position, arguing along the lines that, if other disorders such as PTSD are in the DSM system, why should CG not be (see van den Bout & Kleber)? Cooper's conclusion is not so unequivocal (there are arguments on both sides about considering it a diagnostic category). Wakefield's title makes his position clear: The proposal to add a category of CG to DSM is conceptually and empirically unsound, despite the fact that he regards it as being one of the most thoroughly studied proposals in DSM history. In his view, the proposed diagnostic criteria identify conditions that are not due to psychiatric dysfunctions, but are instances of lengthy, intense normal grieving. Nevertheless, he is respectful of the research efforts of the Prigerson group (and others), which he acknowledges as having added substantially to understanding symptoms and trajectories of grief and grieving.

Other issues concern specific, highly important details, for example the three sets of criteria cover different durations of bereavement (the APA DSM-5 workgroup suggests 12 months; others 6 months' duration at least). PGD/CG criteria have also changed over the past couple of decades (e.g., differing symptoms) as investigators have striven to standardize these (making comparison of results of studies across time difficult). Some problems about CG as a potential new category of mental disorder apply to other established psychiatric disorders too (see Boelen & Prigerson), and others point to unique difficulties. For example, Wakefield criticizes the DSM-5 workgroup's label *bereavement related disorder* on the grounds that it is insufficiently specific (many disorders other than disordered grief itself can be related to bereavement), arguing for the use of the label CG (but he still points to difficulties distinguishing it from normal grief). Wakefield also argues for "far more stringent diagnostic criteria than those proposed, if massive false positive diagnoses are to be avoided" (Chapter 8).

Again, subgroup differences are an issue in the context of DSM inclusion. For example, Dyregrov and Dyregrov point out that DSM would need to reflect the uniqueness of children's grief and that an adult diagnosis should not be used inappropriately for children. In particular, this relates to the fact that children have immature systems for emotional and cognitive regulation, and that they are dependent on adults who may also be grieving (p. 13). Likewise, cultural background needs to be taken into consideration when reflecting whether the (mental health) language of DSM and the proposed criteria are applicable (see Rosenblatt). As Rosenblatt illustrates, assumptions across cultures differ. What we consider deviant may not be so in a different culture; CG as we see it may not even be considered a complication. Boelen and Prigerson argue for testing in heterogeneous groups, supporting a global grounding for PGD/CG, but is DSM (and are the proposed criteria) sensitive enough to the full range of cultural differences?

As this volume goes to press, it remains uncertain whether – or, if so, according

to what criteria – CG (or another label) will go into DSM-5. On the one hand, there are convincing arguments that this should take place; on the other hand, there are equally good reasons for caution, which leads us to our next point.

(Dis)advantages of the diagnostic category of CG

What are the (dis)advantages of including CG as a category of mental disorder in the DSM system? Again, there has been much debate but a short overview must suffice here. Boelen and Prigerson consider benefits and harms, and van den Bout and Kleber look to the lessons to be derived from the inclusion of PTSD in DSM. Advantages include the facilitation of empirical research and recognition of suffering of a significant minority of bereaved having difficulties in their process of recovery. Boelen and Prigerson argue that it would imply not medicalization of something normal but a normalization of something that mostly is not but sometimes is indeed pathological. Clients with CG would receive needed treatment more easily (see van den Bout & Kleber). On the negative side, Wakefield warns against pathologizing normal grief, using a case study to argue that diagnosis and treatment may not be the best option in every case and could even "'derail' such individuals from the hard work they need to do to change their circumstances and themselves to create a new life" (Chapter 8). However, others have noted that a DSM disorder provides the possibility, but not the requirement, to start treatment.

There is need for careful weighing up of the pros and cons of CG entering DSM-5 as a category of mental disorder. Proponents should not sweep disadvantages under the carpet; opponents need to realize the consequences of exclusion of such a category for bereaved persons who suffer from CG symptomatology.

CG and other disorders

Various issues relating to CG in the context of other disorders have been raised. First, is CG a distinct disorder or variant of some other condition? Many perspectives have contributed to our understanding of this issue (e.g., Rando from a clinical orientation, as a major issue in her chapter; Cooper from a philosophical one). Cooper argued that multiple answers to this question might be justified: For some purposes it is helpful to consider complicated grief alongside other conditions; for others it might best be considered separately. Empirical studies have added much to this debate; for example, Raphael and colleagues point out that recent research has confirmed that CG, depression, and PTSD are separate syndromes. Again, O'Connor points to the potential of including neurobiological and physiological markers in study designs, as these markers can sometimes be used to discriminate between disorders such as depression and CG, or PTSD and CG, "even when a clinical gestalt may be murky" (Chapter 15). Rather differently, an important distinction Boerner and colleagues make is between chronic grief (post-loss onset) and chronic depression (pre-loss onset), raising the questions: Should there be two distinct categories of disorder, or is bereavement only an exacerbating factor for the chronic depressive group?

A related matter concerns CG in the context of (i.e., parallel to) other conditions/disorders. Our authors confirm what has become well established in the scientific literature: that there is a range of health consequences associated with bereavement, of which, in most researchers' minds, CG is one (with the exception of Rando, who considers other consequences such as physical illness and mortality as types of presentation of CG). Authors attest to a range of consequences including but not limited to mental and physical health debilities/disorders and social dysfunctions. Among children and adolescents, for example, as reviewed by Dyregrov and Dyregrov, there are both short- and long-term consequences, ranging from increasing mental health problems, decline in school performance, social withdrawal, and behavioral problems to somatic complaints. A minority experience more severe problems, even mortality and increased risk of depression in adulthood. Finally, adding to the already complex picture, some investigators, including Burke and Neimeyer, view CG as a risk factor for other psychological and physical health problems (cardiovascular illness, substance abuse, depression, anxiety, and overall life disruption).

Not surprisingly, given the range of consequences of bereavement, there is also comorbidity. For example, Raphael and colleagues focus on CG and PTSD in adults; Dyregrov and Dyregrov do so among children. Raphael and colleagues detail the reactions to the different stressors of loss and trauma, with different etiologies and different implications for management (among adults and children). They clearly separate the two, including a demarcation of the differing triggering events (see Tables 10.1 and 10.2: phenomena of posttraumatic reactions and bereavement, and other signs of each reactive process). They also provide empirical evidence to back up their analyses.

Taken together, these lines of research indicate that bereavement can exacerbate other mental disorders and that comorbidity with CG can pertain. One ongoing concern in this context is when and how to treat coexisting disorders. Another is the role of pharmacology in therapeutic management. For example, Raphael and colleagues note that, for CG and PTSD comorbidity, this remains to be established.

Risk factors, processes, and mechanisms

We have stressed that most people adjust to bereavement in the course of time, but that a minority experience CG. Research on risk factors, processes, and mechanisms underlying CG all help us understand differential vulnerabilities to CG between bereaved persons.

Risk factor research

Research on risk factors has much to offer in terms of scientific understanding of CG and its application. For one thing, it would seem important for health care professionals to know the characteristics and circumstances that may increase the likelihood of CG. Identification of some of these (not all) may enable health

care professionals to address some of the issues in the time prior to bereavement, as Boerner and colleagues point out, for example, to help find additional support when caregiving begins to be overwhelming; to guide severely distressed bereaved toward appropriate care services; and to make referrals to clinicians who can diagnose CG and provide intervention tailored to the individual's specific needs.

However, this is a difficult area of research, one that is "rife with complexity," in Burke and Neimeyer's words (Chapter 11). Rather than reviewing the full range of risk factors here (indeed, Burke and Neimeyer have done that extensively), it is perhaps useful to highlight these difficulties. These relate to many different aspects. There are multiple factors covering different types of risk, and there are also *protective* factors (e.g., Dyregrov and Dyregrov) and *resilient* characteristics (Boerner et al.). Just to illustrate the range: On the one hand, as Dyregrov and Dyregrov write about bereaved children, a good family climate will be protective whereas a negative family climate is associated with risks. Post-loss factors emerge as critical: If death leads to massive changes in the child's daily environment, the possibility of negative consequences increases; good parental or primary care capacity and discipline are protective. They point to the need to strengthen parental capacity (for intervention too). On the other hand, Kissane and colleagues describe a different type of risk factor: They identify families at risk versus those that are well functioning using a Family Relationships Index. So-called sullen and hostile families were found to be at high risk of complications.

Some variables are poorly defined. Moreover, variables frequently interact with each other to further increase risk. There are control group problems and issues to do with causality. Added to these are the facts that some factors are changeable/modifiable (and therefore psychotherapeutically relevant) whereas others are not; that there is a huge range within the general risk category, from mechanisms to protective variables; that some variables are not at all static (e.g., belief in an afterlife; bereavement is possibly a crisis time for that); or that there may be third factors operating, ones that have not been taken into account. Also, as Burke and Neimeyer point out, some factors may equally predict CG and other disorders and symptoms (depression, suicidality). Are there universal risk factors, or to what extent are they impacted by different cultural, economic, and political contexts (see Burke & Neimeyer; Rosenblatt)? Also, cross-sectional studies frequently form the basis for statements about risk factors for CG (no causality statements are then possible). Burke and Neimeyer point to the need to distinguish between correlates or consequences of CG and genuinely prospective predictors per se, and they identify potential and confirmed risk factors in their review.

An important issue touched on above concerns whether the risk factors are grief-specific or generic. To what extent are the risk factors identified by Burke and Neimeyer, such as social support, insecure attachment styles, or neuroticism, reflective of the general associations between these variables and ill-health, which they are known to have, or to what extent are they unique predictors among the bereaved, predicting pathology over and above the level of association found in general? To unravel this, one needs to compare patterns of risk for bereaved with non-bereaved controls. Obviously grief is non-existent in non-bereaved groups,

but proximal measures (e.g., depression) make comparisons with non-bereaved people possible. One can, for example, compare depression for (non-)bereaved men and women and establish the relative excesses between men and women.

What is the way forward in this complex area of research, to establish who is susceptible to CG? One step that Burke and Neimeyer suggest is a meta-analytical review of risk factor effect sizes, one that would include other relevant bereavement outcomes (PTSD etc.), different study designs, and diverse samples. Clearly, this is no easy task, but there may now be sufficient empirical basis to attempt it.

Processes and mechanisms

Scientific investigation in recent years has witnessed a move toward more micro-level examination of cognitive processes (on CG), as illustrated by Watkins and Moulds's focus on repetitive thinking (RT) and Golden's on autobiographical memory (AM) and overgeneral memory bias (OGM) processes in CG. These processes are examples of transdiagnostic processes, which are becoming more and more familiar in the field of CBT. Repetitive thought (Watkins & Moulds) encompasses processes that are relevant to normal and complicated grief, the consequences of RT varying according to whether its content is positive or negative, concrete or abstract. So there are subtypes with distinct functional consequences (negative and abstract with maladaptive/pathological functioning). Watkins and Moulds examined RT's specific role in integrating the loss into existing mental structures and detailing earlier unspecified operationalizations such as "working through." Golden examined AM and OGM specifically in relation to CG, showing that OGM bias is present in individuals with CG. Such processes have attracted considerable attention in recent years and undoubtedly represent an important line of future research as scientists use newly available techniques and apply lab methods, particularly to unravel more about underlying mechanisms associated with or underlying CG.

A range of additional processes and mechanisms have come under investigation in relationship to CG. O'Connor noted that self-regulation at the psychological as well as physiological level may be important in coping with pangs of grief and assist in acceptance of the death of an attachment figure. Avoidance (symptoms) has been examined not only in absent grief but in chronic grief (PGD) too (see Mikulincer & Shaver; O'Connor). Some knowledge about processes and mechanisms of CG has emerged from research inspired by CBT theorizing. In the work of Boelen and colleagues, three interrelated processes are identified: (a) insufficient elaboration and integration of the loss within autobiographical memory; (b) negative thinking; and (c) anxious and depressive avoidance behaviors. These authors reason that these three processes interact and play a mediating role in CG. Wagner's Internet intervention for CG contrasts with that of Boelen and colleagues but is also based on a CB framework. Three modules were included: self-confrontation, cognitive reappraisal, and social sharing. Quite different processes emerge from other treatment perspectives, such as the use of resilience as a family strength and group processes, in the family and psychotherapy group (Kissane et al.). Rynearson and colleagues' treatment included processes furthering mastery

of personal safety, confronting the death through "reliving," and developing an altered identity through re-engagement with activities and relationships.

Physiological processes/mechanisms are a growing focus of research. O'Connor provides evidence for a physiological co-regulation basis of CG. She reviews empirical work supporting the role of physiology and neurobiology in CG, drawing on her conceptual analysis of two types of physiological stress: (a) the general stress response (fight-or-flight), similar to CG criteria, including efforts to avoid thoughts of the deceased, associated with failure to integrate the reality of the death, leading to continuously realized acute grief; and (b) the attachment-specific stress response driven by loss of rewarding aspects of attachment, analogous to CG criteria including yearning for the deceased.

Investigators of processes underlying CG in this volume all point to the need for further empirical testing of their hypotheses. They recommend the use of multiple methods and extension beyond self-report questionnaires (social cognition techniques; diary-keeping methods), and incorporating experimental research to test the proposed directions of causality between variables. Research needs to establish whether these are the crucial pathways or central mechanisms in influencing clients' emotional problems, or only epiphenomena.

Treatment of complicated grief

Two topics strike us as particularly noteworthy in the context of professional treatment for CG. First, details to do with the conceptual basis of the programs themselves need consideration. Second, efficacy of intervention needs to be addressed.

Principles, paradigms, and procedures

Psychotherapeutic treatments for CG have been described in this book. How have they gone about treatment? What changes do the treatment programs aim to bring about? Just as investigators have identified different processes and mechanisms (described above), so are there differences in the principles, paradigms, and procedures adopted in interventions.

Not surprisingly, Watkins and Moulds suggest training individuals with CG to be more concrete or shift to more adaptive forms of RT, whereas Golden argues that OGM bias should be targeted in therapy, presenting evidence to support this conclusion. The treatment program of Boelen and colleagues includes different CBT interventions to achieve various aims: (a) to integrate the loss with existing knowledge, (b) to identify and alter unhelpful thinking patterns, and (c) to replace unhelpful avoidance strategies with more helpful ones. Wagner reviews Internet research on treating CG, covering various forms, from text-based approaches with therapist feedback to self-help treatments without guidance. Her own intervention follows a treatment program originally developed for PTSD, using structured writing assignments. Advantages of Internet over traditional methods have been discussed, including the possibility to interact with others any time one wants; anonymity and no geographic boundaries; a lower threshold (perhaps for men,

who are less inclined to accept psychotherapy?); the availability of social support without physical interaction and costs; and time for the therapist to reflect. However, it may not suit all clients; the potential for misunderstandings is possibly greater; dealing with a crisis such as suicidality may be more difficult; and there is a need for careful diagnostic procedures before participation (see Wagner).

Although most therapy for CG has been directed toward individuals, we included two very different group perspectives. First, over a number of decades, Kissane and his colleagues have developed a program of family therapy, following the understanding that loss does not occur in a social vacuum but is shared by people, commonly the family. It is also different from other treatments in that it is initiated during anti-cancer treatment before (and continuing through) bereavement, adding the possibility of *preventing* the development of CG, by identifying problem families, and also (as in other approaches) of *ameliorating* it. Kissane and colleagues do not take the stand that family therapy should replace individual modes but argue that it may be an important adjunct to them. These investigators explain that the hypothesized mechanism of change is the strengthening of family bonds. Second, Piper and Ogrodniczuk describe cost-effective time-limited short-term therapy groups, two different models, specifically for patients who meet CG criteria. They describe two types of group therapy, interpretive (to enhance patient insight about repetitive conflicts and traumas associated with their losses) and supportive (the therapist gratifies the patient, provides guidance, and provides non-interpretive interventions), and describe their ongoing research on the effectiveness of these.

Different treatment paradigms seem appropriate for different subgroups. Raphael and colleagues describe assessment and management of CG with trauma syndromes as comorbidity, giving examples of programs for treating such comorbidity, for adults and children. Dyregrov and Dyregrov mention the need to strengthen parental capacity for children, indicating that there may be unique elements at stake in the case of children with CG.

Other approaches reflect theoretical analyses (and their related empirical findings). For example, Mikulincer and Shaver provide an attachment theory perspective on grief resolution and counseling, proceeding on the assumption that, if attachment insecurities are risk factors for CG, then regaining a sense of attachment security (e.g., security priming or provision of a secure base) should ameliorate CG.

The concluding comments on the previous section apply here too. In the context of therapy, we need to establish the specific processes or mechanisms that bring about favorable outcomes of intervention programs (e.g., Boelen and colleagues ask "whether or not CBT indeed produces alleviation of distress because it lessens negative cognitions and avoidance"; Chapter 16).

Efficacy of intervention for CG

There has been pressure for evidence-based treatment (including RCTs) in recent decades, and some of the main players in this domain have contributed to this book. The results of the effectiveness of psychotherapeutic treatment for CG have

been quite positive. Piper and Ogrodniczuk and Wagner reviewed studies (the latter including recent meta-analysis) of efficacy of intervention programs in general, concluding that they are effective for CG. Similar conclusions were drawn by Wagner for Internet studies, and she gave evidence for effectiveness of her own program for CG. Nevertheless, limitations were pointed out: Little is as yet known about the mechanisms through which the structured writing or written disclosure in these programs leads to improvement in CG, a feature that others identified too (e.g., Piper & Ogrodniczuk). Kissane and colleagues have been examining the efficacy of family intervention in improving family communication and report some indication that family therapy reduced the rate of development of CG preventively. This is an ongoing program of research in which efficacy is being further investigated. Boelen and colleagues were able to provide some evidence for the postulated underlying processes as well as the effectiveness of CT treatment for CG. Piper and Ogrodniczuk performed different trials and compared the two models of group treatment, documenting patterns of benefits for some groups. Rynearson and colleagues drew attention to the paucity of research on efficacy of intervention following the extreme case of bereavement following a violent death, in which professional treatment may be more needed than following non-violent, timely deaths.

There are considerable difficulties in conducting such research, as Piper and Ogrudniczuk describe. For example, follow-up investigation of the efficacy of an intervention program at later points in time is essential (e.g., symptoms may increase, before any benefits of the treatment become evident), but this not always done. There are different models and ways to evaluate efficacy for reducing CG. Usually this includes treatment and a waiting-list control condition, whereas an attention-placebo control condition would be better but is not always feasible.

In our view, it is essential that high-quality studies be conducted to establish the efficacy of clinical intervention for CG. Providing sound evidence that our therapeutic techniques are effective – even economically advantageous – can help convince governments and funding agencies of the importance of supporting bereaved people who need help.

Conclusions

In this closing chapter, we have highlighted both the advancements in science as well as limitations in knowledge about CG that have emerged from the foregoing chapters of this book. We have indicated directions for future research in this area. So what about the future perspective in general? In our view, this can build on the multidisciplinary approach to CG, as represented in the pages of our volume. There would be advantages to extending this multidisciplinary approach to make it a truly interdisciplinary one, whereby researchers would collaborate and share their particular vantage points, working toward a common knowledge base to acquire deeper understanding of CG. Indeed, some chapters already show evidence of following such interdisciplinary lines, as exemplified in their integration of different types of theoretical perspectives and multi-method approaches.

This interdisciplinary effort should, we think, not only take effect on a purely scientific level, but also involve practice (and at times even other societal stakeholders such as policy makers). In most publications on CG (ours is for the most part no exception to this) the central idea has been that scientists can provide knowledge that can be subsequently applied in practice (and in society more generally). However, the channel of scientific communication and inspiration in the CG field needs to go both ways: Research needs to look toward practice (and societal concerns more generally) for much of its impetus too. To illustrate this from the therapy area: Some clinicians may consider a particular technique to be effective, but it may not be evident precisely why this intervention works. Researchers can take note of the therapeutic principles adopted in the therapeutic approach, and probe further to discover underlying processes that may explain why the approach or technique is actually effective. So, it is necessary not only to listen to researchers in order to build on our CG knowledge base, but to listen to clinicians as well, and to try to understand what they are in fact doing and then unravel what it is that makes their techniques effective.

Following an interdisciplinary approach and such dual-direction strategies as that described above will, in our view, lead to greater wisdom concerning the phenomena and manifestations of complicated grief, and help to provide health care professionals with a scientifically grounded foundation for conducting their work with bereaved persons.

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